SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 2910

SPONSOR: Health, Aging, and Long-term Care Committee and Senator Peaden

SUBJECT: Health Care

DATE: March 24, 2004 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Fav/CS
2.			BI	
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

This bill incorporates recommendations of the Governor's Task Force on Access to Affordable Health Insurance. Significant provisions that affect the health insurance markets include:

- Creation of the Florida Health Insurance Plan as the high risk pool for uninsurable medical risks, to replace the Florida Comprehensive Health Association;
- Expansion of the Health Flex Program statewide;
- Creation of the Small Employers Access Program to provide additional health insurance options for small businesses of up to 25 employees; and
- Requirement that certain plans providing discount medical services be licensed as prepaid limited health service plans.

The bill creates a Statewide Electronic Medical Records Task Force to guide the Agency for Health Care Administration (AHCA or Agency) in the development of policy related to electronic medical records. The bill also requires certain health care facilities to provide pricing information to the public.

This bill amends ss. 381.026, 395.301, 408.909, 627.410, 627.6487, and 636.003, F.S.

The bill creates three unnumbered sections of law.

II. Present Situation:

Governor's Task Force on Access to Affordable Health Insurance

The Governor's Task force on Access to Affordable Health Insurance (Governor's Task Force) was created for the purpose of identifying factors that contribute to rising health care costs and prevent Floridians from obtaining health insurance coverage. A recent study by the Kaiser Family Foundation ranks Florida sixth in the nation in percent of population without health insurance coverage, with 18 percent of Floridians uninsured during 2001-2002. The Governor's Task Force was charged with recommending policies that will improve access to health insurance at affordable, predictable costs, while maintaining consumer choice. The Governor's Task force was co-chaired by Lieutenant Governor Toni Jennings and Chief Financial Officer Tom Gallagher and was comprised of 17 members representing business leaders, health policy experts, health care providers, consumers, and legislators.

The Governor's Task Force final report[1] contained numerous recommendations to improve Floridian's access to affordable health insurance, including:

- Expanding the Health Flex Program statewide as a means of offering basic, lower-cost health care coverage to uninsured workers who have low incomes;
- Establishing purchasing pools for small employers;
- Creation of health plans for uninsurable and HIPAA-eligible individuals
- Encouraging the use of evidence-based medicine; and
- Encouraging the development of an electronic medical record that could be used statewide.

House Select Committee on Affordable Health Care for Floridians

In an effort to address the issue of affordable and accessible employment-based insurance, on August 14, 2003, Speaker Johnnie Byrd created the Select Committee on Affordable Health Care for Floridians and appointed Representative Frank Farkas, D.C., Chairman. To seek opinions of a wide range of stakeholders, public hearings with predetermined themes were conducted around the state, specifically in Orlando, Miami, Jacksonville, Tampa, Pensacola, Boca Raton, and Tallahassee from October through November, 2003.

Climate of the Florida Health Insurance Market

Florida residents and employers spent $12.5 billion in health insurance premiums, as reported in calendar year 2000. Spending for all privately and publicly funded personal health care services and products (e.g., hospital care, physician services, nursing home care, prescription drugs, etc.) exceeded $60 billion in 1998.

The structure of the Florida health coverage market and the regulations that govern its operations are based on health plan type and size. The types of health plans are categorized as:

[1] Final Report of the Governor's Task Force on Access to Affordable Health Insurance. http://www.fdhc.state.fl.us/affordable_health_insurance/PDFs/task_force_report_021504_final.pdf

- Self-insured plans;
- Large group health plans;
- Small group health plans;
- Individual health plans;
- Out-of-state groups; and
- High-risk pool.

Most fully-insured private health coverage in Florida is issued through an employer group – a small group, which is defined by Florida law as one to 50 employees, or a large group, 51 employees or more. Many larger Florida employers provide coverage by self-insuring and establishing contracts with private insurance companies to provide "stop loss" reinsurance and administrative services, thus taking advantage of the Employment Retirement Income Security Act (ERISA) protections from state laws. As a result, less than 30 percent of Florida's population has health insurance that is governed by state insurance laws. In fact, of Florida's 16.1 million residents in 2002:

- 4.8 million are in the Florida insurance market (fully-insured plans, large groups, small groups, and individual plans);
- 4.3 million are governed by only federal law (ERISA, aka: self-insured plans);
- 1.7 million are enrolled in Medicaid;
- 2.5 million are enrolled in the Medicare program; and
- 2.8 million are uninsured.

