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DATE: April 9, 1997

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 1967

RELATING TO: Health Insurance

SPONSOR(S): Committee on Health Care Services, Rep. Albright & others

STATUTE(S) AFFECTED: Amends ss.: 624.91, 627.6406, 627.6425, 627.6489, 627.6561, 627.6574, 627.6675, 627.6699, 641.31, 641.31071, 641.3921, and 641.3922, F.S.; Creates ss.: 627.6475, 627.6487, 627.64871, 627.6512, 627.65615, 627.65625, 627.6571, 627.6576, 627.9404, 627.9407, 627.94071, 627.94072, 627.94073, 627.94074, 641.2018, 641.3102, 641.31071, 641.31072, 641.31073, and 641.31074, F.S.;

COMPANION BILL(S): SB 1682 (Similar)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 10 NAYS 0
(2)
(3)

I. SUMMARY:

During the fall of 1996, the U.S. Congress passed and the President signed into law landmark health insurance reform legislation titled the “Health Insurance Portability and Accountability Act of 1996" (HIPAA). These reforms take effect July 1, 1997 and will be enforced by the federal Health Care Financing Administration (HCFA) unless Florida adopts the provisions of HIPAA into the Florida Insurance Code, thus providing the Department of Insurance (department) enforcement authority. In addition, HIPAA provides the states an opportunity to adopt an acceptable alternative mechanism (which must be approved by HCFA) in lieu of a federal mandate for guaranteed access to an individual health insurance policy for persons who have qualifying previous insurance coverage.

PCB HCS 97-10 addresses two principle tasks. **First, the proposed bill conforms the Florida Insurance Code to HIPAA provisions**. This is accomplished by amending Florida statutes relating to group health insurance policies, small group health insurance policies, HMO contracts, and individual health insurance policies and imposing the new federal requirements with regard to guaranteed availability of individual coverage, guaranteed renewability of coverage, limitations on excluding coverage for preexisting conditions, special enrollment periods, prohibited discrimination against individual participants under a group policy based on health status, and guaranteed availability of small group coverage. **Second, the proposed bill creates an alternative mechanism which requires all individual insurance carriers in Florida to guarantee issue a policy to any HIPAA eligible (at least 18 months of coverage with no more than a 63 day gap in coverage) who applies.** A reinsurance pool is established for individual insurers who wish to participate. The bill provides that persons who are eligible for an individual conversion policy from the employer’s group carrier, are not otherwise eligible for guaranteed access to individual coverage. A premium cap is placed on conversion contracts from HMOs of 200% of the standard risk rate.

The fiscal impact of this legislation on state and local governments is indeterminate.

II. SUBSTANTIVE RESEARCHS:

A. PRESENT SITUATION:

Overview of Federal Law

In 1996, the federal Health Insurance Portability and Accountability Act (HIPAA) was enacted to provide guaranteed availability and renewability of health insurance coverage for certain employees and individuals, and to increase portability through the limitation on preexisting condition exclusions. These provisions amended the Public Health Services Act. In a separate federal act, insurance provisions relating to maternity coverage, also amending the Public Health Services Act, were addressed.

Group plans are regulated, in part, by the federal government, under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code, and to the extent the plans purchase insurance, in part by the states under state insurance laws and regulations. Policies sold in the individual market are regulated by the individual states.

HIPAA allows each state the option to enact and enforce the federal provisions or fall back to federal enforcement. HIPAA specifies that the federal provisions pertaining to health insurers in the individual market generally do not preempt state regulation of individual insurers. However, if the state's statutory provisions prevent the application of a federal requirement, HIPAA preempts the statutes and the federal requirements prevail. At a minimum, each state must ensure that its provisions comport with HIPAA and do not diminish the federal requirements. However, each state is permitted to adopt provisions that expand or provide more favorable treatment for the individual.

On July 1, 1997, the federal guaranteed access and renewability provisions for individual health insurance become effective, unless Florida has implemented, or the Governor has filed a notice by April 1, 1997, of the state's intent to implement, an acceptable alternative mechanism. If such a notice is filed with, and approved by, H C FA, a state has until January 1, 1998 to adopt its alternative mechanism. Portability, availability, and renewability provisions for group health plans and health insurance coverage offered with the such plans become effective for plans beginning on or after July 1, 1997.

Maternity Length of Stay Coverage

Federal Law -- Under the federal act, an insurer (group or individual) may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn to less than 48 hours (following a normal vaginal delivery) or 96 hours (following a cesarean section) or require that a provider obtain authorization from the insurer for prescribing any length of stay. The federal provisions do not apply in any case in which the decision to discharge the mother or newborn prior to the expiration of the length of stay is made by an attending provider in consultation with the mother.

The federal requirements do not apply in a state that has enacted a law which regulates maternity length of stay coverage in the following areas: (1) provides minimum 48-hour/96-hour length of stay; (2) requires such coverage to provide for care in

accordance with guidelines established by the American College of Obstetricians and Gynecologists, or other established medical associations; or (3) requires, in connection with such converge for maternity care, that the hospital length of stay for such care is left to the decision of the attending provider in consultation with the mother.

The federal act also prohibits an insurer from denying the mother or newborn eligibility, or continued eligibility, to enroll or to renew coverage, solely for the purpose of avoiding the provisions of this section. An insurer is also prohibited from providing monetary payments or rebates to mothers to encourage mothers to accept less than the minimum protections under this section. The maternity coverage provisions apply to policies beginning on or after January 1, 1998.

Florida Law -- Under current Florida law, Chapter 96-195, L.O.F., standardized the coverage for maternity care to require that if a health plan covers maternity care in individual policies, group health policies or HMO contracts, the plan may not limit coverage for the length of maternity stay in a hospital or for follow-up care outside of a hospital, to a time period shorter than that which is determined to be medically necessary by an obstetrical provider or a pediatric provider. In addition, a physician's determination shall be in accordance with "proposed 1996 guidelines" for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. However, the 1992 guidelines for these organizations have not yet been revised.

The law enumerates a minimum standard of outpatient follow up care which must include postpartum assessments of both mother and newborn, along with the performance of any medically necessary clinical tests and immunizations for the newborn. In addition, the law states that its provisions do not affect any provisions in the negotiated contracts between an insurer or HMO and a hospital or other health care providers regarding reimbursement for services, or regarding appropriate utilization review of maternity care by the insurer or HMO.

Preexisting Condition Exclusion

Federal Law -- Under HIPAA, group health plans are authorized to impose a preexisting condition exclusion only if such exclusion relates to a condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date. Such exclusion may extend for a period of not more than 12 months (or 18 months for a late enrollee) after the enrollment date. The exclusion period is reduced by the aggregate of the periods of creditable coverage applicable to the individual or dependent, as of the enrollment date. The act also authorizes insurers to impose a waiting period or, in the case of a health maintenance organization, an affiliation period of two months (or 3 months for a late enrollee). No preexisting exclusion may be imposed on an eligible individual. (See guaranteed issue discussion)

An insurer is prohibited from imposing any preexisting condition on adopted children or newborns. Pregnancy and genetic information, in the absence of a diagnosis of the condition related to genetic information, are not considered to be a preexisting conditions.

