HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1503 CS Health Insurance
SPONSOR(S): Farkas
TIED BILLS: **IDEN./SIM. BILLS:** SB 2514

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee	19 Y, 0 N, w/CS	Tinney	Cooper
2) Health Care General Committee	12 Y, 0 N, w/CS	Schiefelbein	Brown-Barrios
3) Health Care Appropriations Committee			
4) Commerce Council			
5)			

SUMMARY ANALYSIS

The bill amends various provisions of the Florida Insurance Code to regulate specified activities of health insurers in the state. Most changes in the bill amend and refine laws adopted by the 2004 Legislature aimed at increasing the availability of health insurance to Florida consumers rather than imposing new requirements. Specifically, the bill:

- Repeals s. 627.6402, F.S., enacted in 2004; the repealed section requires an insurer to offer a rebate to an employer whose employees participate in wellness or similar program;
- Amends provisions relating to the Florida Health Insurance Plan, the state's residual market for health insurance; FHIP was created in 2004. Requirements governing FHIP premiums are amended to require initial premiums to be 200 percent (rather than 300 percent currently) of the rates under law for individual standard risks.
- Amends law governing the FHIP relating to funding, premiums, reserve requirements, and payments to providers.
- Clarifies that an insurer is not required to issue an individual policy to a person who was insured under FHIP.
- Amends the Insurance Code to authorize a licensed health insurer or HMO to offer a high-deductible plan or contract that meets federal requirements of a health savings account plan or a health reimbursement account.
- Amends Florida's mini-COBRA law to conform timeframes in Florida law to the federal standards under the Health Insurance Portability and Accountability Act (HIPAA). This means an employee or his or her eligible dependents has 63 days, rather than the current 30 days specified in state law, to apply for continuation of coverage after the employee leaves an employer offering group coverage.
- Authorizes insurers offering small group policies, specifically policies to one-life groups, to offer a high deductible plan that meets the requirements of an HSA as defined by federal law.
- Requires insurers to make direct payment to a physician or hospital for treatment received by an insured in an emergency room.
- Amends several provisions relating to the Small Employer Health Reinsurance Program. Changes composition of the program's board of directors and the duties assigned to the board.
- Requires OIR to examine the books and other records of an HMO once every 5 years rather than every 3 years.
- Increases from $20,000 to $50,000 the maximum amount OIR may charge an HMO for an audit or investigation.
- Changes the due date for a report from the Agency for Health Care Administration relating to the Comprehensive Health Information System from March 1, 2005 to January 1, 2006.
- Provides specific report release dates of performance outcome and patient charge data.
- Requires that the impact of alternative methods of actuarially sound risk adjusted provider reimbursement methodologies be included in the actuarial study required by s. 627.64872(6), and requires a December 1, 2005 report date.
- Amends s. 641.31, F.S., and requires the insurer to offer a group rebate to a health maintenance organization when the majority of the members of the group participate in a wellness or similar program.
- Appropriates $5 million from the General Revenue to the Florida Health Insurance Plan to implement the plan.

Under the bill, OIR is authorized to charge an HMO a maximum of $50,000 per year to examine the books and records of the HMO; this is a $30,000 per examination increase over the $20,000 maximum charge currently authorized in law. The bill requires OIR to examine an HMO once every 5 years, rather than every 3 years. Other costs associated with the bill are explained in the Fiscal Analysis and Economic Impact section of the Staff Analysis.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government and Ensure Lower Taxes—The bill amends various provisions of the Florida Insurance Code to regulate specified activities of insurers in the state. Most changes in the bill amend and refine laws adopted by the 2004 Legislature aimed at increasing the availability of health insurance to Florida consumers rather than imposing new requirements. Under the bill, the requirement for OIR to examine the books and records of HMOs is changed from at least once every 3 years to once every 5 years, however, the audit costs an HMO must pay are increased from $20,000 to $50,000 in a single year.

Safeguard Individual Liberty and Empower Families—To the degree that the bill increases the options available to consumers for health insurance, personal freedom may be enhanced. The bill recognizes the difficulty for small-group employers to make health insurance benefits available to their employees. Several measures in the bill attempt to increase the insurance options available to small-group employers.