Consequences of Lack of Health Insurance

Patients who are uninsured often are reluctant to use health services, and therefore wait until there is a crisis. They receive fewer preventive services and less regular care for chronic disease.

Not only does the lack of insurance affect the health and well being of U.S. and Florida residents, but there is a resounding rippling affect on the economy. In 2001, the cost of medical care for uninsured residents in the U.S. totaled $98.9 billion. The Florida Hospital Association reports that in 2002 cost for uncompensated care provided in Florida hospitals amounted to $1.51 billion.

Studies estimate that the potential economic value to be gained in better health outcomes from uninterrupted coverage for all Americans is estimated to be between $65 and $130 billion each year, which is currently being lost per year in lost productivity. Each uninsured U.S. resident loses between $1,645 and $3,280 per year in lost wages and benefits and in the value that improved quality of life and longer lifespan would provide.

The state's budget is also strained by increasing numbers of uninsured. The Social Services Estimating Conference estimates that Florida's Medicaid expenditures will approach $14 billion in FY 2004-05, resulting in a $526 million deficit in General Revenue funding for that year.

As state budgets are stretched, funding care for Florida residents falls on the local communities where care is provided. Counties are mandated by state law to contribute to the state Medicaid

program. For fiscal year 2002-2003, counties contributed approximately $162 million. Counties are required to pay for eligible Medicaid recipients' inpatient hospital stay from day 11 through day 45, with this responsibility being increased by the state several years ago. Counties are currently funding inpatient hospital days at approximately $115 million statewide.

Florida Comprehensive Health Association

In recent years, many states have created health insurance risk pools to address the needs of the under-insured and uninsured. High-risk pools provide a safety net for otherwise uninsurable individuals; however, they typically enroll a relatively small number of individuals. Reasons for low enrollment include: limited funding, lack of public awareness, and the relatively high expense.

As enacted under chapters 82-243 and 82-386, Laws of Florida, the Florida Comprehensive Health Association (FCHA)[2] provides health insurance to individuals who, due to their health status or inability to afford coverage, are unable to obtain health insurance coverage in the private market. Throughout the early years of the program, enrollment and insurance fund losses were low; however, by 1989, enrollment and losses had increased substantially. Legislation was enacted to prohibit the FCHA from issuing policies to new applicants after July 1, 1991. The FCHA currently provides coverage for approximately 500 individuals.

Effective July 1, 1990, the FCHA was amended to require the FCHA to pattern its coverage after the state group health insurance program including benefits, exclusions, and other limitations, except as otherwise provided by law. The major medical expense coverage under FCHA includes a $500,000 lifetime limit per covered life. The FCHA provides for an annual deductible in the amount of $1,000 or more, as approved by the Office of Insurance Regulation (OIR or Office). The FCHA provides for a 12-month exclusion of insurance coverage with respect to a condition that manifested itself within 6 months of the effective date of the coverage or medical advice or treatment recommended or received within a period of 6 months before the effective date of the coverage.

A precondition for FCHA eligibility is that the applicant be rejected by at least 2 insurers offering coverage substantially similar to the FCHA's coverage and the market assistance plan has been unsuccessful in finding an insurer to accept the application. Rejection is defined as an offer of coverage with a material underwriting restriction or an offer of coverage at a rate greater than the FCHA's rate. Therefore, the rejection may or may not be due to a determination that an applicant is literally uninsurable.

Legislative changes in 1990 required the FCHA board or administrator to verify the residency of an applicant and to prohibit the enrollment of a person who is eligible for Medicaid, unless: such person has an illness or disease that requires supplies or medication that are covered by the FCHA, but that are not covered by the Medicaid program; or the person is not receiving benefits under Medicaid. In addition, the law was clarified to allow FCHA to terminate an enrollee immediately if the enrollee ceases to meet the eligibility requirements.

[2] Originally termed the State Comprehensive Health Association.

The Office annually establishes the standard risk rate that is used for determining premiums for the FCHA under s. 627.6498(4)(a), F.S. Under s. 627.6675, F.S., the Office uses reasonable actuarial techniques and standards adopted by rule. As currently provided, the maximum rates for the FCHA are 200 percent, 225 percent, and 250 percent of this standard risk rate for low, medium, and high-risk individuals, respectively.

As a condition of doing business in Florida, health insurers are required to pay assessments to fund the deficits of the FCHA. Companies subject to the assessment include all health insurance companies, health maintenance organizations, fraternal benefit societies, multiple employer welfare arrangements, and prepaid health clinics. Self-funded employers and governmental entities are not subject to the assessment.

