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 Committee on Banking and Insurance

BILL: CS/SB 480

INTRODUCER: Banking and Insurance Committee and Senator DiCeglie

SUBJECT: Nonprofit Agricultural Organization Medical Benefit Plans

DATE: Mar. 10, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			CM	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 480 allows nonprofit agricultural organizations to offer medical benefit plans and specifies that such plans are not insurance for purposes of the Florida Insurance Code (code). The exemption of these plans from the code will provide individuals and families with access to non-insurance product, medical benefit plans, through membership in a nonprofit agricultural organization. Many rural communities have limited access to medical providers and affordable health insurance coverage .[1] The medical benefit plans offered by an eligible nonprofit agricultural organization authorized pursuant to the bill will be exempt from insurance regulation and consumer protections that apply to health insurers, health maintenance organizations, and their policies and contracts under the code.

The bill takes effect July 1, 2025.

The bill may have an indeterminate negative fiscal impact on state government premium tax revenues to the extent that purchasers of health insurance policies or health maintenance organization contracts shift their business from these insurance products insurance to the exempt health plans offered by nonprofit agricultural organizations.

[1] Brownfield, State Farm Bureaus work to join successful health care coverage program (Mar. 22, 2024), https://www.brownfieldagnews.com/news/state-farm-bureaus-work-to-join-successful-health-care-coverage-program/ (last visited Feb. 25, 2025).

II. Present Situation:

The Patient Protection and Affordable Care Act (PPACA)[2]

On March 23, 2010, PPACA was signed into law. Among its sweeping changes to the U.S. health insurance system are requirements for health insurers to make coverage available to all individuals and employers,[3] without exclusions, for preexisting medical conditions[4] and without basing premiums on any health-related factors. PPACA imposes many insurance requirements, such as coverage of essential health benefits,[5] prohibition on lifetime dollar limits[6] on essential health benefits, rating and underwriting standards, reporting of medical loss ratios and payment of rebates,[7] internal and external appeals of adverse benefit determinations, and other requirements.[8] PPACA preempts any state law that prevents the application of a PPACA.

Some health insurance products that consumers may purchase are not required to comply with all the federal health insurance requirements. For example, short-term limited duration insurance[9] and excepted benefits[10] are not required to comply with PPACA requirements. The short-term plans generally have substantially lower premiums than PPACA plans. However, they exclude individuals with pre-existing conditions and offer more limited benefits than PPACA plans.[11]

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[2] P.L. 111-148, 124 Stat. 119-1945 (2010). PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.
[3] PPACA s. 1201; PHSA s. 2702 (42 U.S.C. s. 300gg-1).
[4] 42 U.S.C. s. 300gg-3.
[5] Department of Financial Services, Division of Consumer Services, Health Care Reform and You (Sept. 2021), https://myfloridacfo.com/docs-sf/consumer-services-libraries/consumerservices-documents/understanding-coverage/consumer-guides/health-care-reform_english-web_fl.pdf?sfvrsn=97e2ae45_1 (last visited Feb. 24, 2025).
[6] PPACA s. 1001; PHSA s. 2711 (42 U.S.C. s. 300gg-11).
[7] 42 USC 300gg-1. PPACA requires health insurers to report to the HHS information concerning the percent of premium revenue spent on claims for clinical services and activities (medical loss ratio or MLR). Insurers must provide a rebate to consumers if the MLR is less than 85 percent in the large group market and 80 percent in the small group and individual markets.
[8] The federal Tax Cut and Jobs Act of 2017 eliminated the individual coverage mandate tax penalty, effective 2019. Public Law No. 115-97.
[9] Centers for Medicare and Medicaid Services, Short-term, limited-duration insurance and independent, coordinated excepted benefits coverage (Mar. 28, 2024), https://www.cms.gov/newsroom/fact-sheets/short-term-limited-duration-insurance-and-independent-noncoordinated-excepted-benefits-coverage-cms (last visited Feb. 25, 2025).
[10] 45 CFR s. 148.220. Excepted benefits include coverage only for accident, disability income insurance, liability insurance, workers' compensation insurance, automobile medical payments insurance, and other specified coverage.
[11] Kaiser Family Foundation, Why Do Short-Term Health Insurance Plans Have Lower Premiums Than Plans That Comply with the ACA? (Oct. 31, 2018), https://www.kff.org/affordable-care-act/issue-brief/why-do-short-term-health-insurance-plans-have-lower-premiums-than-plans-that-comply-with-the-aca/ (last visited Feb. 25, 2025).