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.

Chapter 627, F.S., governs rates and contracts for all types of insurance available in Florida, including life, health, property, automobile, credit life and disability, workers' compensation, and title, among other types of policies. For example, part VI, chapter 627, F.S., governs health insurance policies, while part VII of chapter 627, F.S., governs group, blanket, and franchise health insurance policies. Part II of ch. 627, F.S., including ss. 627.401-627.441, outlines the requirements insurers must include in their policies, i.e., contracts.

Health Insurance Policies: General Provisions and Proposed Changes

Part VI of ch. 627, F.S., specifies the requirements for health insurance policies sold in Florida. Section 627.6487, F.S., specifies the eligibility for individual health insurance policies. The terms "health insurance issuer," "individual health insurance," and "eligible individual" are defined in s. 627.6487, F.S. The definition of the term "eligible individual" is amended to specify that a person eligible for an individual policy is a person not eligible for coverage under the Florida Health Insurance Plan, Florida's residual market for persons unable to procure health coverage in the private market.

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. The bill amends s. 627.638, F.S., to require an insurer to make direct payment to a physician or hospital for services provided in an emergency room.

Section 627.6402, F.S., which was enacted in 2004, requires an insurer to offer a rebate of premiums, not to exceed 10 percent, if an individual insured is enrolled in and continues to participate in a wellness or similar program. A policyholder must demonstrate his or her participation in a wellness program by demonstrating maintenance or improvement of the policyholder's health status. The bill repeals this section of law.

The Florida Health Insurance Plan (FHIP)

The Health Insurance Portability and Accountability Act (HIPPA), also known as the Kennedy-Kassebaum Act, named for its U.S Senate sponsors, was adopted in 1996 by Congress. The federal act was designed to help citizens purchase and keep health insurance, even if the insured develops serious health problems. The federal law sets national standards for health insurance reforms, including authorizing an individual to move from one health plan to another without a penalty or waiting period for a pre-existing condition. Over the past 10 years, Florida laws have expanded and otherwise modified the standards under HIPAA.

A segment of the Florida insurance market includes persons in the state's high-risk pool. Generally, a high-risk pool is a state-created, nonprofit residual market that typically is subsidized through a tax assessment on all of a state's health insurers, both individual and group plans; by state funds; or a combination of funding. As in any insurance group, the idea of a high-risk pool, or insurer of last resort, is to spread the cost of providing health services to a sicker population across a larger group of insured people, rather than depending solely on the relatively small individual market to cover the chronically ill. A risk pool, by design, is the safety net for a person with a serious chronic or acute illness or condition that requires ongoing treatment over time or that requires rapid or dramatic medical intervention for the policyholder. Many times, such individuals are considered medically uninsurable because of the high or ongoing costs associated with treatment.

Nationally, high-risk pools have been used by states for more than 30 years; most follow the model designed by the National Association of Insurance Commissioners (NAIC). Although high-risk pools originally were designed to provide health benefits for the uninsurable population, over time, states have increasingly relied on the high-risk pool to guarantee coverage to eligible people entering the individual market from group coverage as required by HIPAA. In 2004, only Alabama operated its high-risk pool exclusively for those eligible under HIPAA. Twenty-six of the 29 state high-risk pools cover those eligible under HIPAA. Federal regulations require all states to waive pre-existing condition exclusion periods for this class of enrollees.

To support the cost of the high-risk pools, many states assess health insurers, generally a percentage of the insurer's total premiums collected in the state. Other states fund all or part of the pool directly from general revenues. In most states that tax insurance premiums to fund their high-risk pools, the state also grants a credit against an insurer's corporate tax liability for the amount of premium tax the insurer is assessed for the high risk pool. A few states earmark other monies, such as tobacco funds, to finance their high-risk pools exclusively or in addition to general revenues.