The board assesses each insurer annually a portion of incurred operating losses of the FCHA, based on the insurer's market share in Florida as measured by premium volume. The total of all assessments per participating insurer is capped at 1 percent of such insurer's health insurance premium earned in Florida during the calendar year preceding the year for which the assessment is levied.

Florida's Patient's Bill of Rights

The Florida Patient's Bill of Rights and Responsibilities includes a listing of rights related to individual dignity, basic information rights, the right to grievances, the right to obtain information related to accepted payment by the facility, the right to be provided a reasonable estimate of the expected charges, the right to access to emergency care, and the right to know if the treatment is for the purpose of experimental research. In addition, the current statutes specify the responsibilities of a patient of a health care facility and or health care provider.

Health Flex Plan Pilot Program

The Health Flex Plan pilot program was created by the Florida Legislature during the 2002 Session. 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 providers of health care coverage. The health flex plan may limit or exclude benefits that are otherwise required by law for insurers offering coverage in Florida (s. 408.909(3), F.S.). The plan may also cap the total amount of claims paid per year per enrollee, and may limit the number of enrollees (s. 408.909(3), F.S.).

A health flex plan may be developed and implemented by health insurers, HMOs, health care provider-sponsored organizations, local governments, heath care districts, or other community-based organizations (s. 408.909(2), F.S.). Current law specifies that the Agency 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 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 that the health flex plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided. (s. 408.909(3), F.S.)

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 Agency and the Office to approve health flex plans in the three areas of the state having the highest number of uninsured persons (s. 408.909(3), F.S.). These areas are in northern Florida (Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, Gulf, Franklin, Liberty, Gadsden, Leon, Wakulla, Jefferson, Taylor, Hamilton, Suwannee, Lafayette, Dixie, Levy, Citrus, Sumter, Columbia, Baker, Union, Bradford, Putnam, Clay, Duval and Madison counties), south Florida (Miami-Dade and Broward county), and Hillsborough County. The statute 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 (s. 408.909(5), F.S.). 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.

The Agency 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 (s. 408.909(9), F.S.). The Agency and the Office are mandated to assess the health flex plans and their potential applicability in other settings. The Agency and the Office submitted a report due January 1, 2004, regarding the applicability of health flex programs to other areas of the state, to the Governor, President of the Senate, and Speaker of the House of Representatives. The report states that several health insurers and governmental entities in areas of the state currently not covered by the program have contacted the Agency to express interest in establishing health flex plans. Each approved health flex plan is required to maintain records of enrollment, finances, and claims experience to enable the Agency and the Office to monitor the plan (s. 408.909(6), F.S.). The statute authorizing the health flex pilot program was amended during the 2003 Session to extend the expiration date of the program from July 1, 2004 to July 1, 2008.

The Agency reports that, to date, three health flex plans have been approved. American Care, Inc., has created a plan in Dade County that covers outpatient services only, including many

outpatient surgery components with substantial co-payments and limitations; the program had 130 enrollees as of November 2003. Preferred Medical Plan, Inc., which has operated as an HMO for a number of years in Florida, was approved to offer a health flex plan in Dade County that offers a primary care and outpatient benefit plan with limited drug coverage, along with preventive services such as immunizations and mammograms. On December 1, 2003, JaxCare (a public/private sector partnership) became the most recent health flex plan to be approved. The plan links community groups and providers with private sector providers to create a network across Duval County. The JaxCare plan was developed through the "Communities In Charge" grant initiative of The Robert Wood Johnson Foundation and the technological infrastructure for the plan was developed through grants from the Department of Health and Human Services. In addition to the already approved plans, local government in Miami-Dade County is currently developing a health flex plan to offer to uninsured workers.

Electronic Medical Records

An electronic medical record is a patient's medical record in a digital format that a physician could transmit electronically to a hospital, to another physician, or to the patient. While most business and governmental record-keeping has been stored and transmitted electronically for many years, medical records are still largely paper records.

In recent years, private and public sector policy leaders have called for electronic medical records in a standard format that could be transmitted among medical professionals. The Institute of Medicine (IOM) issued a report in November 2003[3], calling for the development of a national health information infrastructure with targeted support from the federal government for its development. Such a federal initiative has been compared to the Hill-Burton Act that provided funds for the construction of community hospitals. The proposal could also be compared with the federal legislation that established the e-rate for schools and libraries to permit nationwide access to the Internet.

The Healthy Florida Foundation[4], a group of diverse Florida organizations representing health care providers, insurers, organized labor, state government and community initiatives recommends encouraging development of electronic medical records through financial incentives and the establishment of a universal electronic medical record system in Florida within 5 years that would permit caregivers and patients to share medical records and access clinical information.

