STORAGE NAME: h1253s1.hcc.doc
DATE: April 19, 2001

HOUSE OF REPRESENTATIVES
AS FURTHER REVISED BY THE
COUNCIL FOR HEALTHY COMMUNITIES
ANALYSIS

BILL #: CS/HB 1253

RELATING TO: Health Insurance

SPONSOR(S): Committee on Insurance and Representative Farkas

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH PROMOTION YEAS 11 NAYS 0
(2) INSURANCE YEAS 14 NAYS 0
(3) COUNCIL FOR HEALTHY COMMUNITIES YEAS 13 NAYS 0
(4)
(5)

I. SUMMARY:

In 1992, the Legislature enacted the Employee Health Care Access Act (the Act). An express purpose of the act is to promote the availability of health insurance coverage to small employers (i.e., under the act, at least 1 but not more than 50 eligible employees) regardless of their claims experience or their employees' health status.

The committee substitute would make several changes to the Act. It would:

- Authorize insurers to offer limited benefit policies or contracts as a complement to medical savings account programs established by small employers for the benefit of their employees.
- Require small employer carriers offering employers a basic or standard health benefit plan or limited benefit policy or contract to make a more limited set of disclosures.
- Limit the application of laws restricting or limiting deductibles, copayments, maximum payments for treatment of specific diseases or conditions when a limited benefit policy or contract is offered to a small employer, and allow the limited benefit policy or contract to be offered to an employer with 51 or more employees, if also offered to a small employer.
- Require the appointment of a new health benefit plan committee under the Act every odd-numbered year.

The committee substitute would also authorize the Agency for Health Care Administration and the Department of Insurance to pilot the use of "health flex plans" in three areas of the state having the highest number of uninsured residents. These plans would not be subject to the licensing requirements applicable to health insurers or health maintenance organizations (HMOs), but would be subject to the Unfair Trade Practices Act. Eligibility would be limited to uninsured state residents age 64 or younger with a family income less than or equal to 200 percent of the federal poverty level.

The committee substitute would take effect October 1, 2001.

See Section VI. of this analysis for an explanation of a "strike-everything" amendment adopted by the Council for Healthy Communities on April 18, 2001.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1. Less Government Yes [x] No [] N/A []

The committee substitute would reduce the regulation of health plans offered by carriers to small employers.

2. Lower Taxes Yes [] No [] N/A [x]

3. Individual Freedom Yes [] No [] N/A [x]

4. Personal Responsibility Yes [] No [] N/A [x]

5. Family Empowerment Yes [] No [] N/A [x]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

The Employee Health Care Access Act

In 1992, the Legislature enacted the Employee Health Care Access Act (the act)[1]. An express purpose of the act is to promote the availability of health insurance coverage to small employers (i.e., under the act, at least 1 but not more than 50 eligible employees) regardless of their claims experience or their employees' health status.

According to the Department of Insurance, as of March 8, 2001, there are 32 carriers offering small employer health benefit plans. This number reflects a continuing drop in recent years in the number of carriers offering small employer benefit plans in Florida. In 1997, there were 116 carriers, and in 1998 there were 90 carriers, offering small employer benefit plans in Florida.

Limited Benefit Policies or Contracts

Under the Employee Health Care Access Act, a "limited benefit policy or contract" is a policy or contract providing coverage for named insureds for a specific named disease, accident, or limited market such as the small group market.

Plan Types

For employers with two or more employees, Florida law required carriers to offer, at a minimum, "standard" and "basic" health care plans. These plans are to be "low cost health care plans."[2] The "standard" plan is intended to be generally comparable to a major medical policy typically sold in the group market, with cost containment features intended to make the policy more affordable. The "basic" plan includes certain standard policy benefits with certain restrictions on the benefits and utilization, as well as other features designed to lower the cost of this coverage. Florida law requires each carrier to offer not only the standard and basic plans, but also any other small

[1] Section 627.6699, FS.
[2] Section 627.6699(2)(b), FS.

employer group plans sold by that carrier. (In addition to the basic and standard plans, small employers typically offer additional plans with variations such as higher benefit levels or additional coverages.)

