HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1337 CS High Deductible Health Insurance Plan Study Group
SPONSOR(S): Homan
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee	18 Y, 0 N, w/CS	Cooper	Cooper
2) Health Care Regulation Committee			
3) Commerce Council			
4)			
5)			

SUMMARY ANALYSIS

The bill creates an 13 member health insurance plan study group to examine issues related to high deductible health insurance plans, including health savings accounts and reimbursement arrangements; the impact of these insurance plans on access to care and hospitals, including the ability of hospitals to collect copayments; the assignment of benefit attestations, the standardization of subscriber identification cards, and standardization of claim edits.

The bill specifies the composition of the study group and its staffing. The bill does not contain any appropriation for expenses incurred by the study group.

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

This bill does not appear to implicate any of the House Principles

B. EFFECT OF PROPOSED CHANGES:

The Uninsured in Florida

The Agency for Health Care Administration (AHCA) is created in s. 20.42, F.S., and is directed by law to serve as the state's chief health policy and planning entity. In 1998, the Legislature directed AHCA to gather data for the then newly-created Florida Health Insurance Study (FHIS) to provide reliable data regarding the number of Floridians who were not covered by health insurance. The initial FHIS was completed in 1999; last year, AHCA received a grant to update the 1999 study.

Typically, data collected regarding the uninsured population in the U.S. counts citizens under the age of 65. According to AHCA, most Americans aged 65 or older "have some health coverage through Medicare." As a result, surveys of Americans relating to health insurance generally query Americans under age 65. Data in the FHIS are collected from Florida citizens under age 65.

The 2004 update to FHIS included telephone interviews with 17,435 Florida households. The data in the 2004 FHIS represent an estimated 46,876 Florida citizens. The data that follow are contained in *Highlights from the 2004 Florida Health Insurance Study* available on the AHCA web site at: http://ahca.myflorida.com/Medicaid/Research/Projects/fhis2004/PDF/highlights_from_the_2004_fhis_1104.pdf

- From 1999 to 2004, the number of uninsured Floridians under age 65 rose from 16.8 percent to 19.2 percent;
- Miami-Dade County now has the highest rate of citizens without health insurance at 28.7 percent, an increase from 24.6 percent in 1999;
- Rates of uninsurance increased the most for middle-income families in the state; those with annual family incomes ranging from $15,000 to $45,000 per year;
- As in 1999, Hispanics have the highest rate of uninsurance at 31.8 percent; African Americans are uninsured at the rate of 22.6 percent; white, non-Hispanics are uninsured at the rate of 14.3 percent;
- Employment status has a high correlation to health insurance coverage: almost half, 48.1 percent of unemployed Florida citizens lack coverage; similarly, 32 percent of the self-employed lack health coverage. Full-time employees are uninsured at the rate of 15.7 percent;
- The size of an employer is a key factor in whether a Florida worker has health coverage. Among those in firms with fewer than 10 employees, more than 33 percent do not have health insurance, however, for employees in firms with 1,000 or more workers, only 5.2 percent lack health insurance;
- In describing the "main reason" they lack health insurance, 63 percent of the survey respondents cited cost as the primary factor; almost 10 percent indicated that their employers do not offer health insurance, and 3.7 percent of the respondents were unemployed at the time of the survey; and
- Of Floridians without health coverage, 54 percent have been without coverage for longer than 1 year and almost 19 percent have never had health insurance.

Florida's Current Health Insurance Market

In Florida, regulation of the insurance industry is shared by the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR). The state's Chief Financial Officer (CFO) heads DFS while the head of OIR is the Governor and Cabinet members sitting as the Financial Services Commission. Generally, OIR is responsible for granting a certificate of authority or license to an insurer; a domestic insurer, i.e., an insurer based in Florida, must possess a certificate of authority in order to conduct business in Florida. Similarly, many insurers are required by law to seek OIR approval for their rates, or the prices they charge for coverage, and approval of the insurance forms they use for issuing policies. The Office of Insurance Regulation investigates allegations of fraud against insurers and administers state laws governing the financial reserve requirements imposed on insurers. The regulation and licensure of insurance agents and agencies is the purview of DFS. Staff of DFS also provides consumer information and assistance through the Division of Consumer Services.

Various federal and state laws regulate the health insurance market in the state. The result of the various laws is that Florida's health insurance market is segmented into various groups, including self-insured groups or health plans, large groups of 51 or more participants, small groups ranging in size from 1 to 50 members, individual health policies, and out-of-state groups. Each segment of the market may be further divided into sub-groups, both in Florida, and in most other states, however, the Florida Insurance Code governs the activities, policies, and premiums of health insurance within the market segments identified herein.

