-HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1573 Health Insurance
SPONSOR(S): Farkas
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance		Cooper	Schulte
2) Health Care			
3)			
4)			
5)			

SUMMARY ANALYSIS

This bill amends various provisions of law relating to health insurance. In an effort to increase consumer awareness regarding the cost of health care treatment in hospitals and to encourage comparison shopping, it requires the posting of certain hospital charges. To address increases in health insurance premiums for groups of more than 50 individuals, it prohibits laws restricting or limiting deductibles, coinsurance or copayments.

Regarding health insurance for small employers it expands open enrollment periods and allows the separation, for rating purposes, of the experience of employees who participate in health reimbursement arrangements from the experience of other small employer groups.

The bill provides more time for people to qualify for continuation of health insurance coverage and mandates health maintenance organizations to comply with certain replacement of coverage requirements.

The bill also establishes new options for heath maintenance organizations in their reimbursement of providers of emergency services and care.

A “strike everything after the enacting clause” amendment has been filed by the sponsor of the bill. In addition to making clarifying changes in several sections, the amendment makes two significant changes. First, it provides that reimbursement by health maintenance organizations to non-contracted providers for emergency services and care be based on 125 percent of the prevailing Medicare allowable fee schedule. Second, it expands the current statutorily authorized health flex plan pilot program and extends its time of operation.

State agencies should not experience any fiscal impact with this bill.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[X]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[X]
3. Expand individual freedom?	Yes[X]	No[]	N/A[]
4. Increase personal responsibility?	Yes[]	No[]	N/A[X]
5. Empower families?	Yes[]	No[]	N/A[X]

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

It subjects hospitals to additional requirements and potential penalties.

B. EFFECT OF PROPOSED CHANGES:

Information to Health Care Consumers

Currently, the Agency for Health Care Administration may require the submission by health care facilities, health care providers, and health insurers of data “necessary to carry out the agency's duties”, s.408.061, F.S. Specifications for data to be collected is required to be developed by the agency with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and other interested parties.

Data to be submitted by health care facilities may include, but are not limited to: case-mix data, patient admission or discharge data with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information.

Pursuant to s. 408.062, F.S. the agency, relying on data collected must establish a reliable, timely, and consistent information system that distributes information and serves as the basis for the agency's public education programs. The agency is required to seek advice from consumers, health care purchasers, health care providers, health care facilities, health insurers, and local health councils in the development and implementation of its information system. Also, the agency is to publish and disseminate information to the public which will enhance informed decisionmaking in the selection of health care providers, facilities, and services. These publications may identify average charges for specified services, lengths of stay associated with established diagnostic groups, readmission rates, mortality rates, recommended guidelines for selection and use of health care providers, health care facilities, and health care services, and such other information as the agency deems appropriate.

This bill requires hospitals and ambulatory surgical centers to make available to the public on its Internet website or by other electronic means a list of charges and codes and a description of services of the top 100 diagnostic-related groups discharged from the hospital for that year and the top 100 outpatient occasions of diagnostic and therapeutic procedures. The intent of this requirement is to encourage price comparisons among facilities and improve decisionmaking by consumers.

The bill also requires a health care provider or a health care facility, upon request, to furnish a patient, prior to provision of medical services, a reasonable estimate of charges for such services. The bill also provides that such estimate shall not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or

treatment needs. This mandate is currently found in the "Florida Patient's Bill of Rights and Responsibilities," s. 381.026, F.S. The difference between the current law and the bill's requirement is that the current Patient's Bill of Rights has no enforcement attached to it. There is no liability for failure to comply. The bill places its requirement in the hospital licensure law, thereby making any violation subject to possible administrative sanction.

The Employee Health Care Access Act

In 1992, the Legislature enacted the Employee Health Care Access Act (s. 627.6699, F.S.). 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 one 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 and limited benefit (or "street") plans that reduce the impacts of mandated health benefits, and guarantee issue to any small employer seeking coverage.

In 2002, the Legislature revised the act to authorize less expensive health insurance coverage to small employers. The law now allows small group carriers to rate one-life groups, separate from the rating pool for groups with 2 to 50 employees, but not to exceed 150 percent of the rate determined for groups of 2 to 50 employees, with an interim rate cap of 125 percent effective July 1, 2002. The law also exempts all health plan policies offered to small employers from laws limiting deductibles, coinsurance, co-payments, and maximum lifetime and annual benefits. Consequently, consumers should be offered more affordable policies.