The Governor's Task Force on Access to Affordable Health Insurance recommended that the state encourage the development of electronic medical records by providing financial incentives and promoting the use of digital technology and information systems, involving Florida's medical schools in that effort.

In July 2003, the U.S. Secretary of Health and Human Services (HHS) announced that the department had taken two steps in building a national health information infrastructure by arranging for: (1) the establishment of a standardized medical vocabulary system and (2) the

[3] Institute of Medicine, Aspden, Philip, Corrigan, Janet M., Wolcott, Julie, and Erickson, Shari M., Eds. Patient Safety: Achieving a New Standard. The National Academies Press 2004. Readable at: http://books.nap.edu/catalog/10863.html
[4] http://www.healthyfloridafoundation.org/

design of a standardized model of an electronic health record.[5] Through an agreement with the College of American Pathologists, HHS will license the College's standardized medical vocabulary system and make it available at no cost. HHS also commissioned IOM to design a standardized model of an electronic health record. After the standardized model record is evaluated, HHS will make it available at no cost.

Advisory Bodies

The various types of advisory bodies that are typically established to advise state government are defined in s. 20.03, F.S., as follows:

> *Council* or *advisory council* means an advisory body created by specific statutory enactment and appointed to function on a continuing basis for the study of the problems arising in a specified functional or program area of state government and to provide recommendations and policy alternatives.
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> *Committee* or *task force* means an advisory body created without specific statutory enactment for a time not to exceed 1 year or created by specific statutory enactment for a time not to exceed 3 years and appointed to study a specific problem and recommend a solution or policy alternative with respect to that problem. Its existence terminates upon the completion of its assignment.
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> *Coordinating council* means an interdepartmental advisory body created by law to coordinate programs and activities for which one department has primary responsibility but in which one or more other departments have an interest.
>
> *Commission*, unless otherwise required by the State Constitution, means a body created by specific statutory enactment within a department, the office of the Governor, or the Executive Office of the Governor and exercising limited quasi-legislative or quasi-judicial powers, or both, independently of the head of the department or the Governor.

Under s. 20.052, F.S., each advisory body, commission, board of trustees, or any other collegial body created by specific statutory enactment as an adjunct to an executive agency must be established, evaluated, or maintained in accordance with the following provisions:

- It may be created only when it is found to be necessary and beneficial to the furtherance of a public purpose.
- It must be terminated by the Legislature when it is no longer necessary and beneficial to the furtherance of a public purpose. The executive agency to which the advisory body, commission, board of trustees, or other collegial body is made an adjunct must advise the Legislature at the time the advisory body, commission, board of trustees, or other collegial body ceases to be essential to the furtherance of a public purpose.
- The Legislature and the public must be kept informed of the numbers, purposes, memberships, activities, and expenses of advisory bodies, commissions, boards of trustees, and other collegial bodies established as adjuncts to executive agencies.

[5] http://www.os.dhhs.gov/news/press/2003pres/20030701.html

- An advisory body, commission, board of trustees, and other collegial body may not be created or reestablished unless:

  - It meets a statutorily defined purpose;
  - Its powers and responsibilities conform with the definitions for governmental units in s. 20.03, F.S.;
  - Its members, unless expressly provided otherwise in the State Constitution, are appointed for 4-year staggered terms; and
  - Its members, unless expressly provided otherwise by specific statutory enactment, serve without additional compensation or honorarium, and are authorized to receive only per diem and reimbursement for travel expenses as provided in s. 112.061, F.S.

The private citizen members of an advisory body that is adjunct to an executive agency must be appointed by the Governor, the head of the department, the executive director of the department, or a Cabinet officer. Unless an exemption is otherwise specifically provided by law, all meetings of an advisory body, commission, board of trustees, or other collegial body adjunct to an executive agency are public meetings under s. 286.011, F.S. Minutes, including a record of all votes cast, must be maintained for all meetings. If an advisory body, commission, board of trustees, or other collegial body that is adjunct to an executive agency is abolished, its records must be appropriately stored, within 30 days after the effective date of its abolition, by the executive agency to which it was adjunct, and any property assigned to it must be reclaimed by the executive agency. The advisory body, commission, board of trustees, or other collegial body may not perform any activities after the effective date of its abolition.