Health Insurance and Small Employers

As indicated in the 2004 update to the FHIS, persons who are unemployed or employed by small employers, i.e., those with 50 or fewer employees, are the most likely to lack health insurance. The Legislature has recognized this problem and has created numerous programs over the past 15+ years to encourage small employers to make health insurance available to their employees.

Florida's current laws governing small group health benefits, s. 627.6699, F.S., The Employee Health Care Access Act or Small Group law, require insurance carriers to pool or aggregate all of their small groups into a single rating group or pool when apportioning costs and estimating premiums

Under the Employee Health Care Access Act (the Act), a "small employer" is defined in s. 627.6699(3)(v), F.S., as any person, sole proprietor, self-employed person, independent contractor, firm, association, or other business entity that is based in Florida, actively engaged in business, with at least one, and no more than 50 employees. The Act applies to a health benefit plan providing coverage to a Florida-based small employer, unless the policy is marketed directly to an individual employee whose employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy.

The Act defines a carrier as a person or entity who provides health benefit plans in Florida, including an authorized insurer, a health maintenance organization, and a multiple-employer welfare plan, i.e., a self-insurance plan, unless the self-insurance plan existed in 1992 or earlier. Under the definitions provided in s. 627.6699(3), F.S., an "eligible employee," i.e., an employee who may participate in a group benefit plan, is an employee who works full time, including a normal workweek of 25+ hours. An "eligible employee" includes a sole proprietor, a self-employed person, or a partner.

The Act requires an insurer to offer group health benefits on a guaranteed-issue basis. The term "guaranteed-issue basis" is defined as an insurance policy that must be offered to an employer, employee, or to a dependent of an employee, regardless of health status, previous claims experience, or preexisting condition. A policy offered as a guaranteed issue also must provide all the coverage mandated by state law, including coverage for such services as mammograms, diabetes education and treatment, treatment for cleft lip and cleft palate, among other required benefits.

The current law also requires each small employer carrier issuing new health benefit plans to offer to any small employer, upon request, a standard health benefit plan, a basic health benefit plan, and a high deductible plan that meets the requirements of a health savings account plan as defined by federal law or a health reimbursement arrangement as authorized by the Internal Revenue Service.

Health Insurance Policies: General Provisions

Section 627.638, F.S., authorizes an insurer to make direct payment for services to a hospital or physician if a policyholder's contract authorizes direct payments. The same law requires an insurer to make direct payment to the health care service provider if the insured so requests, unless the health insurance contract specifically provides otherwise.

Section 395.1041, F.S. specifies the conditions under which a patient must be treated in a hospital emergency room. Generally, the law requires each hospital with an emergency department to treat any person who requests emergency services, regardless of whether the person has health insurance. Within the past several years, physicians and some hospitals have complained that they are not paid by some HMOs and insurers for treatment rendered in an emergency room if the physician or hospital is not part of the insurer's network of providers.

Health Savings Accounts

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, included provisions authorizing "tax-favored" health savings accounts (HSAs) for the payment of qualified medical expenses. The federal Act was signed into law by President Bush in December 2003, and it became effective January 1, 2004. An HSA is a portable health savings account a consumer may use to pay for qualified medical expenses. These accounts generally are offered in tandem with a health plan that provides coverage for major medical costs. Currently, consumers may make annual HSA contributions of up to $5,250 for a family and up to $2,650 for an individual.

Floridians for Health Care Choices, comprised of the Florida Chamber of Commerce, Florida Retail Federation and National Federation of Independent Business, is a coalition aimed at promoting new and affordable health care options for Florida employers and consumers. The group sponsors a website at www.saveforyourhealth.com. According to information on the website, "Florida is on the leading edge of promoting and implementing HSA programs, helping employers provide strong, flexible health plans that can benefit all Floridians."

Similarly, the website reports Floridians benefit by saving because once they contribute to an HSA, the money is theirs to spend—tax-free—for health care deductibles, co-payments, and other authorized expenses. Funds that are not used by year-end remain in the account to grow tax deferred, and after age 65 the funds can be used, without penalty, for anything— just like an individual retirement account (IRA). At all times, the money in an HSA account belongs to the consumer.

To be eligible for an HSA, an individual must be covered by a high deductible health plan (HDHP) which meets certain annual minimum deductible and maximum out-of-pocket requirements. In 2005, the minimum deductibles must be at least $1,000 for individual coverage and $2,000 for family coverage; out-of-pocket expenses may not exceed $5,100 for individual coverage and $10,200 for family coverage.

Contributions to an HSA by an eligible individual may be deducted from a participating individual's adjusted gross income on their federal income tax return, regardless of whether they itemize deductions. Distributions from an HSA for "qualified" medical expenses also are excluded from an individual's gross income. Health savings accounts also offer consumers portability, i.e., an HSA may be taken from one employer's health insurance plan to another and the HSA owner may continue to make deposits and withdrawals.

