The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health and Human Services Appropriations Committee

BILL: CS/CS/SB 2534

INTRODUCER: Committee on Health and Human Services Appropriations, Banking and Insurance Committee, Senator Peaden, and Senator Gaetz

SUBJECT: Health Insurance

DATE: April 2, 2008 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	**Fav/CS**
2.	Peters	Peters	HA	**Fav/CS**
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	x	Statement of Substantial Changes
B. AMENDMENTS........................		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

According to the 2005 U.S. Census, Florida has the third highest uninsured rate in the nation at 20.2 percent. The bill provides mechanisms for increasing affordable coverage to the uninsured in Florida by revising eligibility for certain private and public health care coverage.

Cover Florida Health Access Program Act

The bill creates the “Cover Florida Health Access Program Act,” which is designed to provide affordable health care options for uninsured residents. A Cover Florida plan entity must provide non-catastrophic coverage and may provide catastrophic coverage, supplemental insurance, and discount medical plan product options to enrollees. The enrollee must meet the following eligibility requirements:

- Resident of Florida;
- Ages 19 to 64;
- Not covered by private insurance or eligible for public insurance, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements; and

- Uninsured for at least the prior 6 months, with exceptions for persons who lose coverage within the past 6 months under certain conditions.

The Agency for Health Care Administration (agency) and the Office of Insurance Regulation (office) are responsible for jointly establishing and administering the program. The agency and the office are required to issue an invitation to negotiate no later than July 1, 2008, to health insurers, health maintenance organizations (HMOs), health care provider-sponsored organizations, and health care districts ("Cover Florida plan entities"). The agency and the office are required to approve at least one Cover Florida plan entity having an existing statewide provider network, and may approve at least one regional network plan in each Medicaid area.

The Cover Florida general plan must include the following components:

- Guaranteed issue to enrollees, subject to exclusions for pre-existing conditions approved by the agency and the office.
- Plans are portable, regardless of employment status.
- Plans can require limits on the number of services, caps on benefit payments, and copayments.
- Plans must provide information on coverage, benefit limits, cost-sharing, and exclusions in the enrollment materials.
- Plans must offer prescription drug benefit coverage or use a prescription drug manager.
- Plan entities are required to develop two benefit plans having different cost and benefit levels.

Cover Florida plans are not subject to the Florida Insurance Code and ch. 641, relating to HMOs. However, these plans are considered to be insurance subject to the Unfair Insurance Trade Practices in Part IX of ch. 626, F.S.

Retiree Health Insurance Subsidy
Coverage provided through Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy.

Health Flex Plan Program
The Health Flex Plan Program was established to offer basic affordable health care services to low-income, uninsured residents. The bill provides the following changes to the program:

- Expands the population eligible to purchase health flex plans by raising the family income limit from 200 to 300 percent of the federal poverty level. Based on the 2008 Federal Poverty Guidelines, 200 percent of the federal poverty level is $42,400 for a family of four, and 300 percent of the federal poverty level is $63,600 for a family of four.
- Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

Insurance Coverage for Dependent Children
Requires group health insurers to offer policyholders and certificateholders (parents) the option to continue coverage for their children on their family policy until age 30. Current law is maintained that requires coverage for dependent children until age 25. In addition, a group insurer would be required to offer the parent the option to continue coverage for a (non-dependent) child until age 30, if the child is unmarried with no dependents, a resident of Florida or a full time-or part-time student, and does not have insurance coverage under any other private plan or is not entitled to benefits under Title XVII of the Social Security Act.

This bill substantially amends the following sections of the Florida Statutes: 112.363, 408.909, and 627.6562.

The bill creates the following section of the Florida Statutes: 408.9091.