For purposes of giving credit towards a preexisting condition exclusion for time covered under previous coverage, creditable coverage is defined to include, among other coverages, coverage through a group health plan, health insurance coverage, Medicare (parts A or B), Medicaid, and a state health benefits risk pool. Creditable coverage does not include coverage consisting solely of excepted benefits, as defined. If an individual has more than a 63-day break between the period of creditable coverage and an enrollment date, a period of creditable coverage is not counted. Insurers are required to issue certificates of coverage to an individual at the time the individual ceases to be covered under the plan, or becomes covered or ceases to be covered under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), or at the request of the individual no later than 24 months after the date of cessation of coverage.

Florida Law -- Current Florida law, section 627.6045, F.S., prohibits *individual* health insurance policies from excluding coverage for a preexisting condition for any period longer than 24 months, based upon a condition that had manifested itself during the previous 24-month period in such a manner as would cause an ordinarily prudent person to seek medical advice or treatment. Insurers are also required to provide credit for pre-existing conditions for the time a person was covered under previous coverage that was similar to or exceeded the coverage under the new policy, if such previous coverage was effective within the 62 days prior to the effective date of new coverage.

By comparison, under current Florida Law, *group* policies may not exclude coverage for longer than 1 year, based on a condition manifesting itself during the previous 6 months; and credit must be provided for time covered under previous coverage that was effective within 30 days prior to the new coverage, under s. 627.6561, F.S. Small group policies with 3-50 employees may also impose a 1-year exclusion on preexisting conditions. For small groups with 1 or 2 employees, a 24-month exclusion and 24-month look back is permitted, under s. 627.6699(5), F.S. Limitations for preexisting conditions do not apply to out-of-state group policies covering Florida residents. Presently, insurers in Florida are allowed to consider pregnancy as a preexisting condition.

Under the provisions of current Florida law in s. 627.6561, F.S., and s. 627.6699, F.S., large and small group insurers are required to provide credit for qualifying previous coverage, as long there is not a lapse of more than 30 days.

Special Enrollment

Federal Law -- Insurers are required to provide special enrollment periods to employees and dependents that were already covered under another policy or plan, if enrollment is requested within 30 days after the date of termination of the other coverage. An employee or dependent is not required to exhaust COBRA under another plan in order to qualify for special enrollment, if the individual is otherwise not eligible for the other group coverage. An individual is allowed to enroll a dependent within 30-days of marriage, birth, or adoption.

Florida Law -- Current Florida laws for large and small groups, as well as health maintenance organizations, do not address or provide for a special enrollment. However, for group policies that provide coverage for a family member of the policyholder, a newborn must be covered from the moment of birth and an adopted child must be covered upon placement in the residence, under s. 627.6578, F.S. The policy may require the insured to notify the insurer of the birth of the child within 30 days. If

timely notice is not provided, an insurer may charge an additional premium for covering the newborn retroactive to the date of birth or placement for adoption, but the insurer may not deny coverage for the child.

The current small group law requires an annual open enrollment period of at least 30 days, s. 627.6699, F.S.

Prohibition on Discrimination Based of Health Status

Federal Law -- An insurer is prohibited from establishing rules for eligibility, including continued eligibility, of an individual or dependent, based on: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of violence), or disability. An insurer is also prohibited from requiring any individual (as a condition of enrollment or continued enrollment) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor.

Florida Law -- Pursuant to s. 627.6576, F.S., an insurer in the large group market is prohibited from refusing to provide or charging unfairly discriminatory rates for health insurance coverage solely because the person is mentally or physically handicapped. This section does not require an insurer to provide coverage for a handicap which the applicant or policyholder has already sustained. In the small group market, all polices are required to be guaranteed-issue, regardless of health condition, under s. 627.6699, F.S. A small employer carrier is required to use modified community rating, which allows a premium adjustment only for age, gender, family composition, tobacco usage, and geographic area (and no other health-related factors).

Under the various sections in part VII of chapter 627, F.S., that authorize the types of groups for whom a group health insurance policy may be written, the language generally states that all members of the group must be declared eligible for coverage, often referred to as “whole group coverage.” For example, s. 627.653, F.S., allows for employee group policies to be issued in Florida and requires that all employees of the employer, or all members of any class or classes of employees, determined by conditions pertaining to their employment, but not determined so as to exclude those in the more hazardous employment, must be declared eligible and acceptable to the insurer at the time of issuance of the policy.

Guaranteed Renewability of Groups and Individuals

Federal Law -- An insurer issuing individual coverage is required to renew or continue in force coverage, at the option of the policyholder. Provisions for discontinuation or nonrenewal include nonpayment or untimely premium payment, fraud or intentional misrepresentation, cessation of insurer offering a particular type of coverage or all coverage, and certain other exceptions.

If an insurer discontinues or nonrenews all small group coverage or large group coverage, or both, the insurer is prohibited from issuing any new coverage in such a market in the state for 5 years. If all individual health insurance coverage is ceased, a 5-year prohibition on the issuance of any individual coverage in the state is imposed.

Florida Law -- Section 627.6425, F.S., requires individual health insurance policies to be guaranteed renewable, at the option of the insured except if: (1) premiums are not timely paid; (2) there is fraud or misrepresentation by the insured; (3) the insured does not comply with plan provisions; (4) the insurer elects to non-renew all policyholders in the state with a 90-day notice; or (5) a determination by the Department of Insurance that continuation of the policy is not in the best interest of the policyholder or will impair the insurer's ability to meet its contractual obligations. If an insurer exercises its option to non-renew all policies in the state, it may not write any new individual health insurance policies in the state for 5 years, unless approved by the department, and except for certain specified limited benefit policies and other types of non-major medical health coverage. Also, the section exempts short-term, non-renewable health insurance policies of no more than a 6-month policy term from the requirements.

Section 627.6645, F.S., does not require group health policies to be guaranteed renewable; however an insurer must give 45-days notice with reason for nonrenewal, unless the nonrenewal is due to nonpayment of premiums. Under s. 627.6646, an insurer is also prohibited from canceling or nonrenewing a policy of any insured due to the diagnosis or treatment of human immunodeficiency virus infection or acquired immune deficiency syndrome.

A health insurer may discontinue the availability of a particular individual policy form; however, the insurer is prohibited under s. 627.410(6)(e), F.S., from issuing a similar form for a period of 5 years.