Disclosure Requirements

Small employer carriers offering employee coverage under a basic or standard plan or a limited benefit policy or contract must make certain disclosures to small employer groups including:

- Explaining the mandated benefits and providers not covered under the policy or contract;
- Explaining the managed care and cost control features of the policy or contract; and
- Explaining the primary and preventative care features of the policy or contract

Components of the Act

- Modified Community Rating - Community rating is a method of developing health insurance rates taking into account the medical and hospital costs in the entire community or area to be covered. Individual characteristics of the insured employer are not considered. Florida utilizes a variation on this method, allowing carriers to consider a limited set of characteristics specific to the individuals covered under the policy. Factors include age, gender, family composition, tobacco usage, and geographic location (s. 627.6699(3)(n), F.S.). Small group carriers may adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium may be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these additional factors.

- Guarantee-Issue Requirements - Under the act, carriers are required to offer and issue certain health insurance plans, including basic and standard plans, to every eligible small employer with 2 to 50 eligible employees, regardless of their claims experience or health status. Guarantee-issue requirements do not apply to employers with one employee, sole proprietors, and self-employed individuals. Instead, small employer carriers must provide an annual open enrollment period for these persons during the month of August.[3] Coverage begins on October 1, unless the insurer and the policyholder agree to a different date.

- Exemption from Mandates - State laws frequently require private health insurance policies and health maintenance organization (HMOs) contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are commonly referred to as "mandated [health] benefits."[4] These generally do not apply to small employer policies,

[3] Although CS/SB 1300 (2000) provided for the 1-month open enrollment to begin in August 2000, another bill which passed, CS/CS/HB 59 (2000), delayed the implementation of this provision until August 2001, and continued to provide for guaranteed-issue of one life groups until that time. In November 2000, the Department of Insurance and the state's small-group health insurers entered into an agreement to allow Florida businesses with just one employee to buy or switch health insurance plans in a special open enrollment period for the month of December 2000. The agreement also allowed sole proprietor companies to keep any existing coverage when it came up for renewal. The agreement resolved differences between the Department of Insurance and managed care companies and insurers over the interpretation of changes the Legislature made to the Act during the 2000 Legislative Session.

[4] The House Insurance Committee staff identified 51 mandated health benefits applicable to either private insurer or HMO plans. In a separate count, Blue Cross/Blue Shield Association placed the number of mandates in Florida Statutes at 44—the second highest in the nation, compared to an average of 25 among all states. Managing Mandated Health Benefits: Policy Options for Consideration; Prepared by the Staff of the House of Representatives Committee on Insurance; Representative Stan Bainter, Chair; January 28, 2000.

unless made applicable by the Legislature.[5] Despite this limitation, a study completed by the Insurance Committee found these plans contain most of the mandated benefits applicable to private insurance and HMO group plans.[6]

C. EFFECT OF PROPOSED CHANGES:

The committee substitute would make several changes to the Employee Health Care Access Act. Specifically, it would:

- Authorize small employee carriers to offer a limited benefit policy or contract as a complement to a medical savings account program established by a small employer for the benefit of its employees.[7]
- Limit the disclosures small employer carriers must make to small employers, but codify a specific disclosure statement.
- Limit the application of laws restricting or limiting deductibles, copayments, maximum payments limitations for treatment of specific diseases or conditions when a limited benefit policy or contract is offered to a small employer, and allows this coverage to be offered to an employer with 51 or more employees if offered by a carrier to a small employer.
- Require the appointment of a new health benefit plan committee under the Act every odd-numbered year.

The committee substitute would also:

- Authorize the Agency for Health Care Administration and the Department of Insurance to pilot the use of "health flex plans" in three areas of the state having the highest number of uninsured residents. These plans would not be subject to the licensing requirements applicable to health insurers or HMOs, but would be subject to the Unfair Trade Practices Act. Eligibility would be limited to uninsured state residents age 64 or younger with a family income less than or equal to 200 percent of the federal poverty level.

D. SECTION-BY-SECTION ANALYSIS:

N/A

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

[5] Section 627.6699(15(a), F.S.
[6] See footnote 4.
[7] A Medical Savings Account as defined in s.220(d) of the Internal Revenue Code, allows persons to contribute tax deferred money to an account to use for paying their medical bills. As long as the money is withdrawn for qualified medical expenses, the distributions are completely tax free under federal law. A Medical Savings Account gives individuals an alternative way to pay for health care.

2. Expenditures:

N/A

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Certain uninsured Floridians may be afforded expanded opportunities to procure health insurance coverage through the proposed health flex plan pilot.