III. Effect of Proposed Changes:

Section 1. Creates the Florida Health Insurance Plan for Florida residents and their resident dependents who are eligible for coverage because they:

- Have received from one insurer a notice of rejection or refusal to issue substantially similar insurance as provided through the plan for health reasons;
- Have received a refusal by an insurer to issue insurance except at a rate exceeding the plan rate;
- Are eligible for individual coverage in accordance with the Health Insurance Portability and Accountability Act; or
- Have a history of certain medical or health conditions adopted by the Board of Directors.

Subsection (1) provides definitions for the terms “board,” “governor,” “office,” “dependent,” “director,” “health insurance,” “insurer,” “Medicare,” “Medicaid,” “participating insurer,” “provider,” “plan,” “plan of operation,” and “resident.”

Subsection (2) provides for the operation of the plan. The bill requires a three-member team, led by the Director of OIR to implement the plan. After the plan is fully implemented, it will be supervised by a nine-member board of directors. The Director of OIR will serve as a board member and as chairman, and the other eight members will be appointed by the Governor. A majority of the board must be comprised of individuals who are not representatives of insurers or health care providers. The bill provides for staggered terms and specifies that board members

will not be compensated, except for reimbursement for reasonable expenses in accordance with s. 112.061, F.S.

The board must submit a plan of operation to the Governor, which must ensure that the plan qualifies for any available federal funding. The plan of operation must be approved by the Governor. If the board fails to submit a suitable plan of operation within 180 days after the appointment of the board, OIR must adopt rules to implement the Florida Health Insurance Plan.

Subsection (3) establishes requirements for the plan of operation, which must:

- Establish procedures for operation of the plan.
- Establish procedures for selecting an administrator in accordance with subsection (13).
- Establish procedures to create a fund, under management of the board, for administrative expenses.
- Establish procedures for the handling, accounting, and auditing of assets, moneys, and claims of the plan and the plan administrator.
- Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment and to maintain public awareness of the plan.
- Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board after completion of the review, with the committee's recommendation for grievance resolution. The board shall retain all written grievances regarding the plan for at least 3 years.
- Provide for other matters as are necessary and proper for the execution of the board's powers, duties, and obligations under this act.

Subsection (4) establishes the powers of the plan. The plan will have the general powers and authority granted to health insurers under state law and, in addition thereto, the specific authority to:

- Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this act, including the authority, with the approval of the Governor, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;
- Take any legal actions necessary or proper to recover or collect assessments due the plan;
- Take such legal action as is necessary:
    - To avoid payment of improper claims against the plan or the coverage provided by or through the plan;
    - To recover any amounts erroneously or improperly paid by the plan;
    - To recover any amounts paid by the plan as a result of mistake of fact or law; or
    - To recover other amounts due the plan.
- Establish and modify as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial functions appropriate to the operation of the plan. Rates and rate schedules may be adjusted for

appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

- Issue policies of insurance in accordance with the requirements of this act;
- Appoint appropriate legal, actuarial, investment, and other committees as necessary to provide technical assistance in the operation of the plan, develop and educate its policyholders regarding health savings accounts (HSAs), policy and contract design, and any other function within the authority of the plan;
- Borrow money to effect the purposes of the plan. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets;
- Employ and fix the compensation of employees;
- Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public;
- Provide for reinsurance of risks incurred by the plan;
- Provide for and employ cost containment measures and requirements, including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the plan more cost effective;
- Design, use, contract, or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements; and
- Adopt such bylaws, policies, and procedures as are necessary or convenient for the implementation of this act and the operation of the plan.

Subsection (5) requires an interim report. The transition team must submit a report to the Governor, Senate President, and Speaker of the House of Representatives no later than December 1, 2004, including an independent actuarial study of issues specified in the bill.

Subsection (6) requires the board to make an annual report to the Governor and Legislative presiding officers that summarizes the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

Subsection (7) requires the board to submit an evaluation report three years after commencement of the operation of the plan.

Subsection (8) specifies that neither the board nor its employees are liable for any obligations of the plan. A member or employee of the board is not liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under the act, unless such act or omission constitutes willful or wanton misconduct.

Subsection (9) requires submission to the Governor of an audited financial statement no later than June 1 following the close of each calendar year.

Subsection (10) authorizes the board to open up the plan to all eligible individual persons for whom the estimated loss ratio is 100 percent or less. The Governor may establish additional powers and duties of the board to implement the act.

Subsection (11) establishes criteria for persons to be eligible for coverage under the plan. Florida residents and their resident dependents are eligible for coverage if they provide evidence that they:

- Have received from one insurer a notice of rejection or refusal to issue substantially similar insurance as provided through the plan for health reasons;
- Have received a refusal by an insurer to issue insurance except at a rate exceeding the plan rate;
- Are eligible for individual coverage in accordance with the Health Insurance Accountability and Portability Act; or
- Have a history of certain medical or health conditions adopted by the Board of Directors.