Small group policies under s. 627.6699, F.S., Medicare Supplement policies, under s. 627.6741,F.S., and long-term care policies under s. 627.9407, F.S., are required to be guaranteed renewable. For small group policies, s. 627.6699, F.S. requires guaranteed renewability with exceptions. The exceptions include: (1) nonpayment or untimely payment of premiums, (2) fraud or misrepresentation, (3) noncompliance with plan provisions or contribution or participation requirements, (4) termination of small employer’s business, or (5) determination by the Department of Insurance that the continuation is not in the best interest of the policyholders or certificate holders or will impair the carrier’s ability to meet its contractual obligations.

Guaranteed Issue of Coverage

Federal Law -- HIPAA provides that an insurer that offers health insurance coverage in the individual market may not, with respect to an eligible individual, decline to offer such coverage to, or deny enrollment of, such individual or impose any preexisting condition exclusion with respect to such coverage. To implement the guarantee issue requirement, a state may require an insurer to guarantee-issue the insurer’s two most popular policy forms, based on premium volume, or offer the choice of a low and high level (based on weighted actuarial average) of coverage with benefits similar to other coverage offered by the issuer in the state.

An eligible individual is defined as an individual with 18 months or more of aggregate creditable coverage, whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or coverage offered in connection with any such plan) who is not eligible for coverage under a group plan, Medicare Part A or B, or Medicaid, and who does not have other health insurance coverage, and whose

recent group coverage was not terminated due to nonpayment of premiums or fraud, and who has exhausted COBRA or other continuation coverage.

Insurers in the small group market are required to guarantee-issue to small employers with 2 to 50 employees. There is no similar requirement for the large group market.

Florida Law -- Section 627.6699, F.S., requires insurers in the small group market to guaranty the issuance of coverage to any small employer with 1 to 50 employees, including sole proprietors and self-employed individuals. The insurer is also required to establish premiums based on "modified community rating" which prohibits the insurer from basing premiums on any factor other than age, gender, geographic location, family size, and tobacco usage.

There are no other provisions in current Florida law that requires the guaranteed issuance of coverage to an individual or group, except group continuation and conversion laws described below.

COBRA and Other Continuation Coverage

Federal Law -- Currently, employers with 20 or more employees must offer group health benefit plans in compliance with relevant provisions of federal COBRA and ERISA. COBRA group plans must provide, that upon the occurrence of specified events (e.g., termination of employment, retirement, divorce from an employee) an insured that would lose benefits may continue the group coverage for a limited period of time, generally 18 months, at a premium rate slightly in excess of the group rate.

Florida Law -- In 1996, Florida enacted statutory provisions for continuation of coverage comparable to COBRA, under the Florida Health Insurance Continuation of Security Act, which provides to former employees of small employers (less than 20 employees) and their dependents a right to continue their group health coverage. The act requires insurers that sell health plans to small employers to offer in those plans a right to elect continued coverage, without providing evidence of insurability, to the covered employee or their dependents who will lose employer-sponsored group coverage for various reasons and who may not be able to obtain replacement insurance. Coverage may be continued in most circumstances for up to 18 months beyond the time when it would have otherwise ended. The premium for continuation of group coverage cannot exceed 115% of the regular group rate, except in cases where the beneficiary was disabled at the time continuation coverage begins, in which case the beneficiary may extend coverage for an additional 11 months and pay a premium of 150% of the group rate during those additional months.

Conversion Policies and Converted Contracts

Florida Law -- Employees and dependents covered under a group health insurance policy may, pursuant to s. 627.6675, F.S., obtain a conversion policy if their eligibility under the group health plan terminates for any reason except for the failure to pay premiums or replacement by an alternative health plan within 31 days of discontinuance of the group coverage. This right to a conversion policy is interpreted as applying at the end of the period of time that the individual elects to continue the group coverage under COBRA or the state continuation law.

Under a conversion policy, insureds are not entitled to the same level of benefits as under the group plan; however, employees or members are entitled to obtain a conversion policy providing major medical coverage. The maximum premium for the conversion policy is 200 percent of the "standard risk rate" as developed by the Florida Comprehensive Health Association. The standard risk rate is based on the average rate for individual health insurance and would likely be higher than group rates.

Section 641.3922, F.S., requires an HMO to offer a conversion contract to employees and dependents with a level of benefits similar for those services included in the group HMO contract from which the termination was made. No cap is placed on the premiums for an HMO conversion contract.

Election of an Alternative Mechanism

In lieu of implementing the federal guaranty-issue requirements, each state is authorized to implement an acceptable alternative mechanism to provide access to coverage for eligible persons. Each state that implements the federal guaranty-issue approach or an alternative mechanism retains regulatory authority on enforcing such mechanism. An acceptable alternative mechanism, at a minimum, must provide all eligible individuals a choice of insurance coverage, prohibit a preexisting exclusion, and offer choice of at least one policy form that is comparable to the comprehensive coverage in the individual market or to a standard plan under the group law.

Acceptable alternative mechanisms under HIPAA include:

- a state benefit risk pool (such as the Florida Comprehensive Health Association),
- mandatory group conversion policies,
- a reinsurance program,
- enactment of the NAIC Small Employer and Individual Health Insurance Availability Model Act, insofar as it applies to individual health insurance or the Individual Health Insurance Portability Model Act,
- a mechanism that provides eligible individuals with a choice of all individual coverages otherwise available, and
- a mechanism that either provides for risk adjustment or a risk spreading among issuers or policies of an issuer, or otherwise provides for some financial subsidization of eligible individuals, including through assistance to participating issuers.

Florida is presumed to be implementing an alternative mechanism as of July 1, 1997, if the Governor notifies HCFA, which is under the United States Department of Health and Human Services by April 1, 1997, that the state intends to enact by January 1, 1998, any necessary legislation to provide for the implementation of such an alternative mechanism.

As of February 24, 1997, 20 states had formally notified HCFA of their intentions to implement some type of alternative mechanism. According to the National Association of Insurance Commissioners, 35 states anticipate implementing some type of alternative mechanism. Nineteen of the 35 states are planning to use a risk pool; of the remaining 16 states, 10 expect to enact legislation to require guaranteed issue and 6 plan to use other forms of alternative mechanisms.

Florida Comprehensive Health Association

The Florida Comprehensive Health Association (FCHA) was created in 1983 to offer residents of the state, through the participation of health insurance companies, a program of health insurance. The FCHA is a nonprofit legal entity subject to the supervision of a three-member board of directors, appointed by the Insurance Commissioner. The board includes the chairman, who is the Insurance Commissioner or his designee, one representative of policyholders, and one representative of insurers.

The major medical expense coverage under FCHA includes a $500,000 lifetime limit per covered life. The plan provides for an annual deductible in the amount of $1,000 or more, as approved by the Department of Insurance. The plan provides for a 12-month exclusion of coverage with respect to a condition that manifested itself within 6 months of the effective date of the coverage or medical advice or treatment recommended or received within a period of 6 months before the effective date of the coverage. Policyholders pay premiums that are up to 250% of standard rates.