Small employers may have an improved opportunity to offer a limited benefit policy to their employees as a result of this bill.

Carriers serving small employers may have an opportunity to market limited benefit coverage, not only to the small employers but also to employers with 51 or more employees.

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

On page 10, line 9, the committee substitute refers to insurers for purposes of those who would offer small employer coverage. This paragraph is subsequently amended to specifically authorize HMOs to seek approval to offer such coverage. This internal inconsistency could result in a question as to whether an HMO is an insurer in this context.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 29, 2001, the Committee on Health Promotion adopted the following amendments and passed the bill unanimously:

- Amendment #1 created "health flex plans" including: Legislative intent; definitions for five key terms; authorization for a pilot program; criteria for approval or disapproval of health flex plans jointly by the Agency for Health Care Administration and the Department of Insurance; exemptions of approved plans from certain licensing requirements; eligibility enrollment criteria; recordkeeping requirements; provisions for denial, nonrenewal, or cancellation of coverage; specification of nonentitlement; and civil liability against plan entities by the Agency for Health Care Administration.
- Amendment #2 required any limited benefit policy or contract to comply with s. 627.419(1)-(4), F.S., providing reference to the terms and conditions of an insurance contract, and services by dentists, optometrists, podiatric physicians, and chiropractic physicians.
- Amendment #3 amended the definitions of "limited benefit policy or contract" to include a medical savings account program established by a small employer and "small employer carrier" to include a carrier that issues only limited benefit policies to small employers.
- Amendment #4 further amended the definition of a "limited benefit policy or contract" to include specifically named "coverages that fulfill a reasonable need by providing more affordable health insurance."

On April 11, 2001, the Committee on Insurance adopted HB 1253 as a committee substitute, incorporating all amendments adopted by both the Health Promotion Committee and the Insurance Committee.

The committee substitute differs from the original bill in that the committee substitute would:

- Authorize the Agency for Health Care Administration and the Department of Insurance to pilot the use of "health flex plans" in three areas of the state having the highest number of uninsured residents. These plans would not be subject to the licensing requirements applicable to health insurers or HMOs, but would be subject to the Unfair Trade Practices Act. Eligibility would be limited to uninsured state residents age 64 or younger with a family income of less than or equal to 200 percent of the federal poverty level.

- Require any limited benefit policy or contract to comply with s. 627.419(1)-(4), F.S., providing reference to the terms and conditions of an insurance contract, and services by dentists, optometrists, podiatric physicians, and chiropractic physicians.

- Restore several of the disclosures small employer carriers must make to small employers concerning basic or standard health plans and limited benefit policies or contracts. The bill, as amended, had proposed to eliminate all of the currently required disclosures and replace them with a specific disclosure statement.

- Require the appointment of a new health benefit plan committee under the Act every odd-numbered year.

On April 18, 2001, the Council for Healthy Communities adopted a "strike-everything" amendment and one amendment to the "strike-everything" amendment. The amendment differs from the CS as follows:

- Modifies the definition of "limited benefit policy or contract" to include those policies or contracts that fulfill a reasonable need "by providing more affordable health insurance" and deletes reference to medical savings accounts.
- Deletes proposed revisions made to definition of "small employer carrier."
- Revises health plan committee appointments by the commissioner from every odd-numbered year to every 4th year.
- Revises language related to required disclosures by small employer carriers to small employers to specify that disclosures be in writing, and require an "outline of coverage" with specified information.
- Reinstates and revises the requirement that "the prospective policyholder of limited plans must acknowledge, in writing, that he or she has been offered the opportunity to purchase any health benefit plan offered by the carrier and that the prospective policy holder had rejected that coverage."
- Reinstates requirement for department approval of marketing materials.
- Specifies that any covered disease or condition may be treated by any physician, without discrimination who is licensed or certified to treat the disease or condition, and deletes reference to the requirement that any limited benefit policy or contract must comply with s. 627.419(1), (2), (3), and (4), F.S., relating to construction policies and access to specified providers.

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

Prepared by:	Staff Director:
Tonya Sue Chavis, Esq.	Phil E. Williams

AS REVISED BY THE COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Stephen T. Hogge	Stephen T. Hogge

AS FURTHER REVISED BY THE COUNCIL FOR HEALTHY COMMUNITIES:

Prepared by:	Council Director:
Tonya Sue Chavis, J.D.	Mary Pat Moore