Regulation of Insurance in Florida

Florida's Office of Insurance Regulation (OIR)[12] is responsible for the regulation of all activities of insurers and other risk-bearing entities, including licensure, rates,[13] policy forms, market conduct, claims, solvency, administrative supervision, as provided under the Florida Insurance Code (code).[14] Insurance is classified into the following kinds of insurance: life, health, property, casualty, surety, marine, and title.[15] The code defines "insurance" as a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies.[16] Health insurance is insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance pertaining to it.[17] Health insurance does not include workers' compensation coverage, except as provided in s. 624.406, F.S.[18]

The OIR monitors the solvency of insurers, and takes administrative action, if necessary, against any authorized insurer if OIR determines that the continued operation of the insurer may be deemed hazardous to its policyholders or creditors, or to the general public.[19] If an insurer is found to be insolvent and is ordered to be liquidated by a court, a receiver takes over the insurer under court supervision and processes the assets and liabilities through liquidation.

Generally, once an insurance company is liquidated, an insurance guaranty association becomes liable for the policy or contract obligations of the liquidated insurance company. In Florida, the Florida Life and Health Insurance Guaranty Association (association)[20] is the guaranty association for most insurance companies that write life, health insurance or annuities in Florida.[21] Insurance guaranty funds are designed to protect policyholders of liquidated insurers from financial losses and delays in claim payments, up to limits provided by law.[22] The association services covered policies and contracts, collects premiums, and pays valid claims.[23] All insurers authorized to write life insurance policies, health insurance

[12] The OIR is an office under the Financial Services Commission (commission), which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. The commission is not subject to control, supervision, or direction by the Department of Financial Services in any manner, including purchasing, transactions involving real or personal property, personnel, or budgetary matters. Section 20.121(3), F.S.
[13] Pursuant to s. 627.062(1), F.S., rates may not be excessive, inadequate, or unfairly discriminatory.
[14] Section 20.121(3)(a)1., F.S.
[15] Section 624.6011, F.S.
[16] Section 624.402, F.S.
[17] Section 624.403, F.S.
[18] *Id.*
[19] Section 624.805, F.S.
[20] For a consumer or subscriber that has coverage through a health maintenance organization (HMO), the Health Maintenance Organization Consumer Assistance Plan under part IV of chapter 631, F.S., was created to protect subscribers of HMOs, subject to certain limitations, against the failure of an HMO to perform its contractual obligations due to its solvency. Section 631.812, F.S.
[21] Part III of ch. 631, F.S.
[22] Section 631.712, F.S.
[23] See the association's website available at https://www.flahiga.org/About (last viewed Feb. 24, 2025). The maximum amount of protection provided by the association for major medical health insurance is $500,000 per insured life. Florida Life & Health Insurance Guaranty Association - Frequently Asked Questions (last visited Feb. 25, 2025).

policies, supplemental contracts, and annuity contracts (with exceptions) in Florida are required, as a condition of doing business in this state, to be member insurers of the association.[24]

Health Benefits Exempt from the Florida's Insurance Code

Currently the code exempts nonprofit religious organizations,[25] commonly known as a health care sharing ministry, from the regulatory requirements and consumer protections if the nonprofit religious organization meets the following requirements:

- Qualifies under Title 26, s. 501 of the Internal Revenue Code of 1986, as amended.
- Limits its participants to those members who share a common set of ethical or religious beliefs.
- Acts as a facilitator among participants who have financial, physical, or medical needs to assist those with financial, physical, or medical needs in accordance with criteria established by the nonprofit religious organization.
- Provides for the financial or medical needs of a participant through contributions from other participants, or through payments directly from one participant to another participant.
- Provides amounts that participants may contribute, with no assumption of risk and no promise to pay among the participants or by the nonprofit religious organization to the participants.
- Provides a monthly accounting to the participants of the total dollar amount of qualified needs shared in the previous month in accordance with criteria established by the nonprofit religious organization.
- Conducts an annual financial audit that is performed by an independent certified public accountant in accordance with generally accepted accounting principles and that is made available to the public by providing a copy upon request or by posting on the nonprofit religious organization's website.
- Does not market or sell health plans through insurance agents licensed by the Department of Financial Services under ch. 626, F.S.

The nonprofit religious organization must provide a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the nonprofit religious organization. The disclaimer must read in substance:

> "Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Membership is not offered through an insurance company, and the organization is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant is compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance.

[24] Sections 631.713 and 631.715, F.S.

[25] Section 624.1265, F.S., refers to health care sharing ministries as "nonprofit religious organizations." A health care sharing ministry is an organization that facilitates the sharing of health care expenses among individuals with similar and sincerely held beliefs. These organizations resemble insurance in that members generally pay monthly membership fees and submit claims when they incur medical bills.

> Regardless of whether you receive any payments for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills."

However, the provisions of s. 624.1265, F.S. do not prevent:

- A participant from limiting the financial or medical needs that may be eligible for payment; or
- The nonprofit religious organization from canceling the membership of a participant when such participant indicates his or her unwillingness to participate by failing to meet the conditions of membership for a period greater than 60 days.

Approximately 30 states have exempted health care sharing ministries (HCSM) explicitly from insurance regulation.[26] A member of a health care sharing ministry (HCSM) will typically contribute a monthly payment to cover the qualifying medical expenses of other members. The HCSMs will match paying members who need the health care funds or pool all the monthly shares and administer payments to members directly. Some people may enroll in HCSMs because of their typically lower upfront costs, compared to PPACA-compliant plans. HCSMs are not insurance and cannot guarantee payment of claims, i.e., while they may share funds with members who have health needs, they are not legally required to do so. Further, the HCSMs do not have to comply with state or federal insurance regulations and consumer protections.

According to the Department of Financial Services,[27] plans offered by the HCSM are not subject to federal and state mandated benefits and there is no guaranty fund if a company ceases operation. There is little oversight of the organizations since no state or federal agency has regulatory authority unless the organization is determined to be operating illegally in a state. There is a history of illicit organizations claiming they are exempt from state laws based on a health care sharing ministry exemption. Several of these organizations have ceased to operate over the past several years and left individuals throughout the United States with unpaid medical bills.

Nonprofit Agricultural Organizations that Offer Medical Benefit Plans Exempted from Insurance Regulation in Other States

The American Farm Bureau Federation is a national organization that was established in 1919 to advocate for the interests of farmers, ranchers, and other persons associated with agriculture. There are state farm bureau offices in all 50 states and in Puerto Rico.[28] Membership in a local farm bureau is open to anyone who pays the membership fee. Each state farm bureau provides member benefits, which may include offering health care benefits to its members.[29]

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[26] National Association of Insurance Commissioners, What you should know about health care sharing ministries, discount plans, and risk sharing plans, (Dec. 13, 2023), https://content.naic.org/article/what-you-should-know-about-health-care-sharing-ministries-discount-plans-and-risk-sharing-plans (last visited Feb. 25, 2025).
[27] Department of Financial Services, Legislative Bill Analysis of SB 480, as filed (Feb. 14, 2025).
[28] American Farm Bureau Federation, Who we are, https://www.fb.org/about/who-we-are (last visited Feb. 24, 2025).
[29] Congressional Research Service, Applicability of Federal Requirements to Selected Coverage Arrangements: An Overview (Nov. 13, 2019), https://crsreports.congress.gov/product/pdf/IF/IF11359/3 (last visited Feb. 24, 2025).