This bill makes the following changes to s. 627.6699, F.S.:

1) It amends the definition of "eligible employee" to include a minimum wage level along with the minimum number of hours worked. This change is intended to ensure that individuals who qualify for the coverage are actual workers.
2) The definition of "self-employed individual" is amended to require additional verification (relevant Internal Revenue Service documentation) as to one's actual status as being self-employed.
3) The 30-day open enrollment period is changed from once to twice a year.
4) Small employers, as a condition for conducting business in this state, are required to provide, on an annual basis, information on at least three different group health benefit plans to their employees. The effect of this requirement is unclear. First, there is no explanation of what is intended by "information". Second, there is no enforcement provided.
5) The restrictions relating to premium rates are amended. Currently, pursuant to s 627.6699(6)(b)5., F.S., any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers must report information on forms adopted by rule by the Office of Insurance Regulation, to enable the office to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates.

If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier must limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the office. For any

subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 5 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

This bill changes the current 5 percent allowable variation to 2 percent.

6) Carriers are allowed to separate the experience of small employer groups of 1-50 eligible employees using a health reimbursement arrangement for determining an alternative modified community. Health reimbursement arrangements (HRAs) are employer – funded medical care expense reimbursement plans in which reimbursements made from the plan are excludable from employee gross income.

Deductibles, Copayments and Coinsurance

As previously indicated, restrictions or limitations on deductibles, coinsurance and copayments were eliminated in 2002 for health plan policies sold to small employer groups. The bill extends the prohibition on such limitations to insurance policies or HMO contracts offered to individuals or groups with 51 or more persons. The effect of this proposed change is that out-of-pocket expenses for consumers may increase but premiums for coverage should decrease.

Guaranteed Availability of Individual Health Insurance Coverage

Pursuant to s.627.6487 F.S., each health insurance issuer that offers individual health insurance coverage in Florida may not, with respect to an eligible individual who desires to enroll in individual health insurance coverage decline to offer such coverage to, or deny enrollment of, such individual; or impose any preexisting condition exclusion with respect to such coverage. However, certain persons are not eligible including those who were eligible for coverage under a conversion policy after covered under an insured “employer” plan.

This bill replaces “employer” with “group health” plan. Given that the Centers for Medicare & Medicaid Services (CMS) defines “group health plan” as “A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization,” the effect of this change is unclear.

The bill also provides that if an individual’s most recent period of creditable coverage was earned in a state other than Florida, an insurer issuing a policy may impose a surcharge or charge a premium for such a policy equal to that permitted in the state in which the creditable coverage was earned. Creditable coverage, as defined by CMS, is any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period. The bill also requires that additional information be tendered regarding the underlying health plan that provided the creditable coverage.

Continuation of Coverage Under Group Plans

The "Florida Health Insurance Coverage Continuation Act." is intended to ensure continued access to affordable health insurance coverage for employees of small employers and their dependents and other qualified beneficiaries not currently protected by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Federal law which provides certain continuation of coverage benefits). The law requires that a group health plan issued to a small employer must provide that each qualified beneficiary who would lose coverage under the group health plan because of a qualifying event is entitled, without evidence of insurability, to elect, within a designated election period, continuation coverage under the

employer's group health plan. A qualified beneficiary who elects continuation coverage is subject to all the terms and conditions applicable under the group health plan.

The current law also provides that a covered employee or other qualified beneficiary who wishes continuation of coverage must pay the initial premium and elect such continuation in writing to the insurance carrier issuing the employer's group health plan within 30 days after receiving notice from the insurance carrier. The bill replaces 30 days with 63 days, which brings conversion procedures in line with the Federal Health Insurance Portability and Accountability Act (HIPAA).

Extension of Benefits

The bill addresses two provisions relating to extension of benefits.

Currently, s 627.667 F.S. provides that each group health policy must contain a reasonable provision for extension of benefits in the event of the total disability of a certificateholder at the date of discontinuance of the policy or contract. The extension is required regardless of whether the group policyholder or other entity secures replacement coverage from a new insurer or foregoes the provision of coverage. It also provides that requirement also applies to holders of group certificates which are renewed, delivered, or issued for delivery to residents of this state under group policies effectuated or delivered outside this state, unless a succeeding carrier under a group policy has agreed to assume liability for the benefits.

The bill applies this requirement to situations where a succeeding carrier under a group policy has agreed to assume liability for the benefits."

Section s. 641.3111, F.S. relating to extension of benefits for health maintenance organizations, provides that every group health maintenance contract must provide that termination of the contract shall be without prejudice to any continuous loss which commenced while the contract was in force, but any extension of benefits beyond the period the contract was in force may be predicated upon the continuous total disability of the subscriber and may be limited to payment for the treatment of a specific accident or illness incurred while the subscriber was a member.

The bill strikes this latter limitation of payment and replaces it with a requirement that an extension must occur regardless of whether the contract holder secures replacement coverage. Continuation of contract benefits must be continued.