As a condition of doing business in Florida, health insurers are required to pay assessments to fund the deficits of the FCHA. Companies subject to the assessment include all health insurance companies, fraternal benefit societies, HMOs, multiple employer welfare arrangements, and prepaid health clinics. Each insurer is assessed annually by the board a portion of incurred operating losses of the plan, based on the insurer's market share in Florida as measured by premium volume. The total of all assessments upon a participating insurer is capped at 1 percent of such insurer's health insurance premium earned in Florida during the calendar year preceding the year for which the assessment is levied.

Pursuant to law, on July 1, 1991, the FCHA ceased accepting applications due to the Legislature's concerns over mounting financial losses. At that time, two actuarial firms estimated the 1992 deficit of the FCHA to be between $48 - 56 million, as compared to the maximum $27 million that could be assessed against insurers under the funding formula enacted in 1990. In 1991, legislation revised the funding formula providing for maximum assessments against the insurers of 1 percent of health insurance premiums written in Florida. As of June 30, 1996, enrollment totaled 1,461.

According to the *FCHA Summary of Plan Activities, 1995-96,* the average net cost per member for the period of 1990-95 experienced a slight decline/stabilization through 1993 and has increased over the last two years. In 1995, the average annual premium for an FCHA policyholder was approximately $4,600. The average *additional* net cost per insured assessed against insurance carrier for fiscal years 1990-95 is shown on the following chart:

FY	Average Cost (Amount assessed per member)	Percentage Increase/Decrease From Prior FY
1995	$4737	11.3
1994	4255	6.9
1993	3982	-10.4

1992	4445	4.9
1991	4237	-17.5
1990	5133	n/a - base year

Operating losses/assessments declined from a high of $33.9 million in 1990 to $5.8 million at the end of 1993, before increasing to $11.8 million in 1994 and $9.8 million for 1995. In 1995, expenses for medical benefits exceeded premiums earned by approximately $6.7 million. Health benefits and administrative fees ($14 million) comprised approximately 84% of the total expenses for 1995. Professional fees, salaries and benefit expenses, as a percentage of total expenses were approximately 5 percent ($900,000). Bad debt expense, interest expense, and other expenses represent 11 percent (or $1.8 million) of total expenses.

Florida Small Employers Health Reinsurance Program

The Florida Small Employers Health Reinsurance Program (Program) is a nonprofit entity created pursuant to the Employee Health Care Access Act , under s. 627.6699, F.S., to facilitate the guaranteed issuance of standard health benefit plans and basic health benefit plans to all small employers, by providing optional reinsurance coverage to small employer carriers. The Program is governed by a nine-member board, including the Insurance Commissioner, or his designee, and eight additional members who are representatives of carriers.

Each small employer carrier is required to make an election to become a risk-assuming carrier or a reinsuring carrier. A reinsuring carrier is able to cede any covered life it determines as a high risk into the Program and seek reimbursement from the Program for claims paid for the risk. A reinsuring carrier must pay, for reinsuring a single employee, a reinsurance premium equal to 5 times the standard rate determined by the board. If the reinsuring carrier reinsures an entire small employer unit, the premium is equal to 1.5 times the standard rate.

Two tiers of assessment are authorized for Program deficits. Risk-assuming carriers are not subject to the assessment, except for administrative expenses of the Program. Each reinsuring carrier is subject to an assessment, based on the net loss for the year. The first tier of assessments is against reinsuring carriers only, calculated by multiplying the total losses by a fraction. The numerator of the fraction equals the reinsuring carrier's earned premium for small employer plans written in Florida. The denominator equals the total of such premiums earned by reinsuring carriers. The first tier assessment is capped at 5 percent of each carrier's small employer premiums.

In the event losses exceed the first tier assessments, a second tier assessment can be levied, based on the premiums that all carriers, except for risk-assuming carriers, earned in the calendar year for which the assessment is made on all health benefit plans. The second tier is capped at 0.5% of each carrier's health benefit plan premiums.

At the end of 1995, a total of 140,210 groups and 1,028,381 employees and dependents were covered by small group plans. For fiscal years, 1994-96, the Program has experienced the following costs per life ceded:

Program Data (3/14/97):	1994	1995	1996
Average Annual Lives	1204	2168	1411
Program Assessments	4,100,000	4,100,000	1,500,000
Administrative Assessments	184,692	50,000	227,292
Total Earned Premiums	4,000,000	6,800,000	5,440,000
Total Collected from Carriers	8,284,692	10,950,000	7,167,292
Avg. Premium & Assessment Per Life	$6,880	$5,050	$5,079

Long-term Care Insurance Policies

The HIPAA establishes a federally qualified long-term care insurance policy which qualifies for favorable tax treatment in certain circumstances. The policy conditions and coverages, including benefit triggers, of this policy are specifically addressed in the federal act. These policies were authorized effective January 1, 1997 and are currently being sold in Florida because it is the department's position that nothing in current Florida law prevents them from being sold. In 1996, the Legislature passed amendments to part XVII of chapter 627, F.S., in Chapter 96-275, Laws of Florida. This law establishes specific benefit triggers for long-term care insurance policies sold in Florida effective July 1, 1997. These benefit triggers are more"consumer friendly" than the benefit triggers in the federal law and would prevent the sale of federally qualified policies from being sold in Florida after July 1, 1997. The federal benefit triggers differ from the Florida triggers in the following ways:

1. The federal trigger conditions the payment of benefits on the inability of the insured to perform at least two activities of daily living without assistance. The Florida triggers condition payment of benefits on the inability to perform not more than three activities of daily living without assistance.

2. The federal trigger further conditions the payment of benefits on the insured being chronically ill which is defined as being unable to perform at least two activities of daily living for at least 90 days. The Florida trigger contains no such requirement.

Because while the Florida polices are more consumer friendly in triggering of benefit payment even though this policy will not receive favorable tax benefits, the department believes that Florida consumers should have access to both types of policies.

The second reason changes are needed in Florida law is to incorporate several consumer protection provisions from NAIC model law and regulations which must be

included in federally qualified policies but which are not currently in Florida law. The proposed changes are needed to ensure that the department has specific statutory authority to include these provisions as a part of its review and approval of these policies and to incorporate these same protections in Florida policies. Although this latter requirement is not included in the federal law, the department believes that Florida consumers should enjoy equal protection regardless of which policy they purchase.

Florida Healthy Kids Corporation

The Legislature created the Florida Healthy Kids Corporation (FHKC) Act in 1990 (s. 624.91, F.S.) to provide school-based comprehensive health insurance to uninsured children. The not-for-profit corporation is exempt from the Florida Insurance Code and the rules of the Department of Insurance. However, the Department of Insurance may require the corporation's marketing representatives to be appointed as representatives of the insurers or providers with which the corporation contracts.

