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.)

Prepared By: Banking and Insurance Committee

BILL: CS/SB 1660

SPONSOR: Banking and Insurance Committee and Senators Fasano, et al.

SUBJECT: Health Insurance

DATE: April 15, 2005 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	**Favorable/CS**
2.			WM	
3.				
4.				
5.				
6.				

I. Summary:

The bill makes the following changes related to health insurance:

- Appropriates $5 million from General Revenue to implement the Florida Health Insurance Plan (FHIP), in order to begin enrollment in the state's new high-risk pool for persons unable to obtain health insurance due to their health status.

- Provides that persons who are eligible for individual coverage after losing group coverage ("HIPAA-eligible individuals), who are not eligible for an individual conversion policy from a group insurer, would be guaranteed individual coverage from the FHIP, rather than from an insurer or HMO issuing individual coverage, if the FHIP is accepting new enrollment.

- Makes other changes to the FHIP, as follows:
  - Decreases the maximum premium for FHIP coverage from 300 percent to 200 percent of the individual standard risk rate, subject to a sliding scale premium surcharge based on the insured's income.
  - Limits provider reimbursement to 100 percent of the Medicare rate and requires all licensed providers to accept assignment of plan benefits as payment in full.
  - Limits eligibility to persons who reside in Florida no less than 185 days per year
  - Allows the board of the FHIP to cancel existing policies on a nondiscriminatory basis if inadequate funding is provided.

- Provides that the small group law requirements (guaranteed-issue and modified community rating) would not apply to individual coverage marketed to an employee of a

small employer that provides for payroll deduction of the premium, if the employer does not contribute to the premium and has not had group coverage within the prior 12 months.

- Increases from 30 days to 63 days after group coverage is terminated within which an individual is required to notify the insurance carrier of coverage termination and preserve their right to continue group coverage.

- Provides that insurers and HMOs may offer high-deductible plans that meet the federal requirements for a health savings account, without being subject to Florida mandates that prohibit deductibles from applying to certain benefits, if it conflicts with federal law.

- Authorizes the Office of Insurance Regulation (OIR) to disapprove a health flex plan if the officers or directors are incompetent or untrustworthy or lacking in insurance company managerial experience.

- Exempts individual health policies and individual HMO contracts, as well as limited benefit policies, from the requirement to provide premium rebates to policyholders who participates in a wellness program.

- Changes the required frequency of financial examination examinations of HMOs by the Office of Insurance Regulation from once every 3 years to once every 5 years; deletes the use of an independent CPA audit by the HMO in lieu of an examination by OIR; and increases the maximum amount an HMO is charged from $20,000 to $50,000.

This bill substantially amends the following sections of the Florida Statutes: 408.05, 408.909, 627.413, 627.6487, 627.64872, 627.65626, 627.6692, 627.6699, 641.27, 641.31.

The bill repeals s. 627.6402, F.S.

II. Present Situation:

Florida Statistics of Persons Not Covered by Health Insurance

The Florida Health Insurance Study (FHIS) prepared by the Agency for Health Care Administration (AHCA) provides data regarding the number of Floridians who were not covered by health insurance. Data in the FHIS are collected from Floridians under age 65 since most Americans aged 65 or older have health coverage through Medicare. The data that follow are contained in Highlights from the 2004 Florida Health Insurance Study[1]:

- From 1999 to 2004, the number of uninsured Floridians under age 65 rose from 16.8 percent to 19.2 percent;
- Miami-Dade County has the highest rate of citizens without health insurance at 28.7 percent, an increase from 24.6 percent in 1999;

[1] Available at the following website:
http://ahca.myflorida.com/Medicaid/Research/Projects/fhis2004/PDF/highlights_from_the_2004_fhis_1104.pdf

- 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;
- 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. The percentage of uninsured full-time workers (age 18-64) by employer firm size were as follows for 2004:
    - 36.3 percent for firms with 1-4 employee
    - 35.2 percent for firms with 5-9 employees
    - 31.8 percent for firms with 10-24 employees
    - 22.7 percent for firms with 25-49 employees
    - 16.0 percent for firms with 50-99 employees
    - 14.0 percent for firms with 100-249 employees
    - 10.1 percent for firms with 250-499 employees
    - 6.4 percent for firms with 500-999 employees
    - 5.2 percent for firms with 1000 or more employees
- In describing the "main reason" they lack health insurance, 63.1 percent of the survey respondents cited cost as the primary factor; 9.6 percent saying their employer did not offer health insurance, and 3.7 percent citing lack of employment; and
- Of those without health coverage, 54 percent have been without coverage for longer than 1 year and 18.9 percent have never had health insurance.