In 2004, the Legislature established the Florida Health Insurance Plan (FHIP) as the state's high risk pool. The FHIP is run by a nine person board of directors and chaired by the OIR director. By law, a majority of the board must be composed of individuals who are not representatives of insurers or health care providers. In December, 2004, as required by law, the board provided to the Governor, Senate President, and Speaker of the House an actuarial study regarding funding for FHIP and the impact of the FHIP on small employers. The 2004 law required the completion of the actuarial study, including cost projections, before the FHIP could begin enrolling members. Funding for the FHIP is provided

through two mechanisms: premiums, initially capped at 300 percent of standard risk rate, subject to a sliding surcharge based on the insured's income and General Revenue monies to cover deficits incurred in excess of available premiums. Once the FHIP begins enrolling members, the Florida Comprehensive Health Association is statutorily repealed.

Changes Proposed by the Bill: the Florida Health Insurance Plan

Under the bill, s. 627.64872, F.S., provisions governing the FHIP are amended. A definition for "director," referring to the director of OIR is deleted; instead, the word "commissioner" is defined as the Commissioner of Insurance Regulation, i.e., the director of OIR. The definition for the word "resident" is amended to specify that a Florida resident is a person who has lived in the state for at least 6 months *and who physically lives here for at least 6 months*, i.e., 185 days per year.

Obsolete language requiring a report from OIR December 1, 2004 is deleted, although the requirement for an annual report on FHIP is maintained. The bill also amends eligibility requirements for FHIP by specifying that a person is not eligible for FHIP if his or her premiums are paid by an organization sponsored by or affiliated with any health care provider. Requirements governing FHIP premiums also are amended by the bill to require initial premiums to be 200 percent (rather than 300 percent currently) of the rates under law for individual standard risks.

The bill also amends the law creating FHIP relating to funding, premiums, and reserve requirements. Provisions governing a deficit in FHIP are amended to clarify that a deficit in the plan may not be less than the anticipated losses and reserve requirements for existing policyholders. If the plan faces a deficit, the FHIP board is authorized by the bill to cancel existing policies on a nondiscriminatory basis as necessary to address the deficit. The board may not cancel a policy if a covered individual has a claim pending.

The law creating FHIP is further amended by the bill to specify the maximum reimbursement available to health care providers. Under the bill, the maximum reimbursement rate for a covered, medically necessary service is equal to the amount allowed by Medicare for the same provider and service. A licensed health care provider is required by the bill to accept assignment of FHIP benefits and to consider the reimbursement rate as full payment for the service provided. The bill specifies that the actuarial study required by s. 627.64872(6) include the impact of alternative methods of actuarially sound risk adjusted provider reimbursement methodologies, including capitated prepaid arrangements that take into account age, sex, geographic variations, case mix and access to specialty medical care. The bill provides a report date of December 1, 2005.

The bill also amends s. 627.6487, F.S., relating to the guaranteed availability of individual health insurance policies, to clarify that an insurer is not required to make an individual policy available to a person who was previously insured under FHIP.

Health Flex

Health flex is an alternative to a traditional health insurance plan such as one offered by a preferred provider organization (PPO) or health maintenance organization (HMO) plan or a health indemnity plan. Health flex plans are designed to appeal to individuals who have lower incomes (less than or equal to 200 percent of the federal poverty level), who have been uninsured for at least 6 months, are under age 65, and who are not eligible for Medicare or Medicaid. In 2004, the federal poverty rate for a family of four was $18,850. This means an uninsured family of four living in Florida, with a total household income of $37,700 or less, is eligible to participate in a health flex program.

Legislation authorizing several pilot projects to implement health flex plans was introduced during the 2002 legislative session; the program became effective July 1, 2002 and its statutory authority was codified in s. 408.909, F.S. Initially, health flex programs were only authorized through 2004. Under current law, the authority for health flex expires July 1, 2008.

Administration of the Health Flex Program is shared between AHCA and OIR. The two agencies are responsible for sharing oversight and approval of health flex plans under current law. The Health Flex Program differs from insurance products in several ways. Health Flex Plan providers are not subject to licensure under the Florida Insurance Code. Rather, health flex providers must meet quality of care and financial guidelines developed jointly by AHCA and OIR. Health Flex Plans are not subject to the mandated health care benefits specified in law and can design a flexible benefit coverage product that may contain none, a few, or all of the mandates. Health flex plans may be offered by licensed insurers, HMOs, health care providers, local governments, health care districts, or other public or private organizations, and through a small employers' business purchasing arrangement sponsored by a local government.