Changes Proposed by the Bill

The bill creates an 13 member high deductible health insurance plan study group to be composed of: (a) three representatives of employers offering high deductible health plans to their employees, one each who will be appointed by the Florida Chamber of Commerce, the National Federation of Independent Business, and Associated Industries of Florida. Of these representatives, one must be a small employer as defined in s.627.6699, F.S.; (b) three representatives of commercial health plans, to be appointed by America's Health Insurance Plans; (c) three representatives of hospitals, one of whom will be a representative of a statutory teaching hospital, to be appointed by the Florida Hospital Association; (d) two physician representatives, one to be appointed by the Florida Medical Association and one to be appointed by the Florida Osteopathic Medical Association; and (e) the Secretary of the Agency for Health Care Administration and the Director of the Office of Insurance Regulation, who shall serve as co-chairs.

The study group is required to study the following issues related to high deductible health insurance plans, including, but not limited to, health savings accounts and health reimbursement arrangements:

(a) The impact of high deductibles on access to health care services and pharmaceutical benefits.

(b) The impact of high deductibles on utilization of health care services and overutilization of health care services.

(c) The impact on hospitals' inability to collect deductibles and copayments.

(d) The ability of hospitals and insureds to determine, prior to service delivery, the level of deductible and copayment required of the insured.

(e) The methods to assist hospitals and insureds to determine prior to service delivery status of the insured in meeting annual deductible requirements and any subsequentcopayments.

(f) The methods to assist hospitals in the collection of deductibles and copayments, including electronic payments.

(g) Alternative approaches to the collection of deductibles and copayments when either the amounts of patient financial responsibility are unknown in advance or there are no funds electronically available from the patient to pay for the deductible and any associated copayment.

The study group shall also study the following issues:

1) The assignment of benefits attestations and contract provisions which nullify the attestations of insureds.

2) The standardization of insured or subscriber identifications cards.

3) The standardization of claim edits or insuring that claim edits comply with nationally recognized editing guidelines.

The study group is required to meet by August 1, 2005, and must submit recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2006.

The bill specifies that staff support for the study group shall be provided jointly by the Agency for Health Care Administration and the Office of Insurance Regulation. The bill does not contain any appropriation for expenses incurred by the study group.

C. SECTION DIRECTORY:

Section 1. Creates the study group.

Section 2. Provides an effective date of July 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

2. Expenditures:

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

2. Expenditures:

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

D. FISCAL COMMENTS:

In its bill analysis and economic impact statement, the Agency for Health Care Administration made the following comments:

"The bill specifies the composition of the study group but does not specify staffing of the study group. The bill does not contain any appropriation for any expenses incurred by the study group.

Past experience with work groups indicates that the work groups may require staffing to arrange for meetings, publish meeting notices in the FAW, prepare minutes, conduct data research, and prepare draft reports and the final report. Specifically, the staff and the study group would be responsible for collecting the following data:

- The number of high deductible plans by area
- The number of health savings account plans by area
- Survey data on the impact of high deductible plans on access to health care, pharmaceutical benefits, and overutilization of health care services
- Survey data on the impact of high deductible plans on hospitals
- The ability of hospitals statewide to collect copayments and deductibles

- Methods to assist hospitals in collecting copayment and deductibles

- Alternative approaches to the collection of deductibles and copayments when the amounts of patient responsibility is unknown

- The impact of assignment of benefits attestations, and

- The impact of standardization of insured or subscriber identification cards.

In order to arrange for the first meeting on August 1, 2005, as required in the proposed bill, staff would have to be hired by July 1, 2005 and have to be available through the end of December of 2005 in order to complete the final report. An outside contractor would best accomplish this task.

It is estimated that it would cost approximately $210,600. On average it takes about 112 hours of preparation for one meeting. Assuming three meetings during the six months period, it would take 1.5 principal researchers and one senior consultant. The hourly rate for each principal researcher is $250 per hour, and $220 for each senior consultant, totaling about $600 for the team of consultants per hour. The total cost for the three meetings would be three times 112 hours times $600 equaling $210,600."

Note: The comments from the Agency for Health Care Administration were directed to the bill as originally filed which not specify who would staff the study group.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

2. Other:

B. RULE-MAKING AUTHORITY:

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 14,2005, the Insurance Committee adopted a strike–everything amendment. The difference between the original bill and the committee substitute is that the committee substitute increased the membership of the study group from 11 to 13 by adding two physicians, changed the appointing parties and specified the staffing responsibilities. This staff analysis reflects those changes,