Health Flex Plans

The Health Flex Plans were initially authorized by the Florida Legislature as a pilot program in 2002. The 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 exempt from most requirements that apply to licensed health insurers and HMOs. In 2004, the Legislature authorized health flex plans to be established statewide and deleted reference to the plans being a "pilot project," but maintained the scheduled July 1, 2008 repeal of the statute authorizing such plans.

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.). Health Flex Plans must be approved by both the Office of Insurance Regulation and the Agency for Health Care Administration, subject to minimum standards for quality of care and access to care. The plans are also prohibited from containing any ambiguous or misleading provisions, providing benefits that are unreasonable in relation to the premium charged, containing provisions that are unfair or inequitable or contrary to the

public policy of this state, or result in unfair discrimination in sales practices. Applicants are also required to demonstrate that the plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided. (s. 408.909(3), F.S.) However, there is no clear authority to disapprove a plan based on the incompetence, untrustworthiness, or lack of insurance experience of the management, as there is for OIR approval of an insurance company under s. 624404(3), F.S.

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.

Florida Health Insurance Plan (High -Risk Pool)

Legislation in 2004 created the Florida Health Insurance Plan (FHIP) as the new high-risk pool to provide coverage to persons unable to obtain health insurance due to their health status. The plan is intended to replace the Florida Comprehensive Health Association, which continues to operate to provide coverage to persons who have remained in the plan since 1991, when new enrollment was terminated by the Legislature due to funding concerns. But, the FHIP has not yet been provided a funding source to begin new enrollment.

Nationally, high-risk pools have been used by states for more than 30 years. 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. Twenty-six of the 29 state high-risk pools cover those eligible under HIPAA, but only Alabama operates its high-risk pool exclusively for 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 assess 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.

The 2004 act 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. 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 and Legislature 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 (not yet appropriated) to cover deficits incurred in excess of available premiums. Once the FHIP begins enrolling members, the Florida Comprehensive Health Association is statutorily repealed.

Individuals who are residents of Florida for at least 6 months are eligible for coverage if evidence is provided that:

- the person received notices of rejection or refusal to issue substantially similar insurance for health reasons from two or more health insurers; or
- the person is enrolled in the Florida Comprehensive Health Association as of the date the plan is implemented.

Persons are not eligible for the plan if they are eligible for health insurance coverage that is substantially similar or more comprehensive, or eligible for Medicaid, Medicare, the state's children's health insurance program, or any other federal, state, or local government program that provides health benefits.

Guaranteed Availability of Individual Coverage under the Health Insurance Portability and Accountability Act (HIPAA)

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) which requires insurers issuing individual health insurance policies to guarantee the issuance of coverage to persons who previously were covered for at least 18 months with qualifying coverage and meet other eligibility criteria. The Act allows each state to craft alternative methods of guaranteeing availability of coverage that comport with HIPAA and do not diminish the federal requirements.

In 1997, Florida enacted legislation to conform state law to HIPAA, which included an alternative mechanism, in s. 627.6487, F.S. In order to be eligible for guaranteed-issuance of individual coverage, an individual must have had prior creditable coverage for at least 18 months, without a break in coverage of more than 63 days, and not be eligible for any other group coverage, Medicare or Medicaid. Under federal law, the individual's most recent prior coverage must have been under a group plan, a governmental plan, or church plan. However, Florida has since expanded the eligibility criteria under state law to also include persons whose most recent coverage was under an individual plan that is terminated due to the insurer becoming insolvent or discontinuing the offering of individual coverage in the state, or due to the insured no longer living in the service area in Florida of the insurer.