Eligibility for the subsidized part of the program is based on eligibility for the federal School Lunch Program, which is 185 percent of the federal poverty level. All families, regardless of income, are required to contribute based on their ability to pay. Premiums for children whose family incomes are above 185 percent of the federal poverty level are fully paid by the family, with no subsidy. As of February 1997, 25,380 children were enrolled in Healthy Kids. The majority have family incomes at or below 130 percent of the federal poverty level.

The program is financed by a combination of state, local, and participant funds. Local governments are required to make a financial commitment. Currently, there is a five percent minimum contribution set as the base, and each program’s local contribution is increased annually.

The corporation issues bids to providers and insurers to participate in those counties where it is in operation. Currently, all of the contractors are managed care organizations and the average monthly Healthy Kids premium is about $50 per month.

B. EFFECT OF PROPOSED CHANGES:

Children who enroll in the Florida Healthy Kids program after July 1, 1997, will be limited to a total lifetime maximum of 60 months of participation.

The Florida Department of Insurance will have the authority to enforce the provisions of HIPAA.

If HCFA approves Florida’s alternative mechanism for access to a choice of health insurance coverage for all HIPAA eligibles:

- Floridian’s who would have been eligible for a guaranteed issue individual health insurance policy on July 1, 1997, will have to wait until January 1, 1998. However, these persons will remain eligible for the same length of time after January 1, 1998, that they would have remained eligible after July 1, 1997.

- A reinsurance pool will be created for individual health insurers who wish to participate to reinsure HIPAA eligibles. Participating individual insurers and all other

health insurers (other than risk assuming insurers) may be assessed to cover a deficit in the reinsurance pool.

- HIPAA eligibles in Florida will be required to purchase a conversion policy (if available) instead of a guaranteed issue individual health insurance policy.

- Insurers and HMOs which sell conversion policies will be required to offer two types of benefit packages, and HMO's will be capped at 200% of the standard risk rate on these conversion policies (the cap already applies to health insurers).

Purchasers of long-term care insurance will enjoy access to policies which meet federal tax deductability requirements and policies which do not. Consumer protection provisions for long-term care policies contained in HIPAA will be applied to all long term care policies in Florida.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes, the bill gives the Department of Insurance the authority to adopt rules for the enforcement of the law.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes, insurance carriers and HMOs will face new requirements with regard to the selling of policies.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No, although health insurance premiums will likely be affected by this bill.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Yes, through insurance premiums.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

Yes and No. The bill provides additional options for certain individuals to purchase health insurance and imposes new regulations on health insurers and HMOs.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

Yes, insurance companies will no longer be able to deny insurance policies to certain individuals.

5. <u>Family Empowerment:</u>

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. SECTION-BY-SECTION RESEARCH:

Section 1. Healthy Kids Corporation -- Amends s. 624.91, F.S., to impose a maximum lifetime limit on participation in the program of 60 months for children who first enroll after July 1, 1997.

Section 2. Maternity Care (Individual Policies) -- Amends s. 627.6406, F.S., (Maternity Care) to add certain prohibitions, consistent with prohibitions in the federal law that are not currently in the Florida law relating to required coverage for length of a maternity stay. An individual insurer may not:

1. Deny to the mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage, for the purpose of avoiding the provisions of this section.
2. Provide monetary payments or rebates to mothers to encourage mothers to accept less than the minimum protections under this section.
3. Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because such provider provided care to an individual in accordance with this section.
4. Provide incentive to a provider solely to induce the provider to provide care in a manner inconsistent with this section.
5. Restrict benefits for any portion of a period within a hospital length of stay required under this section in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

Current Florida law states that none of the provisions in this section affect any agreement between an insurer and a hospital or other health care provider with respect to reimbursement for health care services provided or prohibits appropriate utilization review by an insurer. The bill adds to this section (language which is not in the federal law) that the section does not affect rate negotiations with providers, capitation of providers, and does not prohibit case management.

The bill also strikes the reference to proposed May 1, 1996, guidelines due to the fact that no such guidelines have been adopted by the entities cited since 1992.

Section 3. Guaranteed Renewability (Individual Coverage) -- Amends s. 627.6425, F.S., to revise the requirement that individual policies be guaranteed renewable. An insurer may not refuse to renew a policy except for:

(a) Failure to pay premiums or untimely premium payment.
(b) Fraud or intentional misrepresentation of a material fact.
(c) The insurer ceases offering covering in the individual market. If a policy form is no longer issued, the insurer may terminate coverage under current forms if it provides 90 days notice and offers policyholders any other coverage offered. If all individual coverage ceased, the insurer must give 180 days notice and is prohibited from issuing any individual coverage in the state for 5-years.
(d) For network plan, the individual no longer resides or works in service area, if applied uniformly.
(e) If coverage sold only through bona fide associations, the individual is no longer in the association, if applied uniformly.

For purposes of this section, individual health insurance means health insurance, as described in s. 627.6561(5)(a)2., F.S., offered to an individual in Florida, including certificates of coverage offered to individuals in Florida as part of a group policy issued to an association outside of Florida.

Section 4. Individual Reinsurance Pool -- Creates s. 627.6475, F.S., establishing a reinsurance program for coverage of individuals who are eligible for issuance of individual health insurance coverage under s. 627.6487, F.S., as created in this act. The reinsurance pool is administered by (and modeled on) the Small Employer Reinsurance Program in s. 627.6699, F.S.

A health insurer or HMO issuing individual policies could elect to become a reinsuring carrier or a risk-assuming carrier. As a risk-assuming carrier, the carrier would assume the risk for all policies issued to an individual eligible for coverage under s. 627.6487, F.S., and the carrier would not be subject to any assessments in the reinsurance pool. Alternatively, a carrier could elect to become a reinsuring carrier, which would give the insurer the option to reinsure any individual eligible for coverage under s. 627.6487, F.S. The carrier would be required to pay a reinsurance premium equal to five times the standard rate established by the board of the reinsurance pool. The reinsuring carrier retains liability for the first $5,000 of claims in a calendar year, 10 percent of the next $50,000, and 5 percent of the next 100,000 of claims, and the reinsurance program covers all claims in excess of this amount. (These are the same premium levels and coverage provided to small group carriers that participate in the small group reinsurance pool.)

The individual reinsurance account must be segregated from the current small employer reinsurance account. In the event of a deficit in the individual account, reinsuring carriers may be assessed up to 5 percent of premiums for individual health insurance policies written in Florida. If a deficit still remains, all health insurance carriers (except individual reinsuring carriers) may be assessed up to 0.5 percent of premiums for all health benefit plans issued in Florida.