II. Present Situation:

The Uninsured in Florida
As of 2006, there were an estimated 3,686,676 uninsured nonelderly people in Florida. Children, age 18 and under, comprised 22 percent (816,979) of the nonelderly uninsured in Florida. The remaining 78 percent (2,868,697) consisted of adults, ages 19 to 64.[1] Approximately 43 percent of persons age 18 to 34 were uninsured.[2]

Health insurance coverage for adults, age 19 to 64, was primarily provided through the employer, as indicated in the chart below. The uninsured rate for this age group was 27 percent. In contrast, the national uninsured rate was 20 percent.[3]

Health Insurance Coverage of Adults 19-64, states (2005-2006), U.S. (2006)

	FL #	FL %	US #	US %
Employer	6,232,130	58%	114,883,073	63%
Individual	672,057	6%	10,677,488	6%
Medicaid	603,749	6%	14,244,607	8%
Other Public	398,415	4%	5,000,512	3%
Uninsured	2,868,697	27%	37,011,340	20%
Total	10,775,048	100%	181,817,020	100%

The costs of uncompensated care in Florida are significant. In 2004 and 2005, these costs were $2,110,518,208 and $2,352,544,130, respectively. For fiscal year 2006, the uninsured represented 8.6 per cent of all inpatient admissions, according to the Florida Hospital Association.

[1] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the U.S. Census Bureau's March 2006 and 2007 Current Population Survey (CPS Annual Social and Economic Supplements).
[2] Florida Health Insurance Study, 2004, Profile of the Uninsured. Agency for Health Care Administration
[3] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the U.S. Census Bureau's March 2006 and 2007 Current Population Survey (CPS Annual Social and Economic Supplements).

Florida Health Flex Plan Program
In 2002 the Legislature established the Health Flex Plan Program as a mechanism to provide basic affordable health care services to low-income, uninsured residents. Health Flex was designed to encourage health insurers, health maintenance organizations, and health care providers to develop alternative approaches to traditional health insurance, which emphasize coverage for basic and preventative care services. The agency administers the Health Flex Plan Program.
Health Flex Plans can be offered by licensed insurers, HMOs, health care providers, local governmental entities, health care districts, or other public or private organizations, and through small employers' business purchasing arrangements sponsored by local governmental entities. These entities must meet quality of care and financial guidelines jointly developed by the agency and the Office of Insurance Regulation.

Currently, eligibility to enroll in the Health Flex Plan is limited to individuals who meet the following requirements:

- residents of Florida;
- age 64 years of age or younger;
- family income equal to or less than 200 percent of the federal poverty level; uninsured status for at least 6 months prior to enrollment; and
- not covered by a private insurance policy and are not eligible for coverage by a public health program.

According to the agency, as of January 2008, there were five active Health Flex Plan providers that had enrolled a total of 2,232 beneficiaries. For the prior year, 2007, there were four health flex plans covering 1,776 members.[4]

Retiree Health Insurance Subsidy

A Florida Retirement System (FRS) participant must have vested rights, that is, six years of service in the Pension Plan or one year of service in the Investment Plan, to be eligible for the HIS payment. The subsidy requires the applicant to demonstrate that there is an out-of-pocket post-retirement health insurance premium for the subsidy to apply. The participant must also separately apply for this additional benefit feature. An estimated 206,000 retirees or beneficiaries were receiving this benefit in March 2005. The benefit is paid by the imposition of an additional employer contribution rate of 1.11 percent, or 111 basis points, on the employer active payroll. The contribution rate is imposed uniformly on all FRS retirement classes. To effect payment of the subsidy the participant must be retired and have terminated employment. Participants in DROP are still actively employed, though retired, and do not receive this payment until cessation of all covered FRS employment and the receipt of a monthly benefit.

[4] Health Flex Plan Program Annual Report, January 2007, by the Agency for Health Care Administration and the Office of Insurance Regulation.

Coverage for Dependent Children
Under current law, a group health insurance policy must insure a dependent child until the end of the calendar year in which the child reaches age 25, if the child is dependent upon the parent for support and is either living in the household of the parent or is a full-time or part-time student. (s. 627.6562, F.S.)

III. Effect of Proposed Changes:

Retiree Health Insurance Subsidy (Section 1)
The bill specifies that coverage provided through Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy.