At this time, there are four approved health flex plans: AmericanCare, a physician group in Dade County; JaxCare, a private not-for-profit organization in Duval County; Preferred Medical Care in Dade County; and Jackson Memorial Health Flex Plan in Dade County. The former three have been in operation for at least 1 year; the Jackson Memorial Plan began accepting members October 1, 2004. As of mid-March, 2005, the four health flex plans collectively had fewer than 1,200 members.

Changes Proposed by the Bill: Health Flex

Section 408.909(3)(b), F.S., of the Health Flex law is amended to authorize OIR to disapprove a health flex plan if the plan or its management does not comply with s. 624.404(3), F.S. The law referenced specifies the general eligibility requirements of licensed insurers including competence, trustworthiness, experience in issuing and servicing insurance policies, and other similar provisions.

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: Health Savings Accounts

Section 627.413, F.S., outlines the process an insurer must follow to apply for a certificate of authority from OIR. The law is amended to authorize a licensed health insurer or HMO to offer a high-deductible plan or contract that meets federal requirements of a health savings account plan; such a plan may be offered by the insurer or HMO in conjunction with a health savings account. Staff of OIR reports that the amendment to current law relating to HSAs ensures that the Florida Insurance Code conforms to federal law and HSA guidelines issued regularly by the U.S. Treasury.

Florida's Health Insurance Coverage Continuation Act ("Mini-COBRA")

COBRA is an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985.
Section 627.6692, F.S., is Florida's mini-COBRA law, meaning it provides state requirements for continuing group health insurance coverage once an employee leaves the employer offering the group coverage. The law states its intent is to ensure that employees of small employers, and the dependents of the employees, have continued access to affordable health insurance.

Changes Proposed by the Bill: Florida's Mini-COBRA Provisions

Section 627.6692, F.S., is amended to conform timeframes in Florida law to the federal standards under HIPAA. This means an employee or his or her eligible dependents has 63 days, rather than the current 30 days specified in state law, to apply for continuation of coverage after the employee leaves an employer offering group coverage. According to information provided by OIR, "the most recent HIPAA time period within which eligible employees may apply for continuation of coverage is 63 days."

Health Insurance and Small Employers

As indicated in the 2004 update to the Florida Health Insurance Study, 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.

Last year, the Legislature adopted several reforms to the various provisions of law that govern health insurance and the provision of health care services in chapter 2004-297, Laws of Florida, entitled "The 2004 Affordable Health Care for Floridians Act". Among the provisions of the 2004 law was the creation of s. 627.6699(15), F.S., entitled The Small Employers Access Program.

The Small Employers Access Program states that the purpose of s. 627.6699(15), F.S., is to facilitate the ability of small employers "to provide health care benefits to their employees at an affordable cost through the creation of purchasing pools for employers with up to 25 employees, and rural hospital employers and nursing home employers regardless of the number of employees."

The Employee Health Care Access Act, s. 627.6699, F.S.

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 Act creates the Small Employer Health Reinsurance Program at s. 627.6699(11), F.S., a not-for-profit entity, to establish procedures for eligible insurers to reinsure the risks associated with covering small groups. The program is governed by a 14-member board of directors; 13 of the members must be representatives of carriers and insurance agents serving the small-group market. The OIR director chairs the board and serves as the 14th board member.

Changes Proposed by the Bill: Small Group Health Insurance

Section 627.6699, F.S., is amended to authorize insurers offering small group policies, specifically policies to one-life groups, to offer a high deductible plan that meets the requirements of a health savings account or health reimbursement account as defined by federal law.

The bill also amends several provisions relating to the Small Employer Health Reinsurance Program. Membership of the program’s board of directors is changed to include five insurance carriers, two agent representatives, four members to represent small-group employers, one consumer who has an individual policy and a representative of the State Center for Health Statistics in AHCA. The director of OIR still chairs the board and serves as the 14th board member. The board will meet at least three times annually.