Section 5. Guaranteed Availability of Individual Health Insurance Coverage to Eligible Individuals -- Creates s. 627.6487, F.S., applicable to insurers and HMOs that offer coverage in the individual market, to require the guaranteed issuance of coverage to eligible individuals.

For purposes of this section, individual health insurance means health insurance, as described in s. 627.6561(5)(a)2., F.S., offered to an individual in Florida, including

certificates of coverage offered to individuals in Florida as part of a group policy issued to an association outside of Florida.

Effective January 1, 1998, such insurers may not decline to offer coverage or deny enrollment of any eligible individual or impose any preexisting condition exclusion. “Preexisting condition” means a condition that was present before the date of enrollment, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

An “eligible individual” must meet the following criteria:

(1) Must have 18 months prior creditable coverage under a group plan, governmental plan, or church plan;
(2) Is not eligible for coverage under a group health plan, a conversion policy, Medicare, or Medicaid, and does not have other coverage; (*Note*: If an individual is eligible for a conversion policy from either a group health insurer under s. 627.6675, F.S., or from a group HMO under s. 641.3921, F.S., the individual is not considered to be “eligible” for guaranteed issuance of an individual health insurance policy under this section. See ss. 627.6574 and 641.3102, F.S., for changes to these two conversion laws intended to make the conversion option an acceptable alternative mechanism for these individuals.)
(3) Prior coverage was not terminated due to nonpayment of premiums or fraud, unless due to acts of an employer or person other than the individual; and
(4) Has exhausted any continuation benefits.

Insurers must offer at least two different policy forms designed for and actively marketed to both eligible and other individuals. Such forms must be the forms for individual coverage with the largest and next to largest premium volume of all such policy forms offered by the insurer in this state or applicable service area.

Coverage may be denied if the insurer demonstrates to the department that it will not have the capacity to deliver services adequately to additional enrollees, and insurer may not offer coverage in the individual market in such service area for 180 days.

An insurer may deny coverage in the individual market if it demonstrates to the department that it does not have the financial reserves necessary to underwrite additional coverage, and if applied uniformly to all individuals. Insurer may not offer coverage in the individual market for 180 days, or until it demonstrates to the department that it has sufficient financial reserves, whichever is later.

An insurer offering coverage to individuals only through bona fide associations, as defined, is not required to offer coverage in the individual market. (A key element of the definition of “bona fide associations” is that the insurer may not condition membership or coverage on the basis of health status or any health-related factor.) Insurers solely offering conversion policies are not required to otherwise offer coverage in the individual market.

Nothing in this section restricts the amount of the premium rates that may be charged or prevent premium discounts or rebates or modifying copayments or deductibles for adherence to programs of health promotion and disease prevention. The current rating

laws that apply to individual health insurance would continue to apply, notably sections 627.410 and 627.411, F.S., which are not amended by this bill.

The section also provides that persons who would have been eligible on July 1, 1997, for guarantee issuance of individual coverage, are eligible on January 1, 1998. Such a person remains eligible for the same length of time after January 1, 1998, that they would have remained eligible after July 1, 1997.

Section 6. Certification of Coverage (Individual Coverage) -- Creates s. 627.64871, F.S., requiring individual health insurers to provide certification of creditable coverage, as required for group health insurers in s. 627.6561, F.S., below.

Section 7. Disease Management Process -- Creates s. 627.6489, F.S., to authorize the Florida Comprehensive Health Association contract with insurers to provide a disease management services. No funds received by the association from assessments may be used in connection with the disease management program.

Section 8. Exemption of Certain Group Health Insurance Policies -- Creates s. 627.6512, F.S., to exempt various types of limited benefit policies from the bill's requirements for group policies related to: prohibited discrimination based on health status (s. 627.6525, F.S.), preexisting condition exclusions (s. 627.6561), special enrollment periods (s. 627.65615, F.S.), and guaranteed renewability (s. 627.6571, F.S.).

The exempt policies are the same policies that are excluded from the definition of "creditable coverage" in s. 627.6561, F.S., with certain additional qualifications, for purposes of counting towards a preexisting condition exclusion period.

Section 9. Preexisting Conditions (Group Policies) -- Amends s. 627.6561, F.S., to revise the requirements on group health insurance policies with regard to excluding coverage for preexisting conditions, as follows:

- Group policies may not exclude coverage for preexisting conditions for longer than 12 months, or 18 months for a late enrollee.

- The exclusion must relate to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.

- Genetic information cannot be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

- No preexisting condition exclusion may apply to newborn or adopted children who are enrolled under the policy within 30 days of birth or adoption or placement for adoption.

- No preexisting condition exclusion may apply to pregnancy.

- Policies must give credit for the time an insured was previously covered under "creditable coverage," as defined, as long as there is not a gap of more than 63 days in being covered.

- Insurers may elect to count as creditable coverage, coverage of benefits within classes or categories of benefits, as specified in rules promulgated by the department, if applied uniformly, and subject to specific notice requirements to enrollees.

- Insurers are required to provide written certifications of periods of creditable coverage to an individual at the time the individual ceases to be covered under the policy or upon request within 24 months after coverage ceases.

Section 10. Special Enrollment Periods (Group Policies) -- Creates s. 627.65615, F.S., to require group insurance policies to permit employees and dependents to enroll under various conditions:

- Employees and dependents must be allowed to enroll if they previously declined coverage because they were already covered under another policy or plan and if enrollment is requested within 30 days after the date of termination of the other coverage. (An employee or dependent is not required to exhaust COBRA under another plan in order to qualify for special enrollment if the individual is otherwise not eligible for the other group coverage.)

- New dependents must be allowed to enroll within 30 days of marriage, birth, or adoption. The employee and spouse must also be allowed to enroll at this time if not otherwise enrolled.

Section 11. Prohibiting Discrimination against Individual Participants and Beneficiaries Based on Health Status -- Creates s. 627.65625, F.S., to prohibit group policies from establishing rules for eligibility based on health status, including medical claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including acts of domestic violence), or disability.

This section does not require an insurer to provide any particular benefits or prevent limiting or restricting benefits for similarly situated individuals.

Insurers may not require an individual to pay a premium or contribution greater than a similarly situated individual enrolled under the policy based on health status. This does not restrict the amount an insurer may charge an employer or prohibit discounts or modified copayment or deductibles based on adherence to programs of health promotion.

Section 12. Guaranteed Renewability of Group Coverage -- Creates s. 627.6571, F.S., to require group policies to be guaranteed renewable at the option of the policyholder, except for:

1. Nonpayment on untimely payment of premiums.
2. Fraud or intentional misrepresentation of a material fact by policyholder (employer).
3. Failure to meet minimum participation or minimum contribution requirements.
4. The insurer is ceasing to offer coverage in a market (small group market or large group market, or both). (See requirements below)
5. For network plans there is no enrollee who lives, resides, or works in the service areas.