A person is not eligible for coverage under the plan if:

- The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to obtain coverage, except that the plan can provide coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;
- The person is eligible for health care benefits under Medicaid or any other government health benefits program;
- The person has previously terminated plan coverage unless 12 months have lapsed since termination;
- The plan has paid out $1 million in benefits on behalf of the person;
- The person is an inmate or resident of a public institution; or
- The person's premiums are paid for or reimbursed under any government-sponsored program, except for persons who are full-time employees or their dependents of a government agency or health care provider.

A person's coverage must cease:

- On the date a person is no longer a resident of this state;
- On the date a person requests coverage to end;
- Upon the death of the covered person;
- On the date state law requires cancellation of the policy; or
- At the option of the plan, 30 days after the plan inquires about the person's eligibility and the person does not reply.

Subsection (12) makes it an unfair trade practice for an insurer, health maintenance organization, insurance agent, insurance broker, or third-party administrator to refer an individual employee to the plan, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from employer-based group health insurance coverage.

Subsection (13) authorizes the board to select, through a competitive bidding process, a plan administrator to administer the plan. The bill establishes criteria for the board to consider in evaluating bids. The administrator shall be either an insurer, a health maintenance organization or a third-party administrator, or another organization duly authorized under the Florida Insurance Code.

Subsection (14) specifies that the plan administrator must serve for a period of time specified in the contract between the plan and the plan administrator. At least 1 year before the expiration of each period of service by a plan administrator, the board must invite eligible entities to submit bids to serve as the plan administrator. Selection of the plan administrator for each succeeding period must be made at least 6 months before the end of the current period.

Subsection (15) specifies the duties of the plan administrator. The functions must include, but not be limited to:

- Determination of eligibility;
- Payment of claims;
- Establishment of a premium billing procedure for collection of premiums from persons covered under the plan; and
- Other necessary functions to assure timely payment of benefits to covered persons under the plan.

The plan administrator must submit regular reports to the board regarding the operation of the plan. On March 1 following the close of each calendar year, the plan administrator must determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the Governor on a form prescribed by the Governor.

Subsection (16) specifies that the plan administrator shall be paid as provided in the contract.

Subsection (17) provides for the funding of the plan. The plan must establish premium rates for plan coverage and must submit premium rates and schedules to OIR for approval before use. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. The plan, in conjunction with OIR, must determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. Initial rates for plan coverage must be no less than 200% of the individual standard risk rate. The plan must also develop a sliding scale premium surcharge based on the insured's income.

Any deficit incurred by the plan shall be funded through appropriated General Revenue sources, including, but not limited to, a portion of the annual growth in existing net insurance premium taxes. The bill establishes requirements for the board to operate the plan in such a way that the costs do not exceed the revenues.

Subsection (18) establishes the benefits of the plan. The benefits provided will be the same as the standard and basic benefit plans as outlined in s. 627.6699, F.S., for small employers. The board

is authorized to establish additional alternative catastrophic coverage as determined by the board. The bill provides factors the board must consider in establishing plan coverage and authorizes the board to adjust deductibles and coinsurance annually according the Medical Component of the Consumer Price Index. The bill provides for a preexisting condition exclusion for charges or expenses incurred during the first 6 months of coverage for any condition for which medical advice, care, or treatment was recommended or received during the 6-month period immediately preceding the effective date of coverage. The bill provides for a waiver of the preexisting condition exclusion under certain circumstances.

Subsection (19) specifies that the plan is the payer of last resort and that benefits otherwise payable under plan coverage must be reduced by all amounts paid or payable through any other health insurance. The plan has a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses.

Subsection (20) establishes a maximum annual benefit of $75,000 and a maximum lifetime benefit of $1 million.

Subsection (21) provides that the plan is exempt from any and all taxes and requires the plan to apply for federal tax exemption.

Section 2. Creates the Small Employers Access Program to provide health insurance to small employers (25 employees).

Subsection (1) provides definitions for the terms "office," "insurer," "participating insurer," "program," and "fair commission."

Subsection (2) establishes eligibility for the program, including:

- Any small employer group up to 25 employees;
- Each dependent of a person eligible for coverage;
- Any municipality, county, school district, or hospital located in a rural community; and
- Nursing home employees.

A small employer group that ceases to meet the eligibility requirements may be terminated at the end of the policy period for which premiums have been paid.

