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HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
INSURANCE
ANALYSIS

BILL #: CS/HB 903

RELATING TO: The Employee Health Care Access Act

SPONSOR(S): Committee on Insurance and Representative Albright

COMPANION BILL(S): SB 1294 (s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 14 NAYS 1
(2) INSURANCE YEAS 10 NAYS 2
(3) GENERAL GOVERNMENT APPROPRIATIONS
(4)
(5)

I. SUMMARY:

In 1992, the Employee Health Care Access Act (Act) was enacted to require insurers in the small group market to guarantee the issuance of coverage to any small employer that applies for coverage, regardless of the health condition of the employees. This law is codified in s. 627.6699, F.S. In 1993, the Act was expanded to cover sole proprietors and self-employed individuals.

This committee substitute makes several changes to this Act, including:

- requiring small employer carriers to offer basic or standard coverage to sole proprietors and self-employed individuals during a 31 day open enrollment period in August;
- requiring small employer carriers to offer basic or standard coverage to employers with 2 to 50 employees;
- permitting small employer carriers to use rating methodologies that include separate rating categories for one, two, or three or more dependent children for family coverage of an employee with a spouse and dependent children or an employee with dependent children only;
- defining "composite rating methodology" as an average of the impact of the rating factors for age and gender;
- prohibiting small employer carriers from using a composite rating methodology to rate an employer with fewer than 10 employees; and
- providing that the rating law procedures of ss. 627.410 and 627.411, F.S., apply to insurers and that the procedures of s. 641.31, F.S., apply to health maintenance organizations that offer small employer coverage.

The committee substitute has no fiscal impact on state or local government.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Florida's Employee Health Care Access Act

The Florida Legislature enacted small-group market reforms in a series of steps from 1992 to 1994. In 1992, the Employee Health Care Access Act (Act) was enacted to require insurers in the small group market to guarantee the issuance of coverage to any small employer that applies for coverage, regardless of the health condition of the employees. This law is codified in s. 627.6699, F.S. In 1993, the Act was expanded to cover sole proprietors and self-employed individuals.

The Act further requires that policies issued to small employers have premiums established on a "modified community rating" basis. Rates may be based only on age, gender, family composition, tobacco usage, and geographic location (s. 627.6699(3)(n), F.S.). Rates may not be based on the health status or claims experience of any individual or group, or any other factor.

An insurer that writes small group policies in Florida (a "small employer carrier") must elect to either be a risk-assuming carrier and assume all risk or be a reinsuring carrier and have the option of reinsuring identified high-risk individuals or groups with a reinsurance pool (s. 627.6699(9), F.S.). A reinsurance pool is established and funded through premiums and assessments on insurers, governed by an appointed board of the Florida Small Employer Health Reinsurance Program. 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. Risk-assuming carriers are not subject to losses in the reinsurance pool (s. 627.6699(11), F.S.).

The Florida Small Employers Health Reinsurance Program is a nonprofit entity created 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.

Under s. 627.6699, F.S., small group carriers are required to offer a "standard" and "basic" policy to small employers. The "standard" policy is generally intended to be comparable to a major medical policy typically sold in the group market, with cost containment features intended to make the policy affordable. The statute specifies certain mandated benefits that apply to both the standard and basic policy, and a Health Benefit Plan Committee is created to develop and modify the standard and basic benefit plans. Small group carriers are required to offer all health benefit plans (not just the basic and standard plans) on a "guaranteed-issue basis," but additional or increased benefits may be added to the standard health benefit plan by rider and such riders may be medically underwritten.

"Small employer" is defined in s. 627.6699, F.S., to mean, "in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met." (s. 627.6699(3)(v), F.S.)

Section 627.6699, F.S., defines the term "self-employed individual" to mean "an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years." (s. 627.6699(3)(u), F.S.)

According to information provided by the Agency for Health Care Administration in its Analysis and Economic Impact Statement for HB 903, since small group health insurance coverage was extended to include one and two person groups in 1993, "small group coverage has soared to include an estimated two million people who were not previously insured."

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. HIPPA requires small employer carriers to guarantee the issuance of coverage to small employers with 2 to 50 employees.

Individual and Group Health Insurance Policies

Under 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 preexisting 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.

Evaluation of Health Insurance Market Reforms

General conclusions of the results of insurance reform laws are difficult to make. Many components of insurance reform laws interact with other components of insurance regulation and many times the market and social conditions effect the outcome. Recently, two academic research studies were done which examined the impact of insurance reform laws. One study was performed in 1998 by the Center for Risk Management and Insurance Research at Georgia State University and funded by the Health Insurance Association of America, while the second study, which was published in February 1999, was performed by the Wake Forest University School of Medicine and funded by the Robert Wood Johnson Foundation. The conclusion of the two studies with regard to insurance reform results on the small-group market were somewhat contrasting.

The Georgia State study found that "the two types of state regulation that have had the greatest effect on the structure of local health insurance markets are coverage mandates and small group reforms." One major conclusion of the study was that "small-group community rating, in conjunction with a guaranteed issue requirement, is associated with a significantly increased probability that an individual will lack health insurance. The use of small-group rating bands coupled with guaranteed issue is also associated with an increased probability that an individual will lack health insurance,

raising the probability by 15.8 percent." The Georgia State study relied on analyses of the March 1998 supplement to the Census Bureau's Current Population Survey. In March of each year, the Census Bureau surveys approximately 57,000 households across the nation, receiving information on about 140,000 individuals.

