FINAL BILL ANALYSIS

BILL #: *CS/HB 1125*

FINAL HOUSE FLOOR ACTION:
117 Y's 0 N's

SPONSOR: *Rep. Corcoran*

GOVERNOR'S ACTION: Approved

COMPANION BILLS: None

SUMMARY ANALYSIS

CS/HB 1125 passed the House on April 29, 2011. The bill was amended by the Senate on May 2, 2011, and subsequently was amended and passed by the House on May 3, 2011. The bill was passed by the Senate on May 4, 2011. The bill was approved by the Governor on June 21, 2011, chapter 2011-195, Laws of Florida, and takes effect July 1, 2011.

In 2008, the Florida Legislature created the Florida Health Choices Program (Program). It includes a single, centralized market for the sale and purchase of health care products including, but not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. Florida Health Choices, Inc., is established in law as a not-for-profit corporation responsible for administering the Program and may function as a third-party administrator for employers participating in the Program.

CS/HB 1125 makes a number of changes to the Florida Health Choices Program. The bill:
Expands the eligibility requirements for employers to participate in the Program by removing the 50-employee upper limit.

- Allows all Medicaid recipients who opt out of Medicaid to participate in the Program.
- Streamlines the process by which new health benefit plans, services, and other contracts are approved to be included in the marketplace.
- Simplifies the procedure by which the Board approves vendors for participation.
- Requires vendors to submit data annually to the Corporation so that premium payments to vendors by enrollees may be risk adjusted to ensure that risk is pooled appropriately and prevent selection bias.
- Eliminates the requirement to develop a plan for tax credits to be made available to employers participating in the marketplace.

The bill expands a current long-term care facility demonstration project in Miami-Dade County, which is exempt from certificate-of-need requirements, to include psychiatric services.

The bill provides a certificate-of-need exemption for a level III neonatal intensive care unit (NICU) if the unit has 5 or more beds, if the hospital applicant is a verified trauma center, as defined in s. 395.4001(14), F.S., and if the hospital applicant has a level II NICU.

The bill removes the age limitation for eligibility to enroll in an approved health flex plan under s. 408.909, F.S. As a result, persons aged 65 years and older are eligible to enroll in a health flex plan.

The bill also adds persons licensed to practice orthotics, prosthetics, or pedorthics to the definition of "health care provider" as used in ss. 766.201, F.S., through 766.212, F.S., for purposes of medical malpractice actions.

The bill appears to have no direct fiscal impact on state or local government. Individuals may benefit from increased choices and marketplace competition.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Current Situation

Florida Health Choices Program

In 2008, the Florida Legislature created the Florida Health Choices Program (Program).[1] The Program includes a single, centralized market for the sale and purchase of health care products including, but not limited to, health insurance plans, health maintenance organization (HMO) plans, prepaid services, service contracts, and flexible spending accounts.[2] Policies sold as part of the Program are exempt from regulation under the Florida Insurance Code[3] and laws governing HMOs.[4] The following entities are authorized to be eligible vendors of these products and plans:

- Insurers authorized under ch. 624, F.S.;
- HMOs authorized under ch. 641, F.S.;
- Prepaid health clinics licensed under part II, ch. 641, F.S.;
- Health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers;
- Provider organizations, including services networks, group practices, and professional associations; and
- Corporate entities providing specific health services.[5]

Under s. 408.910(11), F.S., Florida Health Choices, Inc., (Corporation) is established as a not-for-profit corporation under ch. 617, F.S. The Corporation is responsible for administering the Program and may function as a third-party administrator (TPA) for employers participating in the Program.[6] In its capacity as a TPA, the Corporation is not subject to the licensing requirements for insurance administrators under Part VII, Chapter 626, F.S. The Corporation is authorized to collect premiums and other payments from employers. In addition, the Corporation is not required to maintain any level of bonding. The Corporation is responsible for certifying vendors and ensuring the validity of their offerings. Lastly, the Corporation is not subject to the provisions of the Unfair Insurance Trade Practices Act.[7]