6. For bona fide association plans, as defined, the employer is no longer a member of the association, if nonrenewal is applied uniformly to all covered individuals without regard to health status.

If an insurer discontinues a particular policy form of coverage in the small or large group market, the insurer must notify all beneficiaries 90 days prior to discontinuation and offer to each policyholder (employer) the option to purchase all, or in the case of the large group market, any other coverage currently being offered by the insurer in such market The insurer must act uniformly to all beneficiaries without regard to health status.

If an insurer discontinues all health insurance coverage in the small group or large group market, or both, the insurer must notify all beneficiaries at least 180 days prior to discontinuation, and the insurer may not issue any new coverage in such market in Florida for 5 years.

Insurers are permitted to modify health insurance coverage upon renewal in the large group market. For small group policies, coverage modifications upon renewal must be consistent with the small group law (s. 627.6699, F.S.) and must be applied uniformly among all small group health plans with that product.

Section 13 Maternity Care (Group Policies) -- Amends s. 627.6574, F.S., relating to hospital length of stay for maternity coverage, to make the same changes as made for individual health insurance policies in s. 627.6406, F.S.

Section 14. Conversion Policies -- Amends s. 627.6675, F.S., to revise the current law that requires group health insurance policies to offer individual conversion policies to individuals who lose eligibility for group coverage. Currently, conversion policies must be offered after any continuation coverage is provided (typically 18 months under either the federal COBRA law or the state "mini-COBRA" law). Changes to the law include: (1) group carriers are required to offer the standard policy required to be offered to small employers under s. 627.6699, F.S., in addition to a policy providing the level of benefits currently required to be offered under this section, and (2) increasing the period of time from 30 days to 63 days after termination of group coverage within which the individual may apply for and pay the first premium for the conversion policy.

Section 15. Effective Date for Conversion Policy Changes -- Applies the new requirements of Section 13, above, to conversion policies offered, sold, issued, or renewed on or after January 1, 1998. This section also provides that a person who would have been eligible on July 1, 1997, to an individual conversion policy, are eligible for a conversion policy on January 1, 1998. Such a person remains eligible for the same length of time after January 1, 1998, that they would have remained eligible after July 1, 1997, including the provision that allows a person 63 days after termination of group coverage to elect the conversion policy option.

Section 16. Small Group Policies (Employee Health Care Access Act) -- Amends s. 626.6699, F.S. Maintains current law requirement that insurers in the small group market guarantee the issuance of policies to small employers with 1 to 50 employees and to set premiums on a modified community rated basis without consideration of health status.

Amends definition of “small employer” as follows: (1) average of at least one but not more than 50 eligible employees on business days during the preceding calendar year, and at least one employee on the first day of the plan year (rather than current law, having not more than 50 employees on at least 50 percent of working days during the preceding calendar quarter), (2) the employer’s principal place of business must be in the state, and (3) striking language in current law that allows a carrier to consider affiliated companies to be considered a single employer.

For groups of 2-50 employees, the preexisting condition requirements are replaced with a cross-reference to the preexisting condition statute that applies to all group policies, (summarized in s. 627.6561, F.S., above), requiring a 12-month exclusion, 6-month look back period:

For groups of one, draft maintains the current 24-month exclusion, 24 month look back period.

Application of “preexisting condition” means actual advice or treatment in the 6-month look-back period (for all small groups, including 1 person groups).

Definition of “creditable coverage” replaced definition of “qualifying previous coverage” for purposes of getting credit toward meeting a new preexisting exclusion period (for all small groups, including 1-person groups).

Maximum 63-day gap in creditable coverage for purposes of credit towards meeting a new preexisting condition period (for all small groups, including 1-person groups).

Small employer carriers would be required to offer special enrollment periods, as would be required for all group polices (summarized in s. 627.65615, F.S., above).

The insurer may not write coverage for at least 180 days after coverage is denied, or such later time as the department determines it has sufficient financial reserves to do so.

The bill adds five members to the board of the Small Employer Health Reinsurance Program, appointed by the Insurance Commissioner, including three members representing health insurance carriers that issue individual health insurance policies and two members representing health insurance agents that actively engage in the sale of health insurance. Adding representatives of individual health insurers is due to the establishment of an individual reinsurance account within the program, as provided in s. 627.6475, F.S.

New disclosure requirements are added, requiring small group carriers to disclose in connection with the offering of a policy, the insurer’s right to change premium rates and the factors that may affect changes in premium rates, renewability of coverage, preexisting condition exclusions, and the benefits and premiums available under all health insurance coverage for which the employer is qualified.

Small group policies would be subject to the same guaranteed renewable requirements that are created for all group policies (summarized in s. 627.6571, F.S., above).

Section 17. Long Term Care Insurance -- Amends s. 627.9404, F.S., to add definitions for a number of new terms that are applicable to federally qualified policies.

Section 18. Disclosure, Advertising and Performance Standards for Long-term Care Insurance -- Amends s. 627.9407, F.S., to add a number of new standards from the National Association of Insurance Commissioners models which must be included in all long-term care polices and requires the department to adopt rules. Also adds a new section which provides specific disclosure requirements as to whether a long-term care policy is federally qualified.

Section 19. Minimum Standards for Home Health Care Benefits -- Amends s. 627.94071, F.S., to add five additional minimum standards for home health care benefits which are a part of the NAIC model. These include: 1) excluding coverage for personal care services provided by a home health aide; 2) requiring that the provision of home health care services be at a level of certification greater than that required by the eligible service; 3) requiring that the insured have an acute condition before hone health care services are covered; 4) limiting benefits to services provided by Medicare-certified agencies; and 5) excluding coverage for adult cay care services.

Section 20. Mandatory Offers for Long-term Care Insurance -- Amends s. 627.94072, F.S., to delete the option to provide a cash surrender including the return of premium option as a part of nonforfeiture benefits on long-term care policies. This option is not allowed under federal law.

Section 21. Notice of Cancellation for Long-term Care Policies -- Amends s. 627.94073, F.S., to Incorporates several new requirements related to notice of cancellation and grace periods. These changes are from the NAIC model and include a requirement that the applicant be given the right to designate at least one person in addition to the insured to be notified of termination.

Section 22. Standards for benefit triggers for Long-term Care Policies -- Amends s. 627.94074, F.S., to incorporate federal benefit triggers into Florida law as an alternative trigger.

Section 23. High-Deductible Contracts for Medical Savings Accounts (**HMO Contracts)** -- Creates s. 641.2018, F.S., to authorize health maintenance organizations to sell high-deductible contracts to small employers (on average 50 or fewer employees) that establish medical savings accounts. Due to various provisions in the current law that require HMOs to provide comprehensive coverage, there is some question as to whether or not HMOs would be allowed to sell high deductible policies under current law.