The bill also changes the scope of the board’s responsibilities; the board now will serve in more of an advisory capacity to OIR. The board also will provide stakeholders, i.e., insurers, employers, agents, consumers, and regulators with a forum for discussing the issues that affect the small-group market in Florida. The bill changes dates and content of reports required of the board, as well.

Other Changes Proposed by the Bill

Chapter 641, F.S., governs health service programs including HMOs, prepaid health clinics, and other health care services. Section 641.27, F.S., authorizes OIR to examine the books and other records of an HMO whenever necessary, but at least once every 3 years. Under current law, OIR may accept an independent audit report prepared by a licensed CPA in lieu of auditing the HMO with OIR staff. The law requires an HMO to pay the audit expenses of OIR up to a maximum of $20,000 during any 1 year.

The provisions governing periodic audits and examinations are amended by the bill to require OIR to examine an HMO every 5 years, rather than every 3 years. An HMO may no longer submit an independent audit report from a CPA in lieu of OIR conducting the audit, however. The maximum charge to an HMO for an audit by OIR is increased by the bill from $20,000 per year to $50,000 in a single year.

The provisions governing health maintenance contracts are amended to provide that an insurer must offer a group rebate to a health maintenance organization when the majority of the members of the group participate in a wellness or similar program.

C. SECTION DIRECTORY:

Section 1. Amends s. 408.05, F.S., relating to the State Center for Health Statistics to change the due date for a report from March 1, 2005 to January 1, 2006.

Section 2. Amends s. 408.909, F.S., relating to health flex plans.

Section 3. Amends s. 627.413, F.S., governing the form and contents of insurance policies and contracts.

Section 4. Amends s. 627.638, F.S., to require insurers to make direct payment to a hospital or physician for treatment received by a patient in an emergency room.

Section 5. Amends s. 627.6487, F.S., relating to the guaranteed availability of individual health insurance coverage to eligible persons.

Section 6. Amends s. 627.64872, F.S., relating to the Florida Health Insurance Plan.

Section 7. Amends s. 627.6692, F.S., relating to the continuation of coverage under group health plans.

Section 8. Amends s. 627.6699, F.S., the Employee Health Care Access Act.

Section 9. Amends s. 641.27, F.S., regarding audits of an HMO by OIR.

Section 10. Amends s.641.31(40)(a), relating to health maintenance contracts.

Section 11. Repeals s. 627.6402, F.S., relating to insurance rebates for healthy lifestyles.

Section 12. Provides an effective date of July 1, 2005 and specifies that the bill applies to any policy or contract issued or renewed on July 1, 2005, or subsequently.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Under the bill, OIR is authorized to charge an HMO a maximum of $50,000 per year to examine the books and records of the HMO; this is a $30,000 per examination increase over the $20,000 maximum charge currently authorized in law. The bill requires OIR to examine an HMO once every 5 years, rather than every 3 years.

2. Expenditures:

   The Office of Insurance Regulation provided the following fiscal information relating to HB 1503.

For the period July, 2001 to February, 2004, OIR conducted 18 examinations of HMOs in the state. The 18 examinations cost a total of $ 1,027,035. Of those 18 examinations:

- Only one, a limited examination conducted over a 3-week period, cost under $20,000, the maximum amount by law that OIR may charge an HMO.

- Of the remaining 17 full-scope examinations, 8 cost less than $50,000, the maximum proposed by the bill for OIR to charge an HMO. The aggregate total cost for the eight examinations was $283,538. After the examined HMOs paid the maximum portion of exam costs, (8 x $20,000 = $160,000), OIR absorbed a total of $123,538 in costs associated with the HMO examinations.

- Of the remaining 17 full-scope examinations, a total a total of 9 examinations cost between $50,000 and $135,544. The total aggregate cost of these nine examinations was $ 734,595. After the examined HMOs paid the statutory portion of the examination costs (9 x $20,000 = $180,000), OIR absorbed a total of $554,595.

