# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1157 Health Flex Plans
**SPONSOR(S):** Powell
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1278

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Innovation Subcommittee | 13 Y, 0 N | Poche | Shaw |
| 2) Insurance & Banking Subcommittee | 12 Y, 0 N | Cooper | Cooper |
| 3) Health & Human Services Committee | 17 Y, 0 N | Poche | Calamas |

## SUMMARY ANALYSIS

Health flex plans were established in 2002 as a pilot program in Indian River County to offer basic affordable health care services to low-income uninsured state residents. Health insurers, health maintenance organizations, and other entities were encouraged to develop low cost, basic benefit health coverage plans that would provide uninsured individuals with access to primary care treatment, prescription drugs, screenings, and diagnostic and radiology procedures. Subsequent legislation has expanded availability of the program to other counties.

There are currently more than 12,000 individuals enrolled in three health flex plans in six counties. Under current law, the pilot program will end on July 1, 2013, unless it is extended by legislative action.

House Bill 1157 extends the health flex plan program to July 1, 2018.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of June 30, 2013.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Present Situation**

The health flex plan program was established in 2002 as a pilot program to offer basic affordable health care services to low-income uninsured state residents "by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services."[1] Health flex plans are not insurance products. Plan providers are not subject to the Florida Insurance Code. The plans are also not required to offer the mandated health benefits found in chapter 627, F.S., or chapter 641, F.S., as applicable. Health flex plans provide coverage for basic health care services, such as preventive health screenings, office visits for primary care treatment, basic prescription drug coverage, blood chemistry screenings, and certain diagnostic and radiology procedures.

Eligibility to enroll in a health flex plan is limited to persons who:

- Are residents of the state;
- Are 64 years old or younger;
- Have a family income equal to or less than 300 percent of the federal poverty level;[2]
- Are not covered by private insurance and are not eligible for coverage through a public health insurance program or have not been covered for the past six months, with exceptions.[3]

The program was initially available in Indian River County from July 2002 until July 2004. Subsequent legislation in 2003 extended the program to July 2008, and later legislation expanded the counties of availability. In 2008, the Legislature passed and the Governor signed HB 461, which extended the program from July 2008 to July 2013.[4] Current law provides for expiration of the program on July 1, 2013.[5]

There are three health flex plans in the state, American Care, Inc., Preferred Medical Plan, Inc., and Vita Health Plan, operating in Broward, Hillsborough, Miami-Dade, Palm Beach, Polk, and St. Lucie counties. The following chart shows the total enrollment in each of the plans[6]:

| COMPANY | ENROLLEES |
|---|---|
| American Care, Inc. | 347 |

[1] S. 408.909(1), F.S.; *see also* Florida Agency for Health Care Administration and Office of Insurance Regulation, *Health Flex Plan Program Annual Report-January 2012*, page 2, available at http://ahca.myflorida.com/mchq/managed_health_care/Health_Flex/ANNUAL_REPORT-FINAL_2013[1].pdf (on file with Health Innovation Subcommittee staff).

[2] The federal poverty level for a family of four, based on 2013 federal guidelines, is $23,550. 300 percent of the federal poverty level for a family of four is $70,650. *See* U.S. Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation, *2013 Poverty Guidelines*, available at http://aspe.hhs.gov/poverty/13poverty.cfm (last viewed March 14, 2013); *see also* 78 Fed. Reg. 5,182, 5,183 (January 24, 2013).

[3] S. 408.909(5)(a)2.a. and b., and (b), F.S., contain specific criteria to be eligible for health flex plan coverage under the exceptions.

[4] S. 1, Ch. 2008-118, L.O.F.

[5] S. 408.909(10), F.S.