Several states have exempted nonprofit agricultural organizations or cooperatives, which offer and sell medical benefit plans, from state insurance regulations and consumer protections. State Farm Bureaus offer medical benefit plans in several states[30] an alternative to health insurance coverage that aims to offer lower costs for individual benefits to members and their families, self-employed farmers, and others.[31] The Farm Bureau Health Plans in Tennessee, a member service company of the Tennessee Farm Bureau Federation, has been offering medical benefit plans since 1947 and currently provides medical benefit plans for more than 200,000 residents.[32] The vast majority of farmers and farm workers who lack health insurance coverage have incomes below 400 percent of the federal poverty level, which is the income cut-off for federal subsidies on policies offered on the Health Insurance Marketplace[33] that help pay for premiums in the individual health insurance market.[34] In addition to individual and family plans, Medicare, dental and vision, and small employer medical benefit plans are offered to members.[35]

In regard to pre-existing condition waiting periods, benefits will not be provided until a member has completed a waiting period of at least six months for all contracts and nine months for maternity on family contracts.[36] These plans require medical underwriting,[37] which may affect eligibility and rates.[38] The plans are not compliant with PPACA, which means they can medically underwrite covered individuals, impose waiting periods for preexisting conditions, and are not required to provide essential health benefits, etc. These plans are only available to Farm Bureau members, though an individual does not necessarily need to be affiliated with the agricultural industry to become a member.[9]

In 2017, Minnesota[39] enacted legislation that allows for the formation of agricultural cooperatives to operate self-funded health plans. Plan membership is restricted to farmers or

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[30] Arkansas (2023 SB 324), Indiana (IN Code s. 27-1-2.2-4), Iowa (IA s. 505.20), Kansas (KS Stat s.40-2222), Nebraska (NE Code s. 44-7,119), North Dakota (2023 SB 2349), South Dakota (2021 SB 87), Tennessee (TN Code s. 56-2-121), Texas (TX Ins Code s. 1682.005).

[31] Insurance Newsnet, Farm bureau launches new health plan that is everything but 'insurance' (Oct. 12, 2024), https://insurancenewsnet.com/oarticle/farm-bureau-launches-new-health-plan-that-is-everything-but-insurance (last visited Feb. 24, 2025).

[32] Farm Bureau Health Plans Tennessee, Why Choose Farm Bureau Health Plans? | Farm Bureau Health Plans (last visited Feb. 27, 2025).

33 HealthCare.gov, Welcome to the Health Insurance Marketplace, Welcome to the Health Insurance Marketplace® | HealthCare.gov (last visited Feb. 25, 2025). The website provides individuals with access to obtaining PPACA-compliant health insurance coverage during open enrollment and special enrollment periods. Individuals may qualify for subsidies or Medicaid, contingent on their income.

[34] Center on Budget and Policy Priorities, Expanding Skimpy Health Plans Is the Wrong Solution for Uninsured Farmers and Farm Workers (Jul. 17, 2018), https://www.cbpp.org/research/health/expanding-skimpy-health-plans-is-the-wrong-solution-for-uninsured-farmers-and-farm (last visited Feb. 25, 2025)

[35] Farm Bureau Health Plans Tennessee, Frequently Asked Questions | Farm Bureau Health Plans (last visited Feb. 25, 2025).

[36] Farm Bureau Health Plans Tennessee, Individual and Family Plans | Core Choice | Farm Bureau Health Plans (last visited Feb. 25, 2025).

[37] Medical underwriting is a process used by insurers to determine the health status of an applicant for insurance coverage, and to determine whether to offer an applicant coverage, at what price, and with what exclusions or limits. See https://www.healthcare.gov/glossary/medical-underwriting/ (last visited Feb. 26, 2025).

[38] Farm Bureau Health Plans Tennessee, Home (last visited Jan. 25, 2025).