Subsection (3) provides for administration of the program. The Office is required to administer the program by selecting an insurer, through competitive bidding, to provide coverage to small employers within established geographical areas of the state. The bill provides criteria for OIR to consider in evaluating bids.

Subsection (4) specifies that insurers must be duly authorized insurers or health maintenance organizations.

Subsection (5) specifies duties of the insurers. The insurer must:

- Develop and implement a program to publicize the existence of the program, eligibility requirements, and procedures for enrollment;
- Maintain employer awareness of the program;
- Demonstrate the ability to use delivery of cost effective health care services;
- Encourage, educate, advise, and administer the effective use of health savings accounts by covered employees and dependents; and
- Serve for a period specified in the contract between OIR and the insurer.

Subsection (6) provides that the contract term shall not exceed 3 years. At least 6 months before the expiration of each contract period, OIR must invite eligible entities to submit bids to serve as the insurer for a designated geographic area. Selection of the insurer for the succeeding period must be made at least 3 months before the end of the current period.

Subsection (7) requires participating insurers to report on March 1, following the close of each calendar year, net written and earned premiums, the expense of administration, and the paid and incurred losses for the year.

Subsection (8) establishes application requirements for health insurance agents to submit applications for coverage. The agent must be paid a fair commission if coverage is written. "Fair commission" is defined in (2) as a commission structure determined by OIR and the insurers, which will carry out the intent of this section.

Subsection (9) requires the benefits to be the same as the standard and basic plans for small employers as outlined in s. 627.6699, F.S. The insurer, with the approval of OIR, may also establish an option of alternative coverage such as catastrophic coverage that includes a minimum level of primary care coverage.

Subsection (10) provides alternative coverage which provides that any benefit plan approved by the Office may be issued to small employer groups with up to 25 employees by any licensed insurer or health maintenance organization.

Subsection (11) requires OIR to annually report to the Governor, the President of the Senate, and the Speaker of the House of Representatives summarizing the activities of the program in the preceding calendar year, including the net written and earned premiums, program enrollment, the expense of administration, and the paid and incurred losses.

Subsection (12) requires OIR, in conjunction with representative of each of the regional insurers, provider groups, and small employer representatives, and a person designated by the Governor, to meet at least annually to review the operations of the program, suggest improvements, and recommend incentives to encourage employer participation in the program.

Section 3. Creates a Statewide Electronic Medical Records Task Force to serve as a body of experts to advise the Agency for Health Care Administration in developing policies related to electronic medical records and the technology required for sharing clinical information among caregivers. The task force must be appointed by the Governor and must meet at least quarterly. Members of the task force will serve without compensation but are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061, F.S. AHCA must provide personnel to

support the functions of the task force and to assist the task force in creating the electronic medical records system. AHCA may enter into contracts to carry out the provisions of the bill.

The task force must advise the Governor, the Legislature, and the agency on the following:

- Public and private sector initiatives relating to electronic medical records and the communication systems used to share clinical information among caregivers;
- Regulatory barriers that interfere with the sharing of clinical information among caregivers;
- Investment incentives that might be used to promote the use of recommended technologies by health care providers;
- Educational strategies that could be implemented to educate health care providers about the recommended technologies for sharing clinical information; and
- Standards for public access to facilitate the disclosure of pricing, costs, and quality.

The task force must send to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report by November 30, 2004, and annually thereafter. Each report must include any recommendations or implementation plan developed by the advisory panel. If the task force proposes an implementation plan, the proposed plan must include, but need not be limited to, the capital investment required to begin implementing the system; the costs to operate the system; the financial incentives recommended to increase capital investment; data concerning the providers initially committed to participate in the system, by region; the standards for systemic functionality and features; any marketing plan to increase participation; and implementation schedules for key components.

The bill appropriates $2 million from the General Revenue Fund to the Agency for Health Care Administration for funding the activities relative to the panel. The act will expire July 1, 2007.

Section 4. Amends s. 381.026, F.S., the Florida Patient's Bill of Rights and Responsibilities, to require health care facilities to make available to the public package prices for each of the top 50 most utilized elective inpatient and outpatient procedures. The facilities are also required to make available a list of the top 50 most used inpatient and outpatient procedures. The Agency for Health Care Administration is required to develop rules for implementation of a uniform mechanism for reporting this information on the facility's website. The bill also establishes that a patient has the right to receive a reasonable estimate of charges for a proposed medical service prior to treatment.

