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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH PROMOTION
ANALYSIS

BILL #: HB 1253

RELATING TO: Limited Benefit Policies or Contracts

SPONSOR(S): Representative Farkas

TIED BILL(S):

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

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

I. SUMMARY:

HB 1253 provides additional criteria for limited benefit policies or contracts. The bill authorizes the offering of a limited benefit policy or contract as a complement to a medical savings account program established by a small employer for the benefits of its employee.

The bill deletes certain requirements relating to limited benefit policies and contracts including those relating to: written statements; written certifications and acknowledgments; timeframes; termination of coverage; and submission of marking communications for Department of Insurance review.

The bill requires a small employer carrier offering health maintenance organization coverage to file policy, contract, form, or rate information, including applications, enrollment forms, policies, contracts, endorsements, and disclosure forms with the Department of Insurance and requires that the carrier receive departmental approval prior to offering coverage.

The bill limits application of laws restricting or limiting deductibles, copayments, maximum payments, or payment limitations for treatment of specific diseases or conditions when a limited benefit policy or contract is offered to a small employer, and allows such coverage to be offered to an employer with 51 or more employees if offered to a small employer.

The bill requires benefits to be reasonable in relation to premium charged, and to comply with medical loss ratio requirements, but such coverage need not comply with specified form and rate filing requirements.

The bill takes effect October 1, 2001.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

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

General Background

According to a Kaiser Family Foundation study published in September 2000, many workers and retirees who depend on employer-sponsored health insurance are likely to face significant premium increases in the near future, and some small employers may stop offering coverage. The anticipated premium hikes come in addition to an average increase of 8.3 percent in 2000, and both are driven largely by higher costs for care, including prescription drug costs.

The report, based on a survey of 3,402 employers nationwide, predicted that premiums will continue to go up and that "employers may respond to the rising cost of health insurance [by passing] some portion of the increased cost on to employees." In interviews, managers of companies large and small, as well as health insurance analysts, have said that many workers can expect to pay even bigger percentages in the future, especially in a weak economy.

The resumption of rapidly rising health expenditures reflects, in part, the limits of managed care as a means to control how much treatment Americans receive and how much such treatment costs. Over the last decade, employers have nearly universally embraced health maintenance organizations, preferred-provider plans, and other forms of managed care, believing that such arrangements would rescue them from spiraling health costs of the late 1980s and early 1990s. For several years, managed care helped to stabilize health costs by reducing payments to hospitals, doctors, and other providers of care and by limiting patients' access to expensive medical specialists. More recently, however, managed care companies have, themselves, been buffeted by the rapid escalation of drug prices, which they are passing on to employers. At the same time, political pressures and public opposition to the HMO constraints on care have prompted the industry to loosen up in ways that cost more, permitting patients somewhat more care and more choice of doctors.

From spring 1999 to the spring of 2000, the study found, insurance costs shared by employers and employees "increased five percentage points more than the overall inflation rate and four percentage points more than the rise in workers' earnings." With the 8.3 percent hike in premiums, the average cost of covering a single employee rose to $2,426 a year, and to $6,351 for an average family, the report said. With employers competing fiercely for workers in a robust economy, most

employees of big companies have not yet felt the bite of increased premiums, the report said. However, analysts said, it is only a matter of time until the costs trickle down.

[Source: http://www.kff.org]

Medical Savings Accounts

A Medical Savings Account (MSA) allows a person to contribute tax deferred money to an account that a person would use for paying his or her medical bills. As long as the money is withdrawn for qualified medical expenses, the distributions are completely tax free. Qualified medical expenses are any medical expenses that are typically allowed deductions on a federal tax Schedule A. With an MSA, a person is able to pay his or her medical bills with pre-tax dollars (tax free dollars). There is no need to itemize or reduce medical expenses by 7.5% of adjusted gross income as must be done for Schedule A medical expense deductions.

Under most MSA proposals, individuals and their employers could make regular, tax-free deposits to MSAs, which would be the property of the individual. The individual could withdraw money without penalty only to pay medical expenses or health insurance premiums. MSAs give individuals a new way to pay for health care. Under traditional health insurance, people make monthly premium payments to an insurer and the insurer pays medical bills as they are incurred. With an MSA, people confine health insurance to catastrophic coverage, reduce their monthly premium payments, and make deposits to an MSA instead. Insurance would pay for expensive treatments that occur infrequently, while individuals would use their MSA funds to pay small bills for routine services.