[39] State Health Access Data Assistance Center, Alternatives to ACA Compliant Plans in the Individual Market (Nov. 15, 2019), https://www.shadac.org/news/alternatives-aca-compliant-plans-individual-market (last visited Feb. 25, 2025).

other people in the agriculture industry.[40] The plans accept all who apply but are underwritten such that people with prior health conditions can be charged higher premiums.[41]

III. Effect of Proposed Changes:

Section 1 creates s. 624.4032, F.S., relating to nonprofit agricultural organization medical benefit plans , to authorize nonprofit agricultural organizations to offer health benefit e options to their members. The term, "nonprofit agricultural organization" means an organization that meets the following criteria:

- Is domiciled in Florida.
- Is exempt from federal income tax under s. 501(c)(3) of the Internal Revenue Code.
- Was created primarily to promote programs for the development of rural communities and the economic stability and sustainability of farmers in Florida.
- Exists to serve its members beyond only offering health coverage.
- Collects annual dues from its members.
- Was in existence before 1945.
- Is composed of members who, collectively, are residents of the majority of counties in this state.

Further, a nonprofit agricultural association:

- May offer medical benefit plans to its members. Such plans are not insurance for purposes of the Florida Insurance Code.
- Must provide a written disclaimer on or accompanying all applications and marketing materials for a medical benefit plan, regardless of whether such applications and marketing materials are distributed by or on behalf of the nonprofit agricultural organization. The disclaimer must read substantially in the following form:

  Notice: *This medical benefit plan is not a health insurance policy or health maintenance organization contract and is not subject to the regulatory requirements and consumer protections that apply to health insurance policies or health maintenance organization contracts under the Florida Insurance Code. The nonprofit agricultural organization offering this medical benefit plan is not an authorized insurer or authorized health maintenance organization in Florida and the nonprofit agricultural organization is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code.*

- May not market or sell health benefit plans through agents licensed by the department.[42]

[40] The Minnesota Star Tribune, Farmer cooperative health plans may rattle individual market in Minnesota (Nov. 14, 2017), https://www.startribune.com/farmer-cooperative-health-plans-may-rattle-individual-market-in-minnesota/457321193 (last visited Feb. 25, 2025).
[41] *Id.*
[42] The term, "department," means the Department of Financial Services.

- Must conduct an annual financial audit that is performed by an independent certified public accountant and make a copy of the audit publicly available upon request or post it online on the organization's website.

Because such medical benefit plans are not insurance, various state statutes relating to regulation of forms and rates, financial regulations, availability of a guaranty funds in the event of an insolvency and other consumer protections, and mandated benefits will not apply to nonprofit agricultural organization plans.

Section 4 provides this act takes effect July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Individuals, families, or small businesses who are ineligible for subsidies through the Health Insurance Marketplace may be able to obtain a lower cost alternative to health insurance through plans offered by nonprofit agricultural organizations.

If the nonprofit agricultural organization is unable to pay claims or becomes insolvent, there is no state guaranty fund to pay claims.

C. Government Sector Impact:

Insurance premium tax revenues may be reduced to the extent that purchasers of health plans shift their business from health insurance to the exempt health plans proposed by the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 632.701 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on Mar. 10, 2025:
The CS:

- Revises and transfers the provisions of the bill from newly created Part II of ch. 632, F.S., to newly created s. 624.4032, F.S.
- Replaces the term, "health coverage," a health insurance related term, with the term, "medical benefit plans."
- Authorizes nonprofit agricultural organizations to offer health benefit plans to their members, and specifies such coverage is not insurance for purposes of the Florida Insurance Code.
- Requires a nonprofit agricultural organization to provide a written disclaimer on or accompanying all applications and marketing materials for a medical benefit plan.
- Provides that a nonprofit agricultural organization may not market or sell health benefit plans through agents licensed by the department.
- Requires a nonprofit agricultural organization to conduct an annual financial audit that is performed by an independent certified public accountant and make a copy publicly available upon request or post it online on the organization's website.

B. Amendments:

None.