The Corporation is governed by a 15-member board of directors (Board): three ex-officio members representing the Agency for Health Care Administration (AHCA), Department of Management Services, and the Office of Insurance Regulation (OIR); four appointed by the Governor; four appointed by the President of the Senate; and four appointed by the Speaker of the House of Representatives.[8] The Board members are protected from liability created by any member of the Board or its employees or agents for any action taken by them in the

[1] S. 4, ch. 2008-32, L.O.F. (2008); *see also* s. 408.910, F.S.
[2] S. 408.910(5), F.S.
[3] Ch. 624, F.S.
[4] Part I, Ch. 641, F.S.; *see also* s. 408.910(10)(a), F.S.
[5] S. 408.910(4)(d), F.S
[6] S. 408.910(10)(b), F.S.
[7] Part IX, Ch. 626, F.S.
[8] S. 408.910(11)(a), F.S.

performance of the powers and duties as Board members.[9] No cause of action may rise against a Board member in such a circumstance.[10]

The law specifies which entities are eligible to purchase products through, and participate in, the Program. Employees of the following employers are eligible to purchase coverage through the Program if their employers participate in the Program:

- Employers with 1 to 50 employees;
- Cities with a population of less than 50,000 residents;
- Fiscally constrained counties[11]; and
- School districts located in fiscally constrained counties.[12]

The following vendors are eligible to participate in the Program:

- Insurers licensed under ch. 624, F.S.;
- HMOs licensed under part I of ch. 641, F.S.;
- Prepaid health clinic providers licensed under part II of ch. 641, F.S.;
- Health care providers;
- Provider organizations; and
- Corporate entities providing specific services via service contracts.[13]

The following individuals are eligible to enroll in the Program:

- Individual employees of enrolled employers;
- State employees ineligible for state employee health benefits;
- State retirees;
- Medicaid reform participants who select the opt-out provision of reform; and
- Statutory rural hospitals.[14]

Employers are required to establish section 125 plans in order to participate in, and allow their employees to enroll in, the Program.[15] This allows both employers and employees to purchase insurance coverage through the Program using pre-tax dollars.

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[9] S. 408.910(11)(e), F.S.
[10] *Id.*
[11] S. 218.67(1), F. S. - Each county that is entirely within a rural area of critical economic concern as designated by the Governor pursuant to s. 288.0656 or each county for which the value of a mill will raise no more than $5 million in revenue, based on the taxable value certified pursuant to s. 1011.62(4)(a)1.a., from the previous July 1, shall be considered a fiscally constrained county.
[12] S. 408.910(4)(a), F.S.
[13] S. 408.910(4)(d), F.S.
[14] S. 408.910(4)(b), F.S
[15] S. 125 of the Internal Revenue Code allows employers to offer a cafeteria plan to employees for payment of qualified benefits. A cafeteria plan is a separate written plan maintained by an employer for employees that meets the specific requirements of and regulations of section 125. It provides participants an opportunity to receive certain benefits on a pretax basis. Participants in a cafeteria plan must be permitted to choose among at least one taxable benefit (such as cash) and one qualified benefit.
A qualified benefit is a benefit that does not defer compensation and is excludable from an employee's gross income under a specific provision of the Code, without being subject to the principles of constructive receipt. Qualified benefits include:

- Accident and health benefits (but not Archer medical savings accounts or long-term care insurance);
- Adoption assistance;
- Dependent care assistance;
- Group-term life insurance coverage;
- Health savings accounts, including distributions to pay long-term care services.