The Florida law provides two mechanisms for guaranteeing access to individual coverage. The first method is an individual conversion policy that must be offered by the insurer or HMO that issued the prior group coverage. The insurer or HMO must offer at least two conversion policy options, one being the standard benefit plan that small group carriers must to offer small employers. The maximum premium is limited to 200 percent of the standard risk rate, which is a statewide average rate computed annually by the Office of Insurance Regulation. If the individual is not eligible for a conversion policy issued pursuant to Florida requirements, the second method allows eligible individuals to purchase an individual policy from any insurance company or HMO issuing individual coverage in the state. This generally includes persons who were previously covered under a self-insured employer's plan or who move to Florida after terminating coverage from previous employment in another state. It also applies to persons

whose previous coverage was under an individual plan that was terminated for specified reasons. The insurer or HMO must offer each of their two most popular policy forms, based on statewide premium volume.

Employee Health Care Access Act ("Small Group Law")

The Employee Health Care Access Act of Florida, often referred to as the "small group law," requires that health insurers and health maintenance organizations that issue coverage to small employers must issue such coverage on a guaranteed-issue basis. That is, carriers in the small group market ("small group carriers") must issue coverage to any small employer that applies for coverage, regardless of the health status or prior claims experience of the group. However, the small group carrier may require, as a condition of providing the policy, that a specified minimum percentage of the employees participate (elect coverage), and that the employer contribute a specified minimum percentage of the premium. A small employer is defined to include an employer with one to 50 employees, including a sole proprietor or self-employed individual. Eligible employees are those who work full time, with a normal work week of 25 or more hours.

The federal Health Insurance Portability and Accountability Act (HIPAA) also requires that small group carriers offer coverage on a guaranteed-issue basis to employers with 2 to 50 employees, but in some respects the Florida law imposes additional requirements that are intended to provide greater protections for small employers. One major difference between the state and federal requirements is that the Florida law requires that premiums for small group policies be established on a "modified community rating" basis. This limits the factors that an insurer may use to establish and vary premiums among its small group policyholder, to age, gender, geographic location, family size, tobacco usage, and, within specified limits (generally, plus or minus 15 percent), claims experience and health status. In effect, this requires a small group carrier to combine the loss experience of all its small group policies in a single rating pool in order to spread the costs and premiums relatively evenly. This moderates the premium impact on small employers who have employees with health problems or high claims experience.

The requirements of Florida's small group law currently apply to a policy that provides coverage to a small employer, *unless the policy is marketed directly to the individual employee, and the employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy in any manner*.[2] This language, in effect, prohibits an insurance carrier from selling an individual health insurance policy to a person who is employed by a small employer, if the employer allows for payroll deduction of the premiums. By doing so, the employer would be participating in the collection and distribution of the premiums, which would classify the policy as a small group policy subject to the guaranteed-issue and modified community rating requirements of the small group law. The rationale for this restriction is to prevent insurers from circumventing the requirements of the small group law by "cherry-picking" employees who are healthy and, thereby, have the effect of worsening the overall claims costs for the small group market. Florida law allows insurers issuing health insurance policies to individuals to underwrite such policies, i.e., to reject applicants for coverage that do not pass medical underwriting guidelines. Also, individual policies are subject to rate regulation by the Office of Insurance Regulation, but are not subject to the modified community rating requirements that apply to small group policies. The small group law does not prohibit an insurer

[2] Section 627.6699(4)(a), F.S.

from soliciting and underwriting individual coverage for persons who happen to be employees of a small employer, provided that the employer does not collect or distribute the premiums or facilitate the administration of the policy.

"List billing" is term used by insurers to describe an option which allows premiums for individual policies to be paid by a single payor, such as an employer. Typically, the individual employee pays the entire premium and the employer facilitates payment by providing for payroll deduction of the premiums and forwarding the premium to the insurance carrier. One major health insurance company reports that it provides such list billing in sixteen states where such arrangements apparently due not run afoul of such states' small group requirements such as those in Florida and certain other states.

There are currently 22 small group carriers in Florida (10 health insurers and 12 health maintenance organizations). The Office of Insurance Regulation provided the following information on the number of small group policies (employers), employees covered under such polices, and covered lives (including dependents) for 2000 - 2003, which shows a continuing decline in all categories:

Small Group Coverage in Florida			
Year	Employers Covered	Employees Covered	Lives Covered (incl. dependents)
2000	153,571	797,517	1,343,798
2001	160,426	737,343	1,271,540
2002	141,473	643,579	1,101,604
2003	104,927	573,436	1,020,184

Continuation of Group Coverage ("Mini-COBRA")

Florida law requires that group insurers and HMOs that provide coverage to employers with fewer than 20 employees must offer to continue the coverage for an employee whose group coverage is terminated. (s. 627.6692, F.S.) This law complements the federal COBRA law that applies to employers with 20 or more employees. Under the Florida law, the insurer must continue the coverage for at least 18 months, with certain exceptions, subject to a maximum premium of 115 percent of the applicable group premium. In order to be entitled to continue the group coverage, the employee must notify the employer of the termination of coverage ("qualifying event) within 30 days after the qualifying event. In comparison, the federal COBRA law provides a 63 -day period within which the employee must provide such notice. The current Florida and federal laws also provide a 63-day period within which a person is entitled to guaranteed access to individual coverage after the group coverage terminates (i.e. after the group continuation period).