Florida's Small Group Insurance Reform -- The Employee Health Care Access Act

History

In 1992, the Legislature enacted reforms to the small group insurance market, called 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 regardless of their claims experience or their employees' health status. As enacted in 1992, the act had three key components. These were:

- Modified Community Rating - Community rating is a method of developing health insurance rates which takes 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, which allows carriers to consider a limited set of individual characteristics relating to the individuals actually covered. These factors include age, gender, family composition, tobacco usage, and geographic location (s. 627.6699(3)(n), F.S.). Florida's "modified community rating" method does not allow carriers to adjust premiums for an employer based on any other factors, including an employee's claims experience or health status.

- Guarantee-Issue Requirements - Under the act, carriers were required to offer and renew certain health insurance plans, including basic and standard plans, for small employers regardless of claims experience or health status. For employers with one or two employees, Florida law required carriers to offer, at a minimum, "standard" and "basic" plans. The "standard" policy is generally intended to be comparable to a major medical policy typically sold in the group market, with cost containment features intended to make the policy affordable. The "basic" policy 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. For employers with 3 to 50 employees, Florida law required each carrier to offer not only the standard and basic plans, but any other small 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.)

- Exemption from Mandates - Certain small employer policies are exempt from "mandated health benefits" (i.e., laws which require private insurer and HMO health plans to provide certain service or provider coverages) unless made applicable by the Legislature.

2000 Revisions

In the 2000 Legislative Session, the Legislature made the following changes to the Employee Health Care Access Act:

- Eliminated the prohibition that rates not be based on the health status or claims experience of any individual or group and allowed limited use of such factors. Small group carriers are now allowed to 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.

- Deleted the guarantee-issue requirements for employers with one employee, sole proprietors, and self-employed individuals and, instead, provided for an annual open enrollment period for such persons, during the month of August. Coverage begins on October 1, unless the insurer and the policyholder agree to a different date. Any one-person small employer getting coverage must not be formed primarily for the purposes of buying health insurance and if an individual hires his or her spouse and dependent children as employees, the entire family unit is considered a one-person group, unless both spouses are working full-time.

[**Note**: 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 such 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 be able 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 comes 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 Employee Health Care Access Act during the 2000 Legislative Session.]

- Allowed small group carriers to provide a credit to reflect the administrative and acquisition expense savings resulting from the size of the group. This is expected to result in about 3 to 5 percent credit for larger groups (for example, 25 to 50 employees), and be transferred as an overall cost increase to the smaller groups.
- Prohibited small group carriers from using "composite rating" for employers with fewer than 10 employees, which would prohibit a premium statement to an employer that averages the rates for all employees and, instead, requires the carrier to list the rate applicable to each employee based on that employee's age and gender. (However, the total premium remains unchanged).

- Specified certain family-size categories that small group carriers may use.
- Clarified the applicability of additional rate filling procedures and standards for insurers and HMOs, respectively.

Small Employer Carriers in Florida

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.

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." These mandated benefits affect plans covering an estimated 33 percent of all Floridians and 40 percent of insured Floridians. The nearly one-half of all Floridians who are uninsured or covered under Medicare or Medicaid are not affected. Self-funded plans provided by employers are similarly unaffected because the federal Employee Retirement Income Security Act of 1974 (ERISA) generally preempts state regulation of these plans.

On January 28, 2000, the House Committee on Insurance published its interim project entitled "Managing Mandated Health Benefits: Policy Options for Consideration." The report recognized that while most mandates provide social and health benefits to consumers, "most mandated benefits contribute to the cost of health insurance premiums." Key findings of the report included the following:

- Florida has more mandated benefits than nearly every other state;
- An estimated 33 percent of all Floridians are covered under health plans subject to mandated benefits;
- It is not always apparent in statute which health plans are subject to which state-mandated health benefits;
- The costs of mandated benefits in Florida have not been calculated; and
- The statutorily-prescribed provisions for managing mandated benefits legislation have not been followed.

By most measures, Florida has more mandated benefits than nearly every other state. In preparing this report , 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. [Source: Blue Cross/Blue Shield Association, State Legislative Health Care and Insurance Issues.]

