HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 445 Wellness or Health Improvement Programs
SPONSOR(S): Insurance & Banking Subcommittee, Health & Human Services Quality Subcommittee, Ingram
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee	13 Y, 0 N, As CS	Poche	Calamas
2) Insurance & Banking Subcommittee	10 Y, 0 N, As CS	Barnum	Cooper
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Health Insurance Portability and Accountability Act of 1996 generally prohibits group health plans from charging similarly situated individuals different premiums, or requiring other additional payments on the basis of a health factor. An exception exists for plans that offer rewards or incentives for member participation in health or wellness programs under specified circumstances.

Health insurers and health maintenance organizations (HMOs) are permitted to provide for a rebate of premiums paid on an individual health insurance policy when a covered individual enrolls in and maintains participation in a health wellness, maintenance or improvement program approved by the insurer. The premium rebate is effective for the covered individual on an annual basis.

For group health plans, a rebate of premiums paid during the preceding year is provided to members of the plan when the majority of members have enrolled in and maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan.

Evidence of maintenance or improvement of the enrollees' health status is achieved through assessment of health status indicators.

CS/CS/HB 445 permits group or individual health insurers and HMOs to offer a voluntary health or wellness improvement program to those insured. The bill also permits rewards and incentives to be offered for participation in the program. Those rewards and incentives may include, but are not limited to, merchandise, premium discounts or rebates, and modifications to copayment, deductible, or coinsurance amounts.

The bill allows insurers and HMOs to request verification of a member's inability to participate in a voluntary health or wellness improvement program due to a medical condition. Verification may be in the form of a statement from the member's treating physician concluding that it is difficult or inadvisable for the member to participate in a health or wellness improvement program.

The bill could have a positive fiscal impact on the private sector. It does not have a direct fiscal impact on state and local governments.

The bill is effective July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) generally prohibits group health plans from charging similarly situated individuals different premiums or requiring other additional payments on the basis of a health factor. An exception exists for plans that offer rewards or incentives for member participation in health or wellness programs. If the receipt of a reward or incentive is not conditioned on the individual satisfying a standard related to a health factor, or if no reward or incentive is offered for participation, then the health or wellness program satisfies the nondiscrimination provisions of HIPAA. However, if the group health plan offers a reward or incentive for member participation in a health or wellness program that is based on the individual satisfying a health factor standard, then the program must meet five requirements. These are:

- The total reward or incentive is limited, generally to no more than 20% of the cost of coverage under the plan to the individual or family.
- The program must be reasonably designed to promote health and prevent disease.
- The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year.
- The reward or incentive must be available to all individuals similarly situated and must allow a reasonable alternative standard for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the standard.
- The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard.

If the plan's program does not base any reward on outcome, it is allowed under the HIPAA nondiscrimination provisions without being subject to the five requirements above.[1]

Chapters 626 and 627, Florida Statutes, contain provisions relating to health insurers and health insurance policies in the State of Florida. Chapter 641, Part I, F.S. provides for regulation of health maintenance organizations (HMOs). The Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including HMOs, authorized under the Florida Insurance Code.[2, 3]

Under current law, insurers are permitted to provide for a rebate of premiums paid on an individual health insurance policy when a covered individual enrolls in and maintains participation in a health wellness, maintenance or improvement program approved by the insurer.[4] To qualify for any rebate offered by the insurer, a covered individual must provide evidence of improvement in his or her health status.[5] The measurement of improvement in the health status is accomplished by assessing health status indicators, agreed upon in advance by the individual and the insurer, such as weight loss, decrease in body mass index, and smoking cessation.[6] The premium rebate is effective for the covered individual on an annual basis, unless the individual fails to maintain his or her health status while participating in the wellness program, or evidence shows that the individual is no longer enrolled in the approved wellness program.[7]

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[1] http://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html (Last viewed on March 15, 2011)
[2] s. 20.121(3)(a)1., F.S.
[3] Chapters 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code".
[4] s. 627.6402(1), F.S.
[5] *Id.*
[6] *Id.*
[7] s. 627.6402(2), F.S.