Health Flex Plan Program (Section 2)
the bill revises eligibility criteria for enrollment in the Health Flex Plan and participation as an entity eligible to offer the plan. The bill expands the population eligible to purchase health flex plans by raising the income limit from 200 to 300 percent of the federal poverty level. Based on the 2008 Poverty Guidelines of the U.S. Department of Health and Human Services, 200 percent of the federal poverty level is $42,400 for a family of four, and 300 percent of the federal poverty level is $63,600 for a family of four.[5]

The bill also extends the expiration date of the program from July 1, 2008 to July 1, 2013. In addition, the bill eliminates obsolete provisions related to a federally approved Medicaid demonstration waiver.

Cover Florida Health Access Program Act (Section 3)
Creates the "Cover Florida Health Access Program Act," which is designed to provide affordable health care options for uninsured residents. A Cover Florida plan entity must provide non-catastrophic coverage and may provide catastrophic coverage, supplemental insurance, and discount medical plan product options to enrollees. To be eligible for the program, an enrollee must meet the following requirements:

- Resident of Florida;
- Ages 19 to 64;
- Not covered by private insurance or eligible for public insurance, unless eligibility for coverage lapses due to no longer meeting income or categorical requests; and
- Uninsured for at least the prior 6 months, with exceptions for persons who lose coverage within the past 6 months under certain conditions.

Administration of the Cover Florida Health Access Program:
The Agency for Health Care Administration (agency) and the Office of Insurance Regulation (agency) are responsible for jointly establishing and administering the program. The agency and the office are required to issue an invitation to negotiate no later than July 1, 2008, to health insurers, health maintenance organizations, health care provider-sponsored organizations, and health care districts ("Cover Florida plan entities"). The agency and the office are required to

[5] http://aspe.hhs.gov/poverty/.

approve at least one Cover Florida plan entity having an existing statewide provider network, and may approve at least one regional network plan in each Medicaid area.

Changes in plan benefits, premiums, and forms are subject to regulatory oversight by the agency and the office. The office and the agency are required to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the status of the program.

The Cover Florida general plan must include the following components:

- Guaranteed issue to enrollees, subject to exclusions for pre-existing conditions approved by the agency and the office.
- Plans are portable, regardless of employment status.
- Insurers can require limits on the number of services, caps on benefit payments, and copayments.
- Plans must provide information on coverage, benefit limits, cost-sharing, and exclusions in the enrollment materials.
- Plans must offer prescription drug benefit coverage or use a prescription drug manager.
- Insurers are required to develop two benefit plans having different cost and benefit levels.

Plans without catastrophic coverage are required to provide coverage options for certain services, including but not limited to:

- Preventive health services and screenings, annual assessments, cervical cancer screenings, mammograms, prostate screening, and immunizations.
- Office visits and surgery
- Behavioral health services
- Durable medical equipment and prosthetics
- Diabetic supplies

Plans providing catastrophic coverage must provide coverage for all of the services required for non-catastrophic coverage, above, as well as the following coverage:

- Inpatient hospital stays
- Hospital emergency care
- Urgent care services
- Outpatient services and surgery

Evaluation and Approval of Cover Florida Plans:
A plan must be disapproved or withdrawn if the plan:

- Contains ambiguous, inconsistent, or misleading provisions;
- Provides benefits that are unreasonable in relation to the premiums charged or result in unfair discrimination in sales practices;
- Fails to demonstrate that the plan is financially sound;

- Cannot demonstrate that the applicant and management meet general eligibility requirements for insurers and HMOs, which includes competency and trustworthiness; or
- Does not guarantee that enrollees may participate in the plan entity's network of providers.

Applicability of the Insurance Code and HMO Laws:
Cover Florida plans are not subject to the Florida Insurance Code and ch. 641, relating to HMOs. However, these plans are considered to be insurance subject to the Unfair Insurance Trade Practices in Part IX of ch. 626, F.S. In the event of the insolvency of a Florida plan entity, these plans would not be covered by an insurance or HMO guaranty association.

