STORAGE NAME: h1253.in.doc
DATE: April 9, 2001

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
INSURANCE
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:

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.

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.

The bill 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.

The bill would delete certain small employer carrier disclosure requirements relating to limited benefit policies and contracts.

The bill would limit the 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 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.

The bill would require benefits in a limited benefit policy or contract to be reasonable in relation to premium charged, and to comply with medical loss ratio requirements. However, these policies or contracts would be exempt from the form and rate filing requirements.

The bill would take effect October 1, 2001.

Amendments

There are four amendments adopted by the Committee on Health Promotions traveling with the bill. See Section VI. of this analysis for an explanation.

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:

Health Insurance Costs[1]

According to a Kaiser Family Foundation study published in September 2000, many workers and retirees dependent on employer-sponsored health insurance are likely to face significant premium increases in the near future. 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, indicated that many workers can expect to pay even bigger percentages in the future, especially in a weak economy.

The Employee Health Care Access Act

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.

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. Small employer carriers offering coverage under limited benefit policies or contracts must make certain disclosures to small employer groups including:

[1] The study may be reviewed at: http://www.kff.org

- 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

Key Components of the Act

As enacted in 1992, three key components of the act are:

- 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 their 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 - 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."[2] 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. However,a study completed by the Insurance Committee found that these plans contain most of the mandated benefits applicable to private insurance and HMO group plans.[3]

[2] 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.
[3] Id.

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

- Modified Community Rating - 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.

- Guarantee-Issue Requirements - 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.[4] 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.

- Exemption from Mandates - 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.

- Composite Rating - 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).

C. EFFECT OF PROPOSED CHANGES:

HB 1253 provides a series of "WHEREAS" clauses, including a statement of legislative intent.

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 benefit of its employees.[5]

- Deletes certain small employer disclosure requirements and the requirement to obtain certain certifications and acknowledgments for limited benefit policies and contracts.

---

[4] 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.

[5] 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.

- 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 department form and rate filing requirements.

- 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:

N/A

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:

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?

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 by Health Promotion Committee (Representative Murman) (page 1, line 31) 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 by Health Promotion Committee (Representative Farkas) (page 5, line 5) 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 by Health Promotion Committee (Representative Farkas) (page 2, lines 1-13) 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 by Health Promotion Committee (Representative Farkas) (page 2, lines 9-11) 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

AS REVISED BY THE COMMITTEE ON INSURANCE:

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