This means that from July 2001 until February, 2004, OIR has paid a total of $678,133 in examination costs for HMOs because that amount exceeded the statutory cap of $20,000 per examination that is to be covered by an HMO.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The funding of FHIP will provide Florida residents with access to a health insurance policy if the resident or his/her dependent is ineligible for coverage in the voluntary market.

The legislation increases the maximum charge to an HMO for costs incurred by OIR in examining the books and other records of an HMO, but decreases the frequency of exams from once every 3 years to once very 5 years. The maximum charge to an HMO resulting from an examination of its records by OIR is increased from $20,000 to $50,000 in any 1 year.

D. FISCAL COMMENTS:

Based on the findings of the actuarial study of the Florida Health Insurance Plan, the newly-created residual market for health insurance, OIR has recommended the Legislature appropriate $8 million in FY 2005-06 from the General Revenue Fund to fund FHIP.

The Office of Insurance Regulation reports that in most states with active residual market programs, 40-60 percent of the associated costs are covered by revenues generated from policyholder premium, while the remainder of costs are subsidized either by assessments to insurers in the voluntary market or by a general fund direct appropriation.

In an actuarial study provided to the FHIP board by the consulting firm Mercer Oliver Wyman, the difference between premium income generated at 200% of standard risk rate and estimated claims costs using Medicare provider rates is estimated to be between $4.1 million and $5.3 million. By year 5, when the FHIP is expected to be fully operational, costs are estimated to be between $35 and $45

million. The actuarial study also indicates that, when fully operational, the FHIP will result in estimated savings to the health insurance markets of between $127 and $169 million.

Based upon the actuarial study, OIR recommends a funding level of $8 million in appropriations to FHIP to assure sufficient funds are available for first year start-up expense and to establish a small contingency reserve. Sufficient first year appropriations will assure the fund does not have to close enrollment or cancel policies in the event the lower appropriation estimate is insufficient to carry the FHIP through its first year of operation.

The recommendation from OIR for $8 million to fund FHIP during its first year is not a direct result of HB 1503. Rather, the costs are associated with the creation of the health care residual market by the Legislature in 2004.

The sum of $5 million is appropriated form the General Revenue Fund to the Florida Health Insurance Plan for the purposes of implementing the plan.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At the March 31, 2005 meeting of the House Insurance Committee, several amendments to HB 1503 were adopted. The amendments made the following changes to the bill

- postpones the due date, from March 1, 2005 until January 1, 2006, for a report from AHCA on the Comprehensive Health Information System;
- repeals s. 627.6402, F.S., the law requiring an insurer to offer a rebate to an employer whose employees participate in a wellness or similar program;
- clarifies by further amendment to s. 627.6487, F.S., that an insurer is not required to issue an individual policy to a person who was insured under the Florida Health Insurance Plan;
- amends s. 627.638, F.S., to require insurers to make direct payment to a hospital or physician for treatment received by a patient in an emergency room;
- clarifies that an insurer must offer a high deductible policy with either *a health reimbursement account* or a health savings account; and
- deletes the prohibition for an insurer, an out-of-state group policy, or an HMO contract to require mandatory binding arbitration in their respective insurance contracts.

This Staff Analysis is written to reflect all the amendments adopted by the Insurance Committee at its March 31, 2005 meeting.

At the April 13, 2005 meeting of the House Health Care General Committee, several amendments to HB CS 1503 were adopted. The amendments made the following changes to the bill:

- Provides specific report release dates of performance outcome and patient charge data as follows: January 1, 2006 for infection rates, October 1, 2005 for mortality and complication rates, and October 1, 2006 for performance measures, benefit design and premium cost data.
- Requires that the impact of alternative methods of actuarially sound risk adjusted provider reimbursement methodologies be included in the actuarial study required by s. 627.64872(6), and requires a December 1, 2005 report date.
- Amends s. 641.31, F.S., and requires the insurer to offer a group rebate to a health maintenance organization when the majority of the members of the group participate in a wellness or similar program.
- Appropriates $5 million from the General Revenue Fund to the Florida Health Insurance Plan to implement this act.

The Staff Analysis is written to reflect all the amendments adopted by the House Health Care General Committee.