Coverage for Dependent Children (Section 4)
Requires group health insurers to offer policyholders and certificateholders (parents) the option to continue coverage for their children on their family policy until age 30. Current law is maintained that requires coverage for dependent children until age 25. In addition, a group insurer would be required to offer the parent the option to continue coverage for a (non-dependent) child until age 30, if the child is: (a) unmarried with no dependents, (b) a resident of Florida or a full time-or part-time student, and (c) does not have insurance coverage under any other private plan or is not entitled to benefits under Title XVII of the Social Security Act.

Under current law (retained by the bill), the policy must insure a dependent child until age 25, if the child is dependent upon the parent for support and is living in the household of the parent or is a full-time or part-time student.

If a child is provided coverage under the parent's policy after the child reaches age 25 and the coverage for the child is subsequently terminated, the child is ineligible to be covered again under the parent's policy unless the child was continuously covered by other insurance coverage without a coverage gap of more than 63 days. This would address adverse selection issues relating to children (age 25-30) dropping off and coming back on the parent's policy, due to needed medical treatment or services.

These provisions would not apply to self-insured employers since the federal Employee Retirement Income Security Act (ERISA) preempts state laws affecting self-insured employer plans. Approximately 50 percent of the employers in Florida are self insured.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

See Private and Public Sector Impact, below, regarding federal tax issues.

B. Private Sector Impact:

The bill increase access and eligibility to health care services and coverage through the Health Flex Plan, Cover Florida Health Access, and the dependent coverage provided through group insurance policies.

Health Flex Plan Program
By broadening the income eligibility requirements for the Health Flex Plans for an individual from 200 to 300 percent of the federal poverty level, an indeterminate number of additional persons would be eligible to purchase this coverage. (See Effects of Proposed Changes for income levels.)

According to the agency, this change is also expected to provide an incentive to other health flex plan providers to implement a health flex program. The agency notes that existing health flex plan providers have contended that this change is needed to capture a larger number of individuals that are unable to afford health care premiums for commercial insurance products. Additionally, the expected increase in enrollment is needed to ensure the financial viability of the health flex programs.

Cover Florida Health Access Plans
The bill will allow insurers, HMOs, health-care-sponsored-organizations, or health care districts to offer consumers a choice of benefit plans at affordable prices. These plans will offer the option of catastrophic, non-catastrophic and supplemental coverage. According to the staff of the Governor's Office, the average plan will cost $150 per month or less. Florida residences, ages 19 to 64 that have been uninsured for at least 6 months are eligible for the plans. These plans are issued on a guaranteed issue basis and are portable, such that an enrollee remains covered regardless of employment status or the cost sharing of premiums.

The state retiree Health Insurance Subsidy Program payment ($30 to 150 per month) is designed to offset the cost of health insurance for retirees. It is unclear whether retirees enrolling in a Health Flex Plan or Cover Florida plans would be eligible for this subsidy.

Implications for Changes in Dependent Coverage
Extending converge for dependent children from age 25 to 30 may result in a larger number of insureds since approximately 43 percent of the insured in Florida are comprised of persons aged 18 to 34.

Some concerns have been raised regarding possible adverse selection issues related to expanding dependent coverage. Although the estimated increase in premiums attributable to the continuance of dependent coverage to age 30 is expected to be minimal, some

employers, particularly small employers, may adopt cost-savings strategies to mitigate even modest increases, such as decreasing contributions for employee coverage or dependent coverage.

Federal Tax Liability Implications for Changes in Dependent Coverage
Concerns have been raised regarding potential federal tax issues for private and public employers and employers and employer administrative costs associated with the changes in the dependent coverage requirements. The possible issues include:

- increased income tax liability to an employee (i.e. imputing the fair market value of the non-tax dependent's health coverage to be included in the employee's gross income),
- increased payroll tax liability for employers, and
- additional administration for employers, related to including the fair market value of the non-tax dependent in the employee's taxable income; or if the employer allows contributions for dependent coverage to be paid with pre-tax salary reductions, arranging to take that portion of the salary reduction on a post-tax basis.