HMO Financial Examinations

The OIR is required to conduct a financial examination of each HMO at least once every three years, or more often as it deems necessary. However, the OIR may accept an independent certified public accountant's audit in lieu of conducting its own examination. The OIR may assess a fee to the HMO for conducting the examination, but it cannot exceed $20,000 for any 1-year period. The OIR reports that during the period from June 30, 2001 to February 2004, the

OIR conducted 18 examinations of Florida HMOs, which cost a total of $ 1,027,035. The OIR paid a total of $678,133 in examination costs that exceeded the statutory cap of $20,000 per examination that is to be covered by an HMO. OIR representatives state that in order for the state to be accredited by the National Association of Insurance Commissioners, that it may not accept an independent CPA audit in lieu of its own examination.

ACHA Report on Outcome and Performance Data for Health Care Services
The 2004 Act required AHCA to develop, in conjunction with the State Comprehensive Health Information System Advisory Council, and implement a plan to make performance outcome and financial data available to consumers to compare health care services, including information on pharmaceuticals, physicians, health care facilities, and health insurance and HMOs. The agency was required to submit the plan to the Governor and Legislature by March 1, 2005 and to update the plan annually.(s. 408.05, F.S.) The ACHA has been meeting regularly with the Council to develop this plan and report, but has not yet completed its work product.

III. Effect of Proposed Changes:

Section 1. ACHA Report on Outcome and Performance Data for Health Care Services
Amends s. 408.05, F.S., to change the due date from March 1, 2005 to January 1, 2006.for the report from AHCA on its implementation of a plan to make performance outcome and financial data available to consumers to compare health care services.

Section 2. Health Flex Plans
Amends s. 408.909, F.S., to authorize OIR to disapprove a health flex plan if the officers or directors are incompetent or untrustworthy or so lacking in insurance company managerial experience as to make the proposed operation hazardous to the insurance-buying public; or so lacking in insurance experience as to jeopardize the reasonable promise of successful operation. These are the grounds that currently exist for OIR disapproval of an insurance company under is. 624.494(3), F.S.

Section 3. Federally Qualified High-Deductible Health Plans
Amends. 62.413, F.S., to provide that health insurers and HMOs may offer high-deductible plans that meet the federal requirements for a health savings account qualified high-deductible health plan, notwithstanding any other requirement of the Florida Insurance Code. This means that if the federal requirements are interpreted as prohibiting the high-deductible plan from providing first dollar coverage for any particular benefit, this would supersede any Florida law to the contrary. For example, current Florida law prohibits the deductible from applying to the "well-child" benefits (immunizations, etc.) required under s. 627.6579, F.S. If the federal government determines that qualified high-deductible plans may not pay first dollar coverage for such benefits (which has not, thus far, been determined) then the high deductible plan would be exempt from this state requirement.

Section 4. Guaranteed-Availability of Individual Coverage (High-Risk Pool)
Amends s. 627.6487, F.S., to provide that an individual who is eligible for individual coverage ("HIPAA-eligible"), would no longer be eligible for guaranteed-issuance of an individual health insurance policy from a health insurer or HMO if the Florida Health Insurance Plan is accepting

new enrollments. Individuals are currently eligible for guaranteed-issuance of an individual health insurance policy from a health insurer or HMO if they were covered for at least 18 months under prior group coverage and who lose their eligibility for the group coverage, and are not eligible for an individual conversion policy from a group insurer. This generally includes persons who have lost their group coverage with a self-insured employer or a person moving to Florida from another state. (If the person was covered under an insured group plan, the conversion policy offered by the group insurer is the individual coverage that must be offered.) Under the bill, such "HIPAA-eligible" persons would now be provided access to an individual policy by obtaining coverage from the state's high-risk pool if it is accepting new enrollment, rather than from an insurer or HMO issuing individual health insurance policies. Section 13 of the bill provides $5 million in General Revenue funding to begin limited enrollment in the Florida Health Insurance Plan, the state's new high-risk pool created in 2004.