[6] Florida Agency for Health Care Administration and the Office of Insurance Regulation, *Health Flex Plan Program Annual Report-January 2013*, page 6, available at http://ahca.myflorida.com/mchq/managed_health_care/Health_Flex/ANNUAL_REPORT-FINAL_2013[1].pdf (on file with Health Innovation Subcommittee staff).

| | |
|---|---|
| Preferred Medical Plan, Inc. | 1,630 |
| Vita Health Plan | 10,150 |
| **TOTAL** | **12,127** |

*Patient Protection and Affordable Care Act*

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA")[7], as amended by the Health Care and Education Reconciliation Act of 2010[8]. The law contains comprehensive changes to the entire health care system in the United States. Most of the PPACA provisions take effect in 2014; however, many changes are phased in, starting from the day the bill was signed on March 23, 2010 and continuing through 2019.

Specifically, PPACA:

- Requires most U.S. citizens and legal residents to obtain health insurance coverage or pay a penalty;
- Substantially expands Medicaid;
- Establishes new requirements on employers and health plans;
- Restructures the private health insurance market;
- Creates health insurance exchanges for individuals and employers to obtain coverage;
- Sets minimum standards for health coverage offered in the health insurance exchange; and
- Provides premium tax credits and cost-sharing subsidies for eligible individuals that obtain coverage through the health insurance exchange**.**

*Health Insurance Exchanges under PPACA*

PPACA requires that a health insurance exchange be established in each state. Individuals and small businesses will be able to purchase health insurance coverage that meets the minimum essential coverage provisions of PPACA. The exchanges must begin open enrollment on October 1, 2013, for coverage effective January 1, 2014. The exchange is not an insurer; instead, it will provide eligible individuals and businesses with access to qualified health plans. Each plan must be one of following "metal levels":

- Bronze: 60% actuarial value[9]
- Silver: 70% actuarial value
- Gold: 80% actuarial value
- Platinum: 90% actuarial value

In addition to enrolling individuals in qualified health plans, the exchange will also determine eligibility for Medicaid and the Child Health Insurance Plan (CHIP). The exchange will also determine if an individual is eligible for advance premium tax credits and cost-sharing reductions.

Individuals with household income between 100% and 400% of poverty are eligible to receive an advance premium tax credit if "affordable coverage"[10] is not available through an employer. The amount of the tax credit that an individual can receive is based on the premium for the second lowest cost silver plan in the exchange and area where the person is eligible to purchase coverage. The amount of the tax credit varies with income so the premium that a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income as follows:

[7] P.L. 111-148, 124 Stat. 119 (2010)
[8] P.L. 111-152, 124 Stat. 1029 (2010)
[9] Actuarial value is calculated by computing the ratio of total expected payments by the plan for essential health benefits and cost-sharing rules with the total costs of the essential health benefits the standard population is expected to incur. For example, a health plan with an actuarial value of 80 percent would be expected to pay an average of 80 percent of a standard population's expected medical expenses for the EHB. Individuals covered by the plan would then be expected to pay the remaining 20 percent, on average, through cost sharing such as deductibles, co-pays, and co-insurance.
[10] See discussion of "affordable coverage" under Employer Responsibility supra.

| Income Level | Premium as a Percent of Income |
|---|---|
| Up to 133% FPL | 2% of income |
| 133-150% FPL | 3 – 4% of income |
| 150-200% FPL | 4 – 6.3% of income |
| 200-250% FPL | 6.3 – 8.05% of income |
| 250-300% FPL | 8.05 – 9.5% of income |
| 300-400% FPL | 9.5% of income |

**Effect of Proposed Changes**

The bill extends the health flex plan program for 5 years, from July 1, 2013 to July 1, 2018.

Because eligibility for health flex plans is limited to individuals at or below 300 percent of the federal poverty level, it is likely that many people currently enrolled in a health flex plan would qualify for subsidized health insurance coverage in the federal health insurance exchange. However, since advance premium tax credits are not available to individuals having incomes below 100 percent of the federal poverty level, these individuals are likely to choose to remain in the health flex plan program.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 408.909, F.S., relating to health flex plans.
**Section 2:** Provides an effective date of June 30, 2013.

## 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:

Failure to extend the pilot program could leave 12,127 residents of Florida with no coverage for health care services until January 1, 2014.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.