The Wake Forest study relied on in-depth interviews and insurance data analysis from each of the seven states it studied to make its conclusions. Findings were reported separately for each state's data, but as a whole the findings indicated that "small-group reform laws have had a significant positive impact on the ability of very small 'micro' groups of 5 or fewer workers to obtain group coverage. However, most insurers continue to resist selling to groups this size because of greater administrative cost and adverse selection concerns."

In its separate analysis of the results of insurance reform laws in Florida only, the Wake Forest study concluded that Florida insurance reform laws "have not produced a huge influx of new subscribers....Only increased enrollment for micro groups, which has been especially notable, can be clearly attributed to the law, although even there the small-group enrollment gains may come partly or mostly at the expense of enrollment losses in the individual market. At least it can be said that the deterioration on the small-group market that preceded these laws has been halted, and possibly reversed. In addition, coverage is now readily available for high-risk groups."

The Wake Forest Study of Florida also concluded that small-group insurance availability in Florida appears to be hampered "by practices such as covert field underwriting and explicit reduction in agent commissions to discourage enrollment of micro groups. These and some other more isolated practices appear to constitute manipulation, circumvention, or perhaps outright violation of the law. Their aggregate impact is undetermined, however, and may be significantly blunted by the ready ability to obtain coverage through CHPA."

With regard to affordability of insurance in Florida, the Wake Forest study concluded that "small-group reform has not had a strong negative impact on affordability in Florida. The market is intensely price competitive. Despite some dramatic price increases for a number of insurers and subscribers, and despite fluctuations in price in different years, the overall trend of price in Florida appears to be moderate."

B. EFFECT OF PROPOSED CHANGES:

Beginning August 1, 1999, small employer health insurance carriers would be required to offer to sole proprietors and self-employed individuals basic and standard small employer health benefit plans on a guarantee issue basis during a 31 day open-enrollment period during the month of August. This would not apply to small employers formed primarily for the purpose of buying health insurance. Beginning July 1, 1999, small employer health insurance carriers would be required to offer to offer basic and standard small employer health benefit plans on a guarantee issue basis to employers with 2 to 50 employees.

Small employer health insurance carriers would be permitted to use rating methodologies that include separate rating categories for one, two, or three or more dependent children for family coverage of an employee with a spouse and dependent children or an employee with dependent children only.

The term "composite rating methodology" would be defined to mean a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer. Small employer health insurance carriers would not be permitted to use a composite rating methodology to rate a small employer with fewer than 10 employees.

Lastly, the rating law procedures of ss. 627.410 and 627.411, F.S., would be applied to health insurance companies and the rating law procedures of s. 641.31 would be applied to HMOs offering small employer coverage.

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?

No.

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

No.

(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.

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?

      No.

4. Individual Freedom:

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

      No. The committee substitute would reduce the enrollment period for sole proprietors and self-employed individuals from the full year to just the month of August.

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

      No.

5. Family Empowerment:

   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. STATUTE(S) AFFECTED:

Section 627.6699, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1: Amends s. 627.6699, F.S. See the Effect of Proposed Changes section of the analysis.

Section 2: Provides an effective date of July 1, 1999.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

According to the Department of Insurance, the committee substitute will have no fiscal impact on the Department of Insurance.

2. Recurring Effects:

According to the Department of Insurance, the committee substitute will have no fiscal impact on the Department of Insurance.

3. Long Run Effects Other Than Normal Growth:

According to the Department of Insurance, the committee substitute will have no fiscal impact on the Department of Insurance.

4. Total Revenues and Expenditures:

According to the Department of Insurance, the committee substitute will have no fiscal impact on the Department of Insurance.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   N/A

2. Direct Private Sector Benefits:

   N/A

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

   N/A

D. FISCAL COMMENTS:

None.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This committee substitute does not require counties or municipalities to expend funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This committee substitute does not reduce the authority of counties or municipalities to raise revenues.

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

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

V. COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 7, 1999, the Committee on Insurance adopted a strike-everything amendment to HB 903 as a committee substitute, which is the basis for this analysis. The committee substitute differs from the original bill in that the committee substitute:

- retains current law relating to the definition of "modified community rating" by removing from the original bill the provision which would have expanded that definition to include claims experience, health status, and duration of coverage;
- adds a provision that would require small employer carriers to offer and issue basic and standard benefit plans to sole proprietors and self-employed individuals during a 31 day open enrollment period in the month of August (unlike the original bill which would have eliminated the requirement that small employer carriers offer coverage to sole proprietors and self-employed individuals);
- removes from the original bill the provision that would have allowed small employer carriers to make adjustments to a small employer's premium based on claims experience, health status, duration of coverage, and administrative and acquisition expenses;

- adds a provision that would define "composite rating methodology" as a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all employees of a small employer;
- adds a provision that would prohibit small employer carriers from using a composite rating methodology to rate employers with fewer than 10 employees; and
- changes the effective date of the bill from October 1, 1999 to July 1, 1999.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Amy K. Guinan	Phil E. Williams

AS REVISED BY THE COMMITTEE ON INSURANCE:

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