However, the bill also provides that a person whose previous coverage was under the Florida Health Insurance Plan (FHIP), is not eligible for guaranteed-issuance of an individual health insurance policy. This situation could occur if the FHIP cancels coverage for an individual due to inadequate funding, as the bill authorizes in Section 5. Under the current law, a person is also eligible for guaranteed-issuance of an individual policy if they were covered for at least 18 months under an *individual* policy issued in Florida and the coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing the offering of individual coverage in the state, or due to the insured no longer living in the service area of the insurer or HMO. Such rights to a guaranteed-issue policy would not be provided to a person insured with the FHIP and canceled due to inadequate funding.

Section 5. Florida Health Insurance Plan (High-Risk Pool)
Amends s. 627.64872, F.S., related to the Florida Health Insurance Plan (FHIP), which was created in 2004 as the high-risk pool to provide health insurance to individuals to unable to obtain health insurance due to their health status, but which has not yet been funded to begin enrollment. The bill makes the following changes:

- Provides that a person who is "eligible for individual coverage under s. 627.6487(3)", i.e., a HIPAA-eligible individual, is eligible for coverage in the FHIP. This generally means that a person who loses prior group coverage and is not eligible for a conversion policy, would be eligible for coverage in the FHIP. However, the bill provides an exception ("excluding s. 627.6487(3)(b)5.") that refers to a person whose previous coverage was under the Florida Health Insurance Plan.

- Decreases the maximum premium for FHIP coverage from 300 percent to 200 percent of the individual standard risk rate, subject to a sliding scale premium surcharge based on the insured's income. However the sliding scale surcharge could not be imposed on certain persons. (See, Technical Errors, below.)

- Limits provider reimbursement to 100 percent of the Medicare rate and requires all licensed providers to accept assignment of plan benefits and consider the Medicare payment amount as payment in full.

- Limits eligibility to persons who physically reside in Florida no less than 185 days per year, in addition to the current requirement that the individual must have been domiciled in the state for a period of at least 6 months.

- Provides that a person is not eligible for coverage in the FHIP if the person's premiums are paid by any organization sponsored by or affiliated with a health care provider.

- Allows the board of the FHIP to cancel existing policies on a nondiscriminatory basis if inadequate funding is provided. However, no policy may be canceled if a covered individual is currently making a claim. It is not clear what criteria would be used to make the determination of how to cancel policies on a "nondiscriminatory basis."

- Deletes dated provisions related to an interim study and makes the technical change of referring to the Commissioner of Insurance rather than the Director of the Office of Insurance Regulation, which is the same office.

See Technical Errors, below, for changes the bill makes regarding persons who are not eligible for coverage in the FHIP and the sliding scale premium surcharge.

Section 6 Insurance Rebates for Healthy Lifestyles (Group Health Insurance)
Amends s. 627.65626, F.S., to provide that the requirement for group health insurance policies to provide for a rebate of premiums when the majority of the group members have maintained participation in a wellness program, applies only to a health insurance policy that provides "creditable coverage as defined in s. 627.6561(5)." This would provide an exception for accident-only, disability income, limited benefit, and other policies that are not generally considered to be group health insurance policies.

The bill also provides an exception to the provision that any rebate provided by the health insurer is presumed to be appropriate unless credible data demonstrate otherwise. The additional exception would be if the rebate program requires the insured to incur costs to qualify for the rebate which equal or exceeds the value of the rebate. This assures that OIR could disapprove a rebate program if, for example, it required a physician certification that would cost the insured as much or more than the amount of the rebate itself.

Section 7. Continuation of Coverage Under Group Plans ("Mini-COBRA")
Amends s. 627.6692, F.S., relating to the current Florida law that requires insurers to offer to continue group coverage for 18 months (or 36 months is some cases) for an individual who loses their eligibility for the group coverage. The bill increases the period of time from 30 days to 63 days after the group coverage is terminated ("qualifying event") within which the individual is required to give written notice to the insurance carrier of the coverage being terminated and, thereby, preserve their rights to obtain continuation of the group coverage.