The written plan must specifically describe all benefits and establish rules for eligibility and elections. A section 125 plan is the only means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice

In 2008, the Legislature appropriated $1,000,000 in non-recurring General Revenue to the Corporation to initially implement the Program.[16]

In the summer of 2011, phase one of the Program, known as Florida's Marketplace and dubbed "Quick Start", will be operational. It will offer a central web portal to access and compare multiple insurance products.[17] The web portal will be accessible by employers, vendors and insurance agents.[18] Midterm and long term phases are expected to be completed in late 2011 and late 2012, providing more features and easier access for employers, enrollees, and vendors.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA")[19], as amended by the Health Care and Education Reconciliation Act of 2010[20]. One of the essential elements of the PPACA is the requirement that all U.S. citizens have health insurance. Beginning in 2014, for U.S. citizens who cannot purchase health insurance through an employer because it is not offered, health insurance exchanges will be established, from which citizens can purchase health insurance coverage that meets the minimum essential coverage provisions of PPACA.

The constitutionality of PPACA is currently being challenged in federal court[21] by Florida, 25 other states, the National Federation of Independent Business, and two private citizens. The outcome of litigation is uncertain. If Florida were required to establish an exchange pursuant to PPACA, some of the products currently authorized by law to be available in the Program would not meet the minimum benefit requirements of PPACA.

Effect of Changes

The bill defines the "Corporation's marketplace" as a single, centralized market established by the Program to facilitate the purchase of products made available in the marketplace. The bill also adds HMOs, licensed under part I of Chapter 641, to the definition of "insurer".

The bill expands the eligibility requirements for employers to participate in the Program. An employer that seeks to enter the marketplace must meet all criteria established by the Board and intend to make employees eligible for one, or more, health plan, product or service contract offered by the Program. The expansion of eligibility opens up participation in the Program to all employers in Florida, no matter the number of employees.

Increasing the size of employers that may participate in the marketplace may increase the attractiveness of the marketplace for insurers. Large numbers of potential insureds equates to a potentially larger market share for vendors who offer products in the marketplace. Additional insurers will create more choice for enrollees in the Program and may result in more affordable premium prices due to increased competition.

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causing the benefits to become taxable. A plan offering only a choice between taxable benefits is not a section 125 plan. *See* http://www.irs.gov/govt/fslg/article/0,,id=112720,00.html. (last viewed March 27, 2011).

[16] Ch. 2008-152, L.O.F. (2008).

[17] *See* http://myfloridachoices.org/about/ (last viewed March 27, 2011).

[18] S. 408.910(8), F.S.

[19] P.L. 111-148, 124 Stat. 119 (2010)

[20] P.L. 111-152, 124 Stat. 1029 (2010)

[21] *See* U.S Dept. of Health and Human Serv., et al., v. State of Fla., et al., Case No. 11-11021-HH (11th Cir. Ct.)(on appeal from United States District Court for the Northern District of Florida, Pensacola Division, Case No. 3:10-cv-91-RV/EMT)

The bill changes the category of a "statutory rural hospital"[22] from an eligible individual to an eligible employer for participation in the marketplace. The category change clarifies the status of a statutory rural hospital for purposes of the Program only.

The bill amends s. 408.910(4)(b)4., F.S., to allow all Medicaid recipients who opt out of Medicaid to participate in the Corporation marketplace. Currently, only Medicaid reform participants are eligible to participate in the marketplace. This proposed change in law anticipates proposed Medicaid reform provisions that would allow a Medicaid participant to opt out of the system and use the funds that would have been used by Medicaid to pay for coverage to purchase insurance coverage in the private market. The proposed changes allow those Medicaid dollars to be used to purchase any product offered for sale in the Corporation's marketplace.

The bill makes a technical change, permitting HMOs to sell health maintenance contracts and deleting insurance policies as a product to be sold by an HMO. HMOs market health maintenance contracts rather than traditional insurance policies. The bill also includes health maintenance contracts on the list of products that may be sold in the Corporation's marketplace.