C. EFFECT OF PROPOSED CHANGES:

HB 1253 provides a series of "WHEREAS" clauses to provide background for the bill.

The bill:

- Provides additional criteria for limited benefit policies or contracts.

- Authorizes the offering of 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.
- Limits application of laws restricting or limiting deductibles, copayments, maximum payments, or payment limitations for treatment of specific diseases or conditions when a limited benefit policy or contract is offered to a small employer, and allows such coverage to be offered to an employer with 51 or more employees if offered by a carrier to a small employer.
- Requires benefits to be reasonable in relation to premium charged, and to comply with medical loss ratio requirements, but such coverage need not comply with specified form and rate filing requirements.
- Deletes requirements for limited benefit policies and contracts relating to: written statements; written certifications and acknowledgments; timeframes; termination of coverage; and submission of marketing communications for Department of Insurance review;
- Requires small employer carrier offering health maintenance organization coverage to file specified information with the Department of Insurance, and requires the carrier to receive departmental approval of same prior to offering coverage.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act, as follows:

Expands paragraph 627.6699(3)(m), F.S., defining "limited benefit policy or contract" to include a medical savings account program established by a small employer for the benefit of its employees.

Deletes paragraph 627.6699(12)(d), F.S., relating to the following:

- Written statement requirements provided by the carrier for a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for any small employer;
- How such written statements must be presented;
- Written certifications and acknowledgements from prospective policyholders that small employer carries must obtain before issuing a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract;
- Timeframes for providing such certifications and acknowledgements;
- Termination of coverage under the policy or contract for any material statement made by the applicant which falsely certifies as to the applicant's eligibility for coverage; and
- Submission of marketing communications intended for use in marketing a health benefit plan in this state for review to the Department of Insurance prior to use and disclosure requirements for such materials.

Renumbers paragraph 627.6699(e) as paragraph (d). This paragraph relates to small employer carrier submission, and Department of Insurance approval, of a policy, contract, form, or rate prior to offering of coverage by a carrier. Amends the paragraph as follows:

- Adds a statutory reference to s. 641.31, F.S., relating to health maintenance organization contracts. The effect of this revision is to require small employer carrier offering health maintenance organization coverage to file policy, contract, form, or rate, including applications, enrollment forms, policies, contracts, endorsements, and disclosure forms with the Department of Insurance and to require the carrier to receive departmental approval of same prior to offering coverage.

- Provides an exception as contained in s. 627.6699(15)(b), F.S.

Amends paragraph (a), relating to the nonapplicability of certain types of laws, to include the nonapplicability of a law restricting or limiting deductibles, copayments, annual or lifetime maximum payments, or payments for treatment of a specific disease or condition when offered or delivered to a small employer. Authorizes a limited benefit policy or contract which is offered or delivered to a small employer to be offered or delivered to an employer with 51 or more eligible employees.

Adds paragraph (b), requiring the benefits in a limited benefit policy or contract offered or delivered to a small employer to be reasonable in relation to the premium charged, and to comply with the small employer group health product medical loss ratio requirements established by the Department of Insurance pursuant to ss. 627.410(6)(b) and 641.31(2), F.S. Provides an exemption from form and rate filing requirements of ss. 627.410 and 641.31, F.S, for a limited benefit policy or contract offered or delivered to a small employer.

Renumbers existing paragraph (15)(b) as (c).

Section 2. Provides that this act shall take effect October 1, 2001.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

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:

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 to employers with 51 or more employees also.

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:

Staff comments:

On page 4, line 15, the bill 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.

On page 5, lines 6-14, the bill indicates that the benefits of a limited benefit policy or contract offered or delivered to a small employer be reasonable in relation to the premium charged and comply with the small employer group health product medical loss ratio requirements established by DOI as authorized under specific statutes. This raises two questions. First, in specifying this "compliance,'" there is no indication as to any specific DOI review and approval of compliance. Second, since this paragraph goes on to exempt such policies and contracts from DOI's form and rate filing requirements, will DOI have the detail it needs to determine compliance?

Agency for Health Care Administration comments:

In its analysis of this bill, the Agency for Health Care Administration noted that allowing limited benefit policies offered to small employers to also be offered to employers with 51 or more employees "represents a significant change to the law."

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 creates “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 requires 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 amends 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 amends 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.”

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

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