For group health plans offered by insurers, an appropriate rebate of premiums paid during the preceding year, not to exceed 10 percent of paid premiums, is provided to members of the plan when the majority of members have enrolled in and maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan.[8] Evidence of maintenance or improvement of the enrollees' health status is achieved through assessment of health status indicators similar to those included for individual health policies.[9] The group or health insurer may contract with a third party administrator to gather the necessary information regarding enrollees' health status and provide the necessary report to the insurer.[10] The premium rebate is effective for an insured on an annual basis unless the number of participating members in the health wellness, maintenance or improvement program becomes less than the majority of total members eligible for participation in the program.[11]

Any group rate, rating schedule, or rating manual for an HMO policy which provides creditable coverage must provide for an appropriate rebate of premiums paid in the last year when the majority of members under the policy are enrolled in and have maintained participation in any health wellness or improvement program offered by the group contract holder.[12] Premium rebates are also permissible for individual contracts.[13]

Unfair methods of competition and deceptive acts or practices in the sale of insurance policies and the operation of insurance companies are defined by statute.[14] Certain acts are prohibited, including, but not limited to, the following:

- Unlawful rebates.
- Misrepresentations and false advertising of insurance policies.
- Defamation.
- Boycott, coercion and intimidation.
- Unfair claim settlement practices.
- Illegal dealings in premiums, including excess or reduced charges for insurance.
- Refusal to insure on the basis of race, color, creed, marital status, or sex.
- Misrepresentation of agent qualifications.

Except as provided for in ch. 641, F.S., HMOs are exempt from all other provisions of the Florida Insurance Code except for those provisions that are explicitly made applicable to HMOs.[15] Unfair methods of competition and unfair or deceptive acts or practices, as they relate to an HMO, are addressed in ss. 641.3901 and 641.3903, F.S.

Effect of Proposed Changes

To encourage participation in the wellness or health improvement program, the bill permits a health insurer or an HMO to offer incentives or rewards, such as merchandise, premium rebates or savings, or modifications to copayment, deductible, or coinsurance amounts. The bill does not limit other forms of incentives or rewards that may be offered to health plan members for adherence to a wellness or health improvement program that may otherwise be available by state or federal law. The bill expressly states that the incentives and rewards offered to enrollees in wellness or health improvement programs do not constitute unfair methods of competition or deceptive acts or practices and do not, therefore, violate s. 626.9541, F.S., or s. 641.3903, F.S.

[8] s. 627.65626(1), F.S.
[9] *Id.*
[10] *Id.*
[11] s. 627.65626(2), F.S.
[12] s. 641.31(40)(a), F.S.
[13] s. 641.31(40)(c), F.S.
[14] s. 626.9541, F.S.
[15] s. 641.201, F.S.

The bill makes clear that a health insurer or an HMO may request documentation from a health plan member to verify that the member has a medical condition that makes it difficult or inadvisable for the member to participate in a voluntary wellness or health improvement program. Documentation may be in the form of a statement from the member's treating physician.

Health insurers and HMOs are not required by the bill to offer wellness or health improvement programs. The decision to do so is voluntary. Participation in a wellness or health improvement program by a health plan member is also voluntary. The bill does not penalize a health plan member for non-participation in a wellness or health improvement program.

B. SECTION DIRECTORY:

Section 1: Amends s. 626.9541(4), F.S., related to wellness or health improvement programs.

Section 2: Amends s. 641.3903(15), F.S., related to wellness or health improvement programs.

Section 3: Provides an effective date of July 1, 2011.

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:

None.

D. FISCAL COMMENTS:

Voluntary participants could financially benefit from premium discounts or rebates, contributions to a member's health savings account, or modifications to copayment, deductible, or coinsurance amounts allowed as incentives or rewards by this bill. If the health status of participants improves, or health risks, with accompanying medical costs, are avoided, the result could be a positive fiscal impact on the cost of health care for the participants, co-workers, and employers.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

- Rules which already exist for healthy life styles rebates do not address the rewards and incentives permissible under the bill.[16, 17]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 8, 2011, the Health and Human Services Quality Subcommittee adopted one amendment to House Bill 445.

The amendment deletes the phrase “an insurance benefit or”, to state that a reward or incentive offered under the subsection created by the bill is not a violation of s. 626.9541, F.S., if the reward or incentive is disclosed in the insurance policy or certificate. A reward or incentive could be considered in the calculation of a carrier’s medical loss ratio under federal health care law. The amendment also renders the effective date immediate upon becoming law.

The bill was reported favorably as a Committee Substitute.

At the March 23, 2011 meeting of the Insurance & Banking Subcommittee, one (1) strike-all amendment was proposed and adopted.

The strike-all amendment:

- Provided for health maintenance organizations and insures to have the same option to offer wellness or health improvement programs.
- Provided for an effective date of July 1, 2011.

The bill was reported favorably as a Committee Substitute for the Committee Substitute.

The analysis is drafted to the Committee Substitute for the Committee Substitute.

[16] 69O-149.0055, F.A.C.
[17] 69O-191.0545, F.A.C.