Section 8. Employee Health Care Access Act ("Small Group Law"); Payroll Deduction for Individual Coverage

Amends s. 627.6699, F.S., relating to the "small group law," to allow for individual coverage to be sold to employees of a small employer, with payroll deduction of the premium, without the

coverage being considered a small group policy subject to the requirements of this section, under certain conditions. As amended, the small group law would not apply to coverage marketed directly to individual employees, if the employer does not contribute directly or indirectly to the premiums or facilitate the administration of coverage in any manner. An employer would not be deemed to be contributing to the premiums or facilitating the administration of coverage if the employer merely collects the premiums through payroll deduction, provided that the employer has not had a group health benefit plan in the prior 12 months

The bill further provides that a carrier may offer coverage to employees that are not eligible employees as defined in this section (such as part time employees working less than 25 hours per week), whether or not the small employer has a group health plan.

The bill requires that a carrier offering coverage "as described in this paragraph" apparently referring either to the individual coverage offered through payroll deduction, or the coverage offered to employees that are not eligible employees, must provide a cancellation notice at least 10 days prior to canceling the coverage for nonpayment of premium. This appears to cover the situation of a carrier that provides such coverage through an out-of-state group policy that is not subject to current Florida notice requirements for cancellation.

The bill also requires that small group carriers offer to "one-life groups" (sole proprietors and self-employed individuals) high deductible plans that meet the requirements of a federal health savings account or health reimbursement account, as currently required to be offered to small employers with 2 to 50 employees.

The bill revises the membership of the small employer health reinsurance program and requires the board to advise OIR, AHCA, DFS, and other executive and legislative entities about the health insurance market and to issue an annual report.

Section 9. Financial examinations of HMOs
Amends s. 641.27, F.S., as follows:

- To change the frequency of financial examination examinations of HMOs by the Office of Insurance Regulation from once every 3 years to once every 5 years;
- To delete the use of an independent CPA audit by the HMO in lieu of an examination conducted by the OIR;
- To increase from $20,000 to $50,000 the amount an HMO is charged for an OIR audit.

Section 10. Insurance Rebates for Healthy Lifestyles (HMOs)
Amends s. 641.31, F.S, to limit the requirement for HMO contracts to provide a premium rebate when the majority of the members have maintained participation in a wellness program, to group HMO contracts, thereby exempting individual HMO contracts.

The bill also provides an exception to the provision that any rebate provided by the HMO is presumed to be appropriate unless credible data demonstrate otherwise. The additional exception would be if the rebate program requires the insured to incur costs to qualify for the rebate which equal or exceeds the value of the rebate.

The bill provides an exception to the premium rebate if the number of participating members on the renewal anniversary becomes fewer than the majority of the members eligible for participation in the wellness program.

Section 11. High-Deductible Health Insurance Plan Study Group
The bill creates an 11 member group to study high deductible health insurance plans, due to concerns that have been raised by hospitals and other medical providers of the problems they encounter when attempting to collect payments from patients who are insured under high deductible policies. The study group is to be composed of:

- 3 representatives of employers offering high deductible health plans to their employees, one of whom must be a small employer appointed by the Florida Chamber of Commerce.
- 3 representatives of commercial health plans, appointed by the Florida Insurance Council.
- 3 representatives of hospitals, appointed the Florida Hospital Association.
- the Secretary of the AHCA, or designee, who serves as co-chair.
- the Director of OIR, or designee, who serves as co-chair.

The group will study the impact of high deductibles on access to health care services and pharmaceutical benefits; the impact of high deductibles on utilization of health care services and over utilization of health care services; the impact on hospitals' inability to collect deductibles and co-payments, etc.

The study group must also study the assignment of benefits attestations and contract provisions that nullify the attestations of insureds; the standardization of insured ID cards; and the standardization of claim edits.

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

Section 12. Repeal of Insurance Rebates for Healthy Lifestyles (Individual Health Insurance)
The bill repeals s. 627.6402, F.S., which currently requires that individual health insurance policies provide for a rebate of premiums when the individual maintains participation in a wellness program.

Section 13. General Revenue Funding for the FHIP (High-Risk Pool)
Appropriates $5 million from General Revenue to implement the Florida Health Insurance Plan.

