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HOUSE OF REPRESENTATIVES

COUNCIL FOR COMPETITIVE COMMERCE
ANALYSIS

BILL #: CS/HB 913

RELATING TO: Health Care

SPONSOR(S): Council for Competitive Commerce, Rep. Farkas and others

TIED BILL(S): None

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

(1) INSURANCE YEAS 15 NAYS 0
(2) HEALTH REGULATION YEAS 8 NAYS 2
(3) COUNCIL FOR COMPETITIVE COMMERCE YEAS 11 NAYS 1
(4)
(5)

I. SUMMARY:

The Employee Health Care Access Act was created in 1992 to improve the ability of employers with 50 or fewer employees to provide group health insurance regardless of their claims experience or their employees' health status. The act modifies statutory requirements generally applicable to group health plans in order to make coverage for small groups more affordable. Carriers are required to offer "standard" plans that are comparable to typical major medical group health plans, "basic" plans that contain additional restrictions, and, when an employer rejects standard and basic coverage, "limited" plans that apply only to specific diseases, accidents, or markets and are not subject to coverage mandates.

CS/HB 913 makes the following major changes, effective October 1, 2002:

- Removes restrictions on the coverage that must be provided in a "limited" plan and renames these plans as "flexible" plans.
- Specifies that a flexible benefit policy must provide an annual maximum benefit, which must be $10,000 or more.
- Allows small employer carriers to rate small employer groups of 1 employee separately from small employer groups of 2 to 50 employees;
- Allows an increase in the rate applicable to small employer groups of 1 employee, subject to a rate cap of 150 percent above the small employer carrier's approved rate (the rate cap would be 125 percent for policies in effect on July 1, 2001);
- Requires the appointment of a new health benefit plan committee (which determines the benefits provided in standard and basic plans) every 4 years beginning October 1, 2003; and
- Provides that restrictions on deductibles, coinsurance, copayments, annual benefits, and lifetime benefits do not apply to any flexible benefit policy or other policy offered or delivered to a small employer unless the restriction is specifically made applicable by law.

The bill does not appear to have a fiscal impact on state or local government.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

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

The bill reduces the regulation of health plans offered by carriers to small employers and allow small employer carriers to issue the same "flexible health benefit policies," formerly "limited benefit policies," to large employers, as well.

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

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

The bill increases the options available to small employers who wish to provide health insurance coverage for their employees.

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

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

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. The components of the Act applied toward this purpose are group rating through the use of "Modified Community Rating," comparability of policies through the formulation and approval of "standard" and "basic" plans that reduce the impacts of mandated health benefits, and guarantee-issue to any small employer seeking coverage.

According to the Department of Insurance, as of December 31, 2001, there were 28 carriers offering small employer health benefit plans with additional withdrawals pending. 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 offering small employer benefit plans in Florida. In 1998, there were 90 small employer carriers. While there has been a reduction in the number of carriers offering small employer group coverage, the market may nonetheless be competitive at current or lower levels of carrier participation. Some of the reduction in active small employer carriers may result from de-listing inactive small employer carriers and some consolidation in the health market generally.

According to recent membership surveys by the Florida Chamber of Commerce, 77 percent of employers offered health insurance benefits to their employees in fall of 2001. Earlier editions of the survey indicated that 86 percent of employers offered these benefits in 2000 and 91 percent offered them in 1999.

[1] Section 627.6699, F.S.

Health Benefit Plan Committee

As part of the 1992 enactment, a health benefit plan committee, appointed by the Insurance Commissioner, was authorized to formulate and file the “standard” and “basic” plan types for approval by the Department of Insurance. Following its creation in 1992, the health benefit plan committee met once to formulate the plans, which were submitted and approved by the Department. It has not met since that time. While statute authorizes the Insurance Commissioner to appoint a new health benefit plan committee for the purpose of recommending modifications to the approved plans, this has not occurred.