Section 5. Amends s. 395.301, F.S., relating to itemized patient billing, to require each licensed facility (hospitals, ambulatory surgical centers, and mobile surgical facilities) to make available to the public, on its Internet website or through other electronic means, the package prices for the top 50 most used elective inpatient and outpatient procedures. The facilities are also required to make available a list of the top 50 most used inpatient and outpatient procedures. The Agency for Health Care Administration is required to develop rules for implementation of a uniform mechanism for reporting this information on the facility's website.

The bill requires each licensed hospital, ambulatory surgical center or mobile surgical facility to give a prospective patient a reasonable estimate of charges for a proposed medical service prior to treatment.

Section 6. Amends s. 408.909, F.S., relating to Health Flex plans, to expand eligibility statewide and eliminating "pilot" status; and to permit public-private partnerships to participate in the program. Health Flex plans must follow standardized grievance procedures similar to those required of health maintenance organizations. The bill requires OIR to oversee health flex plan advertisement and marketing procedures, and requires AHCA and OIR to use health flex plans to gather information to evaluate low-income consumer-driven benefit packages.

Section 7. Amends s. 627.410, F.S., relating to filing and approval of forms, to exempt group health insurance policies insuring groups of 26, rather than 51, or more persons.

Section 8. Amends s. 627.6487, F.S., which establishes guaranteed availability of individual health insurance coverage to eligible individuals. The bill specifies that an individual who is not eligible for coverage under the Florida Health Insurance Plan and the plan is accepting new enrollment is eligible for guaranteed-issue individual coverage under s. 627.2487, F.S.

Section 9. Amends s. 636.003, F.S., related to prepaid limited health service organizations. The bill adds providers "providing access to any discounted medical services" to the definition of prepaid limited health service organization. However, the bill further provides that any plan or program of discounted medical services that charges consumers $15 or less per month or $180 or less per year is not a prepaid limited health service organization if it:

- Clearly indicates that the plan is not insurance, that the plan is not obligated to pay any portion of the discounted fees, and that the consumer is responsible for paying the full amount of the discounted fees;
- Does not use the term "affordable health care" or "coverage," or any other term that misrepresents the nature of the program; and
- Requires a statement beside the provider network on the discount care alerting the network providers and facilities that the cardholder does not have insurance and is merely entitled to the network discount rate for services provided.

Section 10. Provides that the bill will take effect October 1, 2004, except that sections 5 and 10 will take effect July 1, 2004, and paragraph (17)(b) of section 1 will take effect July 1, 2005.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Insurance carriers will incur certain costs associated with Florida Health Insurance Plan.

Significant costs are associated with achieving licensing and solvency requirements required of specified discount medical plans.

If the Florida Health Insurance Plan is eventually opened to new enrollment, small businesses should experience modest declines in future premium increases. One person groups would experience significant declines in medical premiums. Uninsurable risks would find medical coverage available, potentially decreasing out of pocket expenditures for medical care.

Small businesses and the uninsured may find affordable coverage through the expansion of the Health Flex program or the creation of the Small Employers Access Program.

Florida's uninsured population, small employer groups, rural hospitals, and local governments are expected to benefit from both the establishment of the Florida Health Insurance Plan and the establishment of the Small Employers Access Program.

Health care providers and consumers will benefit from the Statewide Electronic Medical Records Data System.

The proposed bill will increase competition by providing transparency in pricing among health care providers.

C. Government Sector Impact:

Cost to the Office of Insurance Regulation

Expenditures	FY 04-05	FY 05-06	FY 06-07
Recurring	$155,386	$159,271	$163,253
Non-recurring	$13,683		

In the first year, OIR estimates a cost in non-recurring revenues of $13,683. This estimate covers three (3) FTE, Insurance Analyst II’s at 10% above base plus benefits and expense and operating capital outlay package.

Cost to the Agency for Health Care Administration

The bill appropriates $2 million from the General Revenue Fund to the Agency for Health Care Administration for the purpose of implementing this act during the 2004-2005 fiscal year.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The membership of the Electronic Medical Records Task Force is not specified, either by number of members or representation to be included on the panel.

On page 23, lines 14 and 15, the bill requires AHCA to assist the task force in "creating" the electronic medical records system, however, the advisory panel is charged with advising the Governor, the Legislature, and AHCA on a variety of issues, but is not charged with actually creating an electronic medical records system. Thus, it is unclear how the $2 million appropriation would be spent. If the intention of the bill is to create an electronic medical records system, the $2 million could be the beginning of a long-term commitment of significant resources. If the advisory role of the panel is limited to the areas included in the bill, it is not clear why AHCA would need $2 million in FY 2004-2005.

VIII. Amendments:

None.