Section 14. Effective Date
The act takes effect July 1, 2005 and applies to policies or contracts issued or renewed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Persons who cannot obtain health insurance coverage due to health status would potentially benefit by having access to the FHIP (high-risk pool), but funding limitations will significantly limit the number of persons who will be provided coverage. HIPAA-eligible individuals who are not eligible for a conversion policy, i.e. individuals who were insured under a self-insured plan or who have moved to Florida after losing group coverage in another state, would also be provided access to individual coverage from the FHIP, within funding limitations, rather than from a health insurer or HMO offering individual coverage. Even though premiums are capped in the FHIP they may be higher than the premium from a carrier. The individual carriers would benefit by no longer being required to provide coverage to HIPAA-eligible individuals, if the FHIP is accepting new enrollment. Health care providers will be subject to the Medicare fee schedule.

The $5 million appropriation to implement the FHIP would provide adequate funding for about 2,000 individuals to enroll, based on the actuarial study conducted by the FHIP. See Government Sector Impact, below, for further information.

Individual insured by the FHIP may have their coverage canceled if the board of the FHIP determines that funding is not adequate. It also appears that the bill would not entitle such persons to guaranteed access to individual coverage in the private market.

Insurers selling individual health insurance policies would benefit by being allowed to market such coverage, subject to individual underwriting, to employees of small employers on a “list billing” or payroll deduction basis, without being subject to the requirements of the small group law (which effectively prohibits list billing today). Employees of small employers could be offered individual coverage on a list billing, or payroll deduction basis, which may be less expensive or otherwise not offered by the carrier if subject to individual billing. On the other hand, small employers might be encouraged to drop small group coverage for 12 months in order to avoid paying part of the premium and to, instead, provide their employees with the option for individual coverage subject to payroll deduction of the entire premium. To the extent that healthy or low risk employees are more likely to be provided this option, it may increase the overall claims costs and premiums for the small group market.

Employees of small employers (less than 20 employees) would have additional time (63 days, rather than 30) to elect to continue their group coverage for at least 18 months.

C. Government Sector Impact:

The bill appropriates $5 million from General Revenue to implement the FHIP. Unless such funding is recurring each year, or a different funding source is provided, the FHIP will be required to cancel coverage for its insureds. Significant additional funding would be required to provide access to all individuals who may seek such coverage. The Office of Insurance Regulation provided the following comments regarding this issue:

> *In states with active residual market programs, 40-60% of 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 general revenue appropriation.*
>
> *In a report provided to the FHIP Board by the consultant firm of Mercer Oliver Wyman, the difference between premium revenue income generated at 200% of standard risk rate and estimated claims cost 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 same actuarial study indicates that when fully operational, the FHIP will result in savings to the health insurance markets of between $127 and $169 million.*
>
> *Thus, the OIR recommends a funding level of $8 million in appropriations 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 and/or cancel policies in the event the lower appropriation estimate is insufficient to carry the FHIP through its first year of operation.*

The bill also allows the OIR to charge up to $50,000 rather than $20,000 to examine an HMO and allows the OIR to examine an HMO every 5 years, rather than every 3 years. But, it also would delete the authority to accept an independent CPA audit in lieu of the OIR exam. In the period June 30, 2001 to February, 2004, the OIR has conducted 18 examinations of Florida HMOs. The 18 examinations cost a total of $ 1,027,035, for which OIR paid a total of $678,133 in examination costs that exceeded the statutory cap of $20,000 per examination that is covered by an HMO.

VI. Technical Deficiencies:

On page 13 the bill changes the conditions under which a person is *not* eligible for coverage under the FHIP (currently, persons who obtain substantially similar coverage, persons eligible

for Medicaid or Medicare, etc.), by providing that such conditions do *not* apply to any person who is otherwise eligible for coverage under the FHIP other than dependents of the individual. This appears to be a drafting error, and was intended to provide an exception for individuals who are HIPAA-eligible. The apparent error is on page 13, line 15, by referring to "paragraph (a)" rather than referring to "subparagraph (a)3."

Similarly, on page 15, the bill allows a sliding scale premium surcharge in the FHIP, but provides an exception for all persons who are eligible for coverage from the plan, other than covered dependents. This appears to be the same drafting error, and was intended to provide an exception only for individuals who are HIPAA-eligible. The apparent error is on page 15, line 14, by referring to "paragraph (9)(a)" rather than referring to "subparagraph (9)(a)3."

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.