Plan Types

Florida law requires carriers issuing coverage to small employers with two or more employees to offer, at a minimum, "standard" and "basic" health care plans. These plans are to be “low cost health care plans.” [2] In addition to the required offer of “standard” and “basic” plans, the Act requires the carrier to offer any other small employer group plans sold by that carrier or so called “street” plans. The small employer carrier also is allowed to offer a “limited” benefit policy.

Standard Plan - required

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. (See *Mandates Applicable to Standard and Basic Plans*, under Mandated Health Benefits below, for a description of mandatory benefits.)

Basic Plan - required

The "basic" plan must include all of the required benefits of the “standard” policy. These required benefits are subject to certain restrictions on benefits and utilization, as well as other features designed to lower the cost of this coverage. (See *Mandates Applicable to Standard and Basic Plans*, under Mandated Health Benefits below, for a description of mandatory benefits.)

Street Plan – optional

Small employer carriers typically offer “street” plans with variations such as higher benefit levels or additional coverage. “Street” plans are subject to form filing and approval requirements and must provide the “mandated [health] benefits” applicable to the “standard” and “basic” plans. (See *Mandates Applicable to Standard and Basic Plans*, under Mandated Health Benefits below, for a description of mandatory benefits.)

Limited Benefit Policy - optional

Upon the employer’s written rejection of the “standard” and “basic” plans, small employer carriers are allowed to offer a “limited” benefit policy. This is a policy that covers a specific disease(s), accident, or limited market. There are no minimum coverage requirements and mandated health benefits do not apply.

Mandated Health Benefits

[2] Section 627.6699(2)(b), F.S.

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." While mandated health benefits only apply to small employer group coverage where the Legislature expressly applies them,[3] a study completed by the Insurance Committee in 2000, found these plans contain most of the mandated benefits applicable to private insurance and HMO group plans.

Mandates Applicable to Standard and Basic Plans

The "standard" and "basic" plans offered by small employer carriers must include[4] the following "mandated [health] benefits":

- Limitations on exclusions for preexisting conditions;
- Dependent coverage;
- HIV/AIDS parity, without exclusion;
- Mastectomy – length of stay, surgical procedures and devices;
- Maternity care – post-delivery care;
- Osteopathic hospitals;
- Inpatient hospitalization;
- Outpatient services;
- Newborn coverage;
- Child care supervision services;
- Adopted children coverage;
- Mammograms;
- Handicapped children coverage;
- Emergency or urgent care outside of geographic service areas; and
- Appropriate hospice services.

The following "mandated [health] benefits" also are required but limits on the number of authorized treatments are expressly allowed, if reasonable and non-discriminatory:

- Treatment, for services within their license, by
    - Dentists;
    - Optometrists;
    - Podiatrists; and
    - Chiropractors;
- Maternity care – length of stay, nurse-midwives/midwives, licensed birthing centers;
- Mastectomy – outpatient post surgical care and routine follow up;
- Ambulatory surgical center services;
- Payment to certified acupuncturist, when acupuncture is covered;
- Optional mental health coverage; and

[3] Section 627.6699(15)(a), F.S.
[4] The nature of the mandate varies. In some instances, the mandate requires specific coverage in every policy written. Sometimes, the mandate requires the offering of a particular coverage at the time of contracting.

- Coverage for cleft lip and cleft palate, if children are covered.

"Mandated [health] benefits" may be subject to a schedule of benefit limitation adopted by the health benefit plan committee or restrictions on benefits, utilization, or cost containment provisions as required within the "basic" plan.

Disclosure Requirements

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

- The mandated benefits and providers not covered under the policy or contract;
- The managed care and cost control features of the policy or contract, with contact information for the insured's use; and
- The primary and preventative care features of the policy or contract.

Prior to the issuance of the policy, the small employer must sign a written statement that:

- Certifies the small employer's eligibility for small employer group coverage under the Act; and
- Acknowledges;
    - The limited nature of the coverage;
    - An understanding of the managed care and cost control features;
    - That misrepresentations will result in forfeiture of coverage; and
    - In the case of a "limited" benefit policy, that the policyholder rejects other coverage offered by the carrier.

A copy of the written statement is to be given to the policyholder and the original is to be retained in the files of the carrier for five years or the term of the policy, whichever is later.