Section 125 of the Internal Revenue Code allows private and public employers to offer premium only plans, a cafeteria plan, or a Flexible Spending Account to their employees. These plans are designed to allow employers to deduct employee paid premiums for certain group and disability related benefits on a tax-exempt basis. As a result, the employer pays less payroll taxes and the employee pays less federal withholding taxes and income taxes. The eligibility changes in the dependent coverage health insurance coverage in the bill have raised concerns related to the impact on 125 plans. The Internal Revenue Code defines a certain class of dependents under federal law, which generally requires financial dependence on the parent. It is possible that the federal law would view payment of the premiums through a cafeteria plan with pre-tax dollars as a violation of s. 125 IRC.

C. Government Sector Impact:

The tax attorney for the Division of State Group Insurance provided the following comments on the fiscal impact related to the federal tax aspects of the dependent coverage changes for the State Group:

> An employee can only pay on a pre-tax basis under a cafeteria plan for the health coverage of a spouse (as defined under the Defense of Marriage Act) or a Code Section 105(b) dependent. A cafeteria plan could be disqualified if it permits a participant to elect coverage on a pre-tax basis for a person who is neither. However, the cafeteria plan rules permit non-Code §105(b) dependent coverage health coverage to be offered under a cafeteria plan as a taxable benefit.
>
> In summary, while the offering of coverage may be mandated by state law, the tax treatment (and ramifications for cafeteria plan administration) would be governed

by federal tax law. As a result, while coverage may be extended under the state law to any (recently expanded) eligible employee, only a subset of the eligible dependent children would be entitled to receive that coverage on a tax-free basis. Thus, for example, while pre-tax coverage could be extended to a child who receives over half of their support from the employee, other covered dependent children must have their coverage funded on an after-tax basis and/or have any employer subsidy imputed into income -- i.e., in much the same way that coverage is provided to non-tax dependent domestic partners and/or domestic partner children. Moreover, the otherwise eligible medical expenses of non-tax dependent children would not be eligible for pre-tax reimbursement under the health Flexible Spending Accounts or for tax-free distributions from the Health Savings Accounts. These nuances would need to be communicated (and administrative processes put in place) before coverage is extended to non-tax dependents.

There may be an increase in payment of the retiree health insurance subsidy as the bill specifies that coverage provided through the Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Cover Florida plans established in the bill is not considered “creditable coverage,” for purposes of state (s. 627.6561(5)(a), F.S.) and federal laws (federal Health Insurance Portability and Accountability Act of 1996) that require health plans to give the policyholder credit for time covered under previous insurance coverage towards meeting any new preexisting condition exclusion. If the Legislature amended the Florida definition of creditable coverage, s. 627.6561, F.S., to include Cover Florida plans, this would appear to be effective under state law as applied to fully insured plans issued in Florida , but would appear not to apply, under federal law to self-insured plans or health plans in other states. This could potential confusion and administrative burdens for insurers and consumers in determining creditable coverage applicable in other states.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Committee on Health and Human Services Appropriations on April 2, 2008

- Removes the elimination of the 10 percent cap on enrollment in the KidCare program.
- Specifies that coverage provided through the Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy.

- Revises eligibility for the Cover Florida Health Care Access Program to specify that persons are eligible if not covered by private insurance or eligible for public insurance, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements;

CS by Committee on Banking and Insurance on March 18, 2008

The CS provides the following changes:

- Creates the Cover Florida Health Care Access Program as a mechanism to provide guaranteed issue coverage through the private market to Florida residents ages 19-64 that do not have insurance coverage during the prior six months.
- Eliminates current 10 percent cap on enrollment in Kidcare for enrollees that pay full premium and have an income over 200 percent of the federal poverty level.
- Eliminates changes to the definition of premium assistance for purposes of the Florida Kidcare program.
- Eliminates provision allowing an employer group meeting certain criteria from participating in the Health Flex Plan.
- Deletes provision requiring eligible employees and their dependents to be covered under a health care plan offered by the employer unless the employee declines.
- Revises dependent coverage requirements.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.