Liability of Succeeding Insurer on Replacement of Health Insurance

Pursuant to s.627.666 F.S., upon replacement of a health insurance policy each person who was covered by the prior insurer must be covered by the succeeding insurer; however, the prior insurer is liable for any extension of benefits in accordance with s. 627.667. The succeeding insurer, in applying any deductible, out-of-pocket limitation, or waiting period in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan. As to deductible provisions, the credit applies for expenses actually incurred and applied against the deductible provisions of the prior insurer's plan during the 90 days preceding the effective date of the succeeding insurer's plan, but only to the extent that the expenses actually incurred are recognized under the terms of the succeeding insurer's plan and are subject to a similar deductible provision.

The bill requires that any HMO that is replacing any other group health coverage with its group health maintenance coverage shall comply with s. 627.666.

Requirements for Providing Emergency Services and Care

Pursuant to s. 395.1041, F.S., every general hospital which has an emergency department must provide emergency services and care for any emergency medical condition. For subscribers of HMOs,

the health maintenance organization must, pursuant to s. 641.513, F.S., compensate a provider for the screening, evaluation, and examination that is reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient's condition is an emergency medical condition. The health maintenance organization must compensate the provider for emergency services and care. If a determination is made that an emergency medical condition does not exist, payment for services rendered subsequent to that determination is governed by the contract under which the subscriber is covered.

Also according to current law, the health maintenance organization may have a member of the hospital staff with whom it has a contract participates in the treatment of the subscriber within the scope of the physician's hospital staff privileges. The subscriber may be transferred, in accordance with state and federal law, to a hospital that has a contract with the health maintenance organization and has the service capability to treat the subscriber's emergency medical condition.

Section 641.513 (5), F.S., specifies the reimbursements procedures when emergency services and care is provided to HMO subscribers. Reimbursement for services by a provider who does not have a contract with the health maintenance organization must be the lesser of:

(a) The provider's charges;
(b) The usual and customary provider charges for similar services in the community where the services were provided; or
(c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

This bill adds a new paragraph (d) to subsection (5) to allow reimbursement to be based upon no more than 125 percent of the hospital's average contract price which the hospital contracts with health maintenance organizations in the hospital's geographic service area. Given the difficulty in determining what would otherwise be proprietary information (i.e. contract prices) and the further difficulty in collecting and determining "average contract prices", another benchmark may be more useful. This issue is being addressed in the sponsor's "strike everything" amendment which will base reimbursement on 125 percent of the Medicare payment rate for services in accordance with the prevailing Medicare allowable fee schedule.

Health Flex Plan Pilot Program

The bill currently does not address the Health Flex Plan Pilot Program. However, the bill's sponsor has filed a "strike everything" amendment which makes several changes in the program. Therefore, the following background information is provided.

In 2002, the Legislature created, in s. 408.909, F.S., the Health Flex Plan pilot program. The pilot program permits entities to develop alternative health care coverage plans, referred to as health flex plans, for uninsured persons who have a family income equal to or less than 200 percent of the federal poverty level. The goal of the program is to improve the affordability and availability of heath care coverage for low-income Floridians who are unable to obtain health coverage, by encouraging the development of alternative approaches to traditional health insurance that still provide basic and preventative health care services.

A health flex plan is permitted to take measures that are impermissible for regular care providers. The health flex plan may limit or exclude benefits that are otherwise required by law for insurers offering coverage in Florida. The plan may also cap the total amount of claims paid per year per enrollee, and may limit the number of enrollees

A health flex plan may be developed and implemented by health insurers, health maintenance organizations (HMOs), health care provider-sponsored organizations, local governments, heath care districts, or other community-based organizations. Current law specifies that the Agency for Health

Care Administration (ACHA) must develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that do not meet minimum standards for quality of care and access to care. The Office of Insurance Regulation (OIR) must also develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that:

- Contain any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;
- Provide benefits that are unreasonable in relation to the premium charged, contain provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or
- Cannot demonstrate the health flex plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided.

The statute attempts to target the pilot programs in areas of the state that have the greatest number of the uninsured poor. The statute authorizes the ACHA and OIR to approve health flex plans in the three areas of the state having the highest number of uninsured persons. These areas are District 1 (Bay, Escambia, Gadsden, Leon, Okaloosa, and Santa Rosa Counties), District 16 (Broward County), and District 17 (Dade County). The statue also authorizes the issuance of health flex plans in Indian River County.

Eligibility to enroll in a health flex plan is limited to Florida residents who are under 65 years of age and have a family income equal to or less than 200 percent of the federal poverty level. The enrollee must not be covered by a private insurance policy, must not be eligible for coverage through a public health insurance program such as Medicare, Medicaid, or Kidcare, and must not have been covered at any time during the past 6 months. The enrollee must also have applied for health care coverage through an approved plan and agree to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

AHCA must evaluate the pilot program and its effects on the entities that seek approval as health flex plans, as well as the number of enrollees and the scope of the coverage afforded. The AHCA and the OIR are mandated to assess the health flex plans and their potential applicability in other settings. By January 1, 2004, AHCA and OIR are to submit their findings in a report to the Governor, President of the Senate, and the Speaker of the House of Representatives. Each approved health flex plan is required to maintain records of enrollment, finances, and claims experience to enable the agency and the department to monitor the plan. The statute authorizing the creation of the health flex pilot program expires on July 1, 2004.