The bill streamlines the process by which new health insurance plans, services, and other contracts are approved to be included in the marketplace. The bill requires all risk-bearing products permitted to be sold by insurers and HMOs in the Corporation's marketplace to be approved by OIR. The bill removes the requirement that the Board develop a methodology by which it will evaluate the actuarial soundness of the products and premiums offered by the plan. The bill also eliminates the procedure for the Board to seek guidance from the OIR regarding the approval or denial of inclusion of a plan or product in the Corporation's marketplace. The OIR is charged with approving all health insurance policies and other health insurance products that are sold in the state of Florida. The bill allows for the initial approval of products for sale in Florida by the OIR to serve as approval for inclusion in the Corporation's marketplace. Products other than those listed in s. 408.910(4)(d)1., F.S., and s. 408.910(4)(d)2., F.S., are not subject to the licensing requirement of the Florida Insurance Code.[23]

The bill simplifies the procedure by which the Board approves vendors for participation in the Corporation's marketplace. The procedure may include the elements currently listed in the statute and may include medical underwriting for premium prices based on age, gender, and location of participant.

Currently, s. 408.910(5)(b), F.S., requires that policies, plans and other contracts for services purchased through the Program ensure availability of covered services for a period of at least one full enrollment year. The bill removes the one year requirement. As a result, policies, plans and other contracts for services may be able to offer covered services for time periods greater than or less than one full enrollment year.

The bill confirms that the Corporation has authority to approve all non-risk-bearing products to be sold in the Corporation's marketplace. Currently, OIR has the authority to approve all risk-bearing products to be sold through the marketplace.

[22] S. 395.602(2)(e), F.S., defines a "rural hospital".
[23] S. 624.01, F.S.

The bill renames the “Exchange Process” to “The Marketplace Process.” The bill requires the Corporation to establish initial, open, and special enrollment periods for enrollees in the marketplace.

The bill requires the Corporation to inform individuals about other public health care programs that are available. Also, the bill requires the Corporation to operate a toll-free hotline to respond to requests for assistance from enrollees, prospective enrollees, vendors, and other participants in the Program.

The bill requires vendors to submit data annually to the Corporation so that premium payments to vendors by enrollees may be risk adjusted to ensure that risk is pooled appropriately and prevent selection bias. The bill also eliminates the plan for tax credits to be made available to employers participating in the marketplace.

For administration of the Program, the bill requires the disclosure of personal identifying information about a Florida Kidcare Program applicant or enrollee to the Corporation by AHCA, the Department of Children and Families, the Department of Health, or the Florida Healthy Kids Corporation.

The bill provides a certificate-of-need exemption for a level III neonatal intensive care unit (NICU) if the unit has 5 or more beds, if the hospital applicant is a verified trauma center, as defined in s. 395.4001(14), F.S., and if the hospital applicant has a level II NICU.

The bill removes the age limitation for eligibility to enroll in an approved health flex plan under s. 408.909, F.S. As a result, persons aged 65 years and older are eligible to enroll in a health flex plan.

Lastly, the bill adds persons licensed to practice orthotics, prosthetics, or pedorthics to the definition of “health care provider” as used in ss. 766.201, F.S., through 766.212, F.S., for purposes of medical malpractice actions.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will likely open the Corporation's marketplace to more enrollees and offer more choice in affordable health care coverage. Also, a larger number of individuals enrolled in the Program with the ability to purchase health insurance policies, plans, and other contracts for services, should lower insurance premiums for all enrollees in the Program.

Individuals aged 65 years and older will be eligible to enroll in health flex plans under the bill. This provides these individuals with additional choices for health care coverage that may result in lower costs.

D. FISCAL COMMENTS:

The requirement that the Corporation operate a toll-free hotline to respond to requests for assistance regarding the marketplace carries an indeterminate, and possibly significant, fiscal impact. The Corporation will need to purchase hardware and software to establish, operate, manage, and maintaining the hotline. Additional staff will also need to be hired and trained. If the Corporation chooses to outsource the operation of the hotline, that action will also carry a fiscal impact on the Corporation.