Section 24. Maternity Coverage (HMO Contracts) -- Amends s. 641.31, F.S., to make the same changes relating to length of a maternity stay for HMO contracts, as required for health insurance policies in s. 627.6406, F.S.

Section 25. Guarantee Issue Coverage (HMO Contracts) -- Amends s. 641.3102, F.S. to require HMOs to guarantee issue coverage to eligible individuals, as more specifically required in s. 627.6487, F.S.

Section 26. Preexisting Conditions (HMO Contracts) -- Creates s. 641.31071, F.S., to require HMO contracts to meet the same preexisting condition requirements as required for group health insurance policies in s. 627.6561, F.S., except that HMOs

would be permitted to establish an affiliation period of up to two months (three months for late enrollees), as also permitted under the federal law.

Section 27. Special Enrollment Periods (HMO Contracts) -- Creates s. 641.31072, F.S., to require HMO contracts to provide special enrollment periods as required for group health insurance policies in s. 627.65615, F.S.

Section 28. Prohibiting Discrimination against Individual Participants and Beneficiaries Based on Health Status (HMO Contracts) -- Creates s. 641.31073, F.S., to prohibit HMOs from discriminating based on health status, as prohibited for group health insurers in s. 627.65625, F.S.

Section 29. Guaranteed Renewability of Coverage (HMO Contracts) -- Creates s. 641.31074, F.S., to require HMO contracts to be guaranteed renewable, as required for group health insurance policies in s. 627.6571, F.S.

Section 30. Conversion on Termination of Eligibility (HMO Contracts) -- Amends s. 641.3921, F.S., to revise the conditions under which an individual is entitled to an HMO conversion policy. Currently, a conversion option is not allowed if the group HMO contract is terminated due to nonpayment of premium. The bill provides that this will not disqualify a person if the nonpayment was due to acts of an employer or person other than the individual.

Section 31. HMO Conversion Contracts -- Amends s. 641.3922, F.S., to make the same changes for individual conversion contracts issued by HMOs as made for conversion policies issued by group health insurers in s. 627.6675, F.S., (1) requiring that the maximum premium for the individual HMO conversion contact be 200% of the standard risk rate, (2) requiring the HMO to offer the standard policy required to be offered to small employers under s. 627.6699, F.S., in addition to an HMO contract providing the level of benefits currently required to be offered under the conversion statute, and (3) increasing the period of time from 30 days to 63 days after termination of group coverage within which the individual may apply for and pay the first premium for the conversion contract. (Note that the current HMO conversion law does not provide a cap on premiums, as compared to the current group health conversion statute that imposes a cap of 200 percent of the standard risk rate.)

Section 32. Effective Date for HMO Conversion Requirements -- The changes in Section 30 apply to conversion policies offered, sold, issued, or renewed on or after January 1, 1998.

The section also provides that if a person who would have been eligible on July 1, 1997, to an HMO conversion contract, then the person is eligible for a conversion contract on January 1, 1998. Such a person remains eligible for the same length of time after January 1, 1998, that they would have remained eligible after July 1, 1997, including the provision that allows a person 63 days after termination of group coverage to elect the conversion option.

Section 33. Important State Interest -- Provides that the act fulfills an important state interest. This provision is intended to assure that the provisions of the bill are applicable to municipalities and counties that establish health insurance plans for their employees. See the discussion under “Constitutional Issues,” below.

Section 34. Repeal -- Repeals s. 627.6576, F.S., relating to prohibited discrimination against handicapped persons due to being covered by unfair discrimination prohibitions of s. 627.65625, F.S.

Section 35. Effective Date of Changes Affecting Policies and Contracts -- Except as otherwise provided (such as the January 1, 1998, effective dates for the guarantee-issue and conversion requirements in ss. 627.6487, and Sections 15, and 32), and except for certain requirements related to providing certificates of creditable coverage, the act applies to policies or contracts with plan years that begin on or after July 1, 1997. An exception is provided for group health plans maintained pursuant to a collective bargaining agreement ratified before the act becomes law, in which case the group and HMO provisions apply to policies or contracts with plan years that begin on or after the later of July 1, 1997, or the date on which the last collective bargaining agreement terminates.

Section 36. Interim study - Directs the Banking and Insurance Committee of the Senate ant the Health Care Services Committee of the House of Representatives to conduct a study to make recommendations to the Legislature for 1988 Regular Session regarding high cost insureds and potential insureds and how the needs of such insureds are being met under this act.

Section 36. Effective Dates for Conversion Law Changes -- Provides that the amendments to the two conversion statutes for group health and group HMO (ss. 627.6675 and 641.3922) and the creation of s. 627.6487(3)(b)2., which provides that an individual who is eligible for a conversion policy is not eligible for guaranteed-issuance of an individual policy, take effect upon the earlier of approval by the HCFA, within the Department of Health and Human Services, or 90 days after submission to HCFA, if HCFA does not approve. If the alternative mechanism is not approved, the conversion changes would not take effect.

Section 37. Effective Date of Act -- Except as otherwise provided in the act, the act becomes effective upon becoming law.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

The Department of Insurance has not determined the fiscal impact of this proposal.

1. Non-recurring Effects:

   Not available.

2. Recurring Effects:

   Not available.

3. Long Run Effects Other Than Normal Growth:

   Not available.

4. Total Revenues and Expenditures:

   Not available.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   Indeterminate.

2. Recurring Effects:

   Indeterminate.

3. Long Run Effects Other Than Normal Growth:

   Indeterminate.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   Insurance carriers and HMOs which write conversion policies will be required to offer a choice of two benefit plans, where now they must only offer one. HMO conversion policies will be subject to cap on premiums. If HCFA approves the alternative mechanism included in this bill, HIPAA eligibles will experience a delay in their date of eligibility from July 1, 1997 to January 1, 1998.

2. Direct Private Sector Benefits:

   Individual insurance carriers will not be required to write as many insurance policies as they otherwise would have had to write under HIPAA since HIPAA eligibles with access to a conversion policy must purchase the conversion policy in lieu of an individual policy. Individual insurers will also have access to a reinsurance pool which will not be available if this bill is not enacted.

3. Effects on Competition, Private Enterprise and Employment Markets:

   Since the number of HIPAA eligibles who will actually purchase a policy is unknown, this is difficult to determine. Estimates range from a few hundred per year to thousands.

D. FISCAL COMMENTS:

None.

IV. <u>CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION</u>:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does require counties and municipalities to spend funds or to take an action requiring the expenditure of funds related to the provision of employee health benefits. However, two constitutional exemptions apply: all similarly situated persons are required to comply; and the this bill is required to comply with a federal requirement.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. <u>COMMENTS</u>:

None.

VI. <u>AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES</u>:

None.

VII. <u>SIGNATURES</u>:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Legislative Research Director:
Michael P. Hansen	Michael P. Hansen