Rates

Application and Adjustment

The small employer carrier's rate, approved by the Department of Insurance, is applied to the pool of small employer policies written by the carrier collectively, not individually. On an individual policy basis, a small group carrier may adjust a small employer's rate from the approved rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. Accordingly, any increase in small employer's individual rate should be offset by a reduction in the rate of other small employers in the pool. Also, the small employer's 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 the same factors.

Rating Method

Modified Community Rating – this is a variation on 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. Under Modified Community Rating, small employer carriers are permitted to additionally consider age, gender, family composition, tobacco usage, and geographic location.[5]

Guarantee-Issue

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. Alternatively, small employer carriers must provide an annual open enrollment period for these persons during the month of August.[6] Coverage begins on October 1, unless the insurer and the policyholder agree to a different date. Every small employer willing to purchase a small employer group policy offered pursuant to the Act will be issued a policy.

C. EFFECT OF PROPOSED CHANGES:

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

- Rename the "limited" benefit policy as the "flexible" benefit policy, and remove the requirement that the policy provide coverage for specific diseases, accidents, or markets;
- Provide that flexible benefit policies and other policies offered or delivered to a small employer are not subject to any restrictions on deductibles, coinsurance, copayments, and maximum annual and lifetime payments unless the restrictions are specifically made applicable by law;
- Provide that a flexible benefit policy must have a restriction on annual payments of at least $10,000;
- Allow, for rating purposes, the experience of small employer groups of 1 employee to be separated from the small employer groups of 2 to 50 employees;
- Permit increases in the rate applicable to small employer groups of 1 employee, subject to a rate cap of 150 percent above the small employer carrier's approved rate (the rate cap would be 125 percent for policies in effect on July 1, 2001) ;
- Require the appointment of a new health benefit plan committee under the Act every four years beginning October 1, 2003, for the purpose of recommending modifications to the plans, which would be reported annually to the Senate President and House Speaker;
- Provide that flexible benefit policies are subject to the statutory provision preventing discrimination between medical doctors, dentists, optometrists, podiatrists, and chiropractors when the physicians are providing services within the scope of their respective licenses;
- Require that when a flexible benefit policy is offered to an employer, the employer must also be offered catastrophic coverage;
- Require, in 10 point type of a contrasting color, the following statement:

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[5] S. 627.6699(3)(n), F.S.

[6] 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.

"The benefits provided by this health plan are limited and may not cover all of your medical needs. You should carefully review the benefits offered under this health plan."

The bill provides an effective date of October 1, 2002.

D. SECTION-BY-SECTION ANALYSIS:

Please see Effect of Proposed Changes section above.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill would authorize individual application of increased rates to small employer groups with one employee, not to exceed 150 percent of the small employer carriers' approved rate.

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 "flexible" benefit policy to their employees as a result of this bill.

D. FISCAL COMMENTS:

The bill does not appear to have a fiscal impact on state or local government.

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:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

Council Substitute for HB 913 differs from HB 913 as originally filed in the following major respects:

The CS does not include the ability to offer flexible benefit policies to groups of more than 50 employees.

The CS provides for appointment of a new health benefit committee by October 1, 2003 (instead of the October 1, 2002 date specified in the bill as filed) and every fourth year thereafter.

The CS retains provisions of current law relating to disclosure of the benefits and limitations of flexible benefit policies; the bill as filed substantially reduced these disclosure requirements.

The CS adds a requirement that if a flexible benefit policy has an annual benefit cap, the cap must be at least $10,000.

The CS adds a requirement that when a flexible benefit policy is offered to an employer, the employer must also be offered catastrophic coverage.

VII. SIGNATURES:

COUNCIL FOR COMPETITIVE COMMERCE:

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

AS REVISED BY THE COMMITTEE ON HEALTH REGULATION:

Prepared by:	Staff Director:
Wendy Smith Hansen	Lucretia Shaw Collins

AS FURTHER REVISED BY THE COUNCIL FOR COMPETITIVE COMMERCE:

Prepared by:	Council Director:
Leonard Schulte	Matthew M. Carter II