ACHA reports that to date, two health flex plans have been approved, in Dade County. One plan is physician group based; the other is HMO based. No other applications have been received by the agency, and no health flex programs have been created other than the two in Dade County.

The agency has also reported they have conducted a survey to assess the interest of health plan providers in the health flex plan pilot program. Of the 145 surveys that were mailed electronically to potential providers, 76 (52%) responded. Forty-one respondents knew about the program. Two indicated an interest in applying. Forty-seven were not interested in expanding their product line; one indicated that the 200 percent poverty line was too restrictive; one was interested in other areas of the state; five believed the plan would not be profitable; and 15 indicated they did not have the resources to market the plan. The agency is implementing an informational and marketing plan to encourage more program participation

C. SECTION DIRECTORY:

Section 1: Amends s. 395.301, F.S., relating to itemized patient bills.

Section 2: Amends s. 627.410, F.S., relating to approval of health insurance forms.

Section 3: Amends s. 627.6487, F.S., related to guaranteed availability of individual health insurance coverage to eligible individuals.

Section 4: Amends s. 627.6561, F.S., relating to preexisting conditions.

Section 5: Amends s. 627.667, F.S., relating to extension of benefits.

Section 6: Amends s. 627.6692, F.S., relating to the Florida Health Insurance Coverage Continuation Act.

Section 7: Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act.

Section 8: Amends s. 641.31, F.S., relating to health maintenance contracts.

Section 9: Creates s. 641.31075, F.S., relating to requirements for replacing health insurance.

Section 10: Amends s. 641.3111, F.S., relating to extension of benefits.

Section 11: Amends s. 641.513, F.S., relating to requirements for providing emergency services and care.

Section 12: Provides an effective date.

II. 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:

1. Direct Private Sector Costs:

Section 1 requires that more information regarding treatment charges be provided to health care consumers. Hospitals and ambulatory surgery center will bear the cost of identifying and posting the required information on electronic media. No cost estimates are available.

Regarding reimbursement for emergency services and care, establishing a reimbursement rate to be paid by health maintenance organizations to providers of emergency services and care, which is lower than the usual and customary provider charges, will more than likely result in lower payments for those providers. Hospitals have indicated that will negatively impact their ability to subsidize indigent and uncompensated health care. Health maintenance organizations contend that the status quo contributes to high costs and therefore higher premiums and less affordable heath insurance for the public.

2. Direct Private Sector Benefits:

Health care consumers will have further information available to assist in choosing a hospital or ambulatory surgery provider.

3. Effects on Competition, Private Enterprise and Employment Markets:

Health care consumers will have further information available to assist in choosing a hospital provider, thereby potentially stimulating competition among providers.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A “strike everything after the enacting clause” amendment has been filed by the bill’s sponsor. The amendment makes the following changes:

Section 1, amending s. 395.301, F.S., itemized patient bill:

- Clarifies list of charges to be the licensed facilities' "master list";
- Clarifies that "prospective" patients must be provided a reasonable estimate of charges upon request; and
- Deletes reference to "health care providers."

Section 2, amending s. 627.410, F.S., filing, approval of forms

- Provides statutory cross-reference.

Section 7, amending s. 627.6699, F.S., Employee Health Care Access Act

Deletes requirement of providing information on three health benefit plans to employees as a "condition for doing business in Florida"; and

- Deletes requirement that the health benefit information provided to the employees be "group" health benefit plans.

Section 8, amending s. 641.31, F.S., health maintenance contracts:

Provides statutory cross-reference.

Section 9, creating s. 641.31075, F.S., requirements for replacing health coverage:

- Deletes requirement for any HMO that is replacing any other individual health coverage with its individual HMO to comply with s. 627.6045, F.S., pre-existing condition.

Section 11, amending s. 641.513, F.S., requirements for providing emergency services and care:

- Deletes reference to noncontracted hospital based providers;
- Provides that reimbursement for services pursuant to this section, for hospitals, to no more than 125 percent of the prevailing Medicare allowable fee schedule.

New Section 12, amending s. 408.909, F.S., health flex plans:

Expands health flex plans to include approved plans purchased by enrollees directly from the plan or through a small business purchasing arrangement sponsored by a local government;

- Authorizes a health flex plan to limit the term of coverage; and
- Extends the pilot project to July 1, 2008 (from the current expiration of July 1, 2004).

New Section 13, provides severability

Amends title