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HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 2061 (PCB IN 00-02)

RELATING TO: Mandated Health Benefits

SPONSOR(S): Committee on Insurance, Representatives Bainter, Cosgrove & others

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) INSURANCE YEAS 14 NAYS 0
(2) HEALTH CARE SERVICES YEAS 12 NAYS 5
(3) GOVERNMENTAL OPERATIONS
(4) FINANCE AND TAXATION
(5) GENERAL GOVERNMENTAL APPROPRIATIONS

I. SUMMARY:

HB 2061 creates the Advisory Commission on Mandated Health Benefits. The purpose of the commission is to review legislative proposals related to mandated health benefits and manage the cumulative impact of mandated health benefits. The bill provides that the commission is to consist of 3 members of the Senate and 3 members of the House of Representatives and that one of the commissioner members from each body must be a member of the minority party.

The bill provides that the commission will, among other responsibilities: inventory mandated health benefits; complete a baseline cost impact assessment of existing mandated health benefits through contract; conduct the required impact assessments of proposed mandated benefits; adopt rules governing commission operations; and, as warranted, recommend legislation to manage the cumulative effects of mandated health benefits, resolve statutory ambiguities or inconsistencies creating interpretative differences over the application of particular mandated health benefits, and recommend limits on the percentage of total premium costs that mandated health benefits represent.

The bill provides a definition for "mandated health benefits" for the purposes of the review process prior to adoption. The bill requires proponents of a mandated health benefit to submit an impact assessment conducted by certified actuaries to the commission for review. The bill provides that, except as otherwise provided in legislative rules, a proposed mandated benefit can not be considered in either house until the commission submits an impact analysis. The bill requires that any mandated health benefits enacted on or after July 1, 2000, will be automatically repealed 5 years after enactment, unless reenacted by the Legislature.

The bill provides that funds "sufficient to implement this act" will be appropriated from the Insurance Commissioner's Regulatory Trust Fund to fund this act.

The bill provides that the bill will take effect upon becoming law.

On March 30, 2000, the Committee on Health Care Services adopted an amended "strike-everything" amendment. [*See:* AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES.]

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [X]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [X]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

State laws frequently require private health insurance policies and health maintenance organization (HMO) contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are commonly referred to as "mandated [health] benefits." These mandated benefits affect plans covering an estimated 33 percent of all Floridians and 40 percent of insured Floridians. The nearly one-half of all Floridians who either are uninsured or covered under Medicare or Medicaid are not affected. Self-funded plans provided by employers also are similarly unaffected because the federal Employee Retirement Income Security Act of 1974 (ERISA) generally preempts state regulation of these plans (29 U.S.C. s. 1001, et. seq.).

Recognizing that "most mandated benefits" contribute to the cost of health insurance yet acknowledging the social and health benefits of many of these mandates, the Legislature in 1987 called for a "systematic review of current and proposed" mandated benefits. At that point, the Legislature had approved 16 mandated benefits. In the 13 years since, the Legislature has approved an additional 35 mandated benefits. With a total of 51 mandated health benefits applicable either to private insurer or HMO health plans, Florida now has one of the nation's most extensive set of coverage requirements. The lone procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandated benefit prior to consideration--has been largely ignored. House Insurance Committee staff could confirm only 4 instances since 1987 in which the required study was completed for a mandated benefit.

In 1998, nearly a quarter of non-elderly Floridians were uninsured. According to the 1998 Health Confidence Survey sponsored by the Employee Benefit Research Institute, 48 percent of the uninsured nationwide cite cost as the primary reason for being uninsured. Costs would have to be "cut in half " to entice one-third of these respondents back into the marketplace.

On January 28, 2000, the House Committee on Insurance published its interim project entitled “Managing Mandated Health Benefits: Policy Options for Consideration.” The report recognized that while the mandates provide social and health benefits to the consumers, “most mandated benefits contribute to the cost of health insurance premiums.” Key findings of the report included the following:

- Florida has more mandated benefits than nearly every other state;
- An estimated 33 percent of all Floridians are covered under health plans subject to mandated benefits;
- It is not always apparent in statute which health plans are subject to which state-mandated health benefits;
- The costs of mandated benefits in Florida have not been calculated; and
- The statutorily-prescribed provisions for managing mandated benefits legislation have not been followed.

Number of Mandated Health Benefits

By some measures, Florida has more mandated benefits than nearly every other state. In preparing this report, House Insurance Committee staff identified 51 mandated health benefits applicable either to private insurer or HMO plans. Of the 51 mandated benefits, 40 apply to either private individual or group policies provided by insurers. Individual policies are subject to 34 and group policies to 39. Health maintenance organizations must comply with 39 mandated benefits.

In a separate count, Blue Cross/Blue Shield Association placed the number of mandates in Florida statutes at 44--the second highest in the nation, compared to an average of 25 among all states. [*Source:* Blue Cross/Blue Shield Association, State Legislative Health Care and Insurance Issues: 1998 Survey of Plans.]

The Reach of Mandated Health Benefits: Floridians Affected

An estimated 33 percent of all Floridians are covered under health plans subject to mandated health benefits. These Floridians are covered under a private insurer or HMO plan, other than a basic or standard small employer group plan. The other 67 percent are unaffected by mandated health benefits because they either are uninsured or covered under plans not subject to these mandates. These include Medicare or Medicaid plans, and self-funded ERISA plans provided by certain employers. Among insured Floridians, 40 percent are in plans subject to mandated health benefits.

Health Plans	% Insured Floridians	% of all Floridians	Mandates applicable?
Insurer/HMO	40%	33%	Yes
Self-Funded Employer	26%	21%	No
Medicare	22%	18%	No
Medicaid	12%	10%	No
No health plan/uninsured	N/A	17%	N/A

In 1992, in the Florida Employee Health Care Access Act, s. 627.6699, F.S., the Legislature authorized insurers and HMOs to offer "basic" and "standard" small employer group plans and exempted these 2 plan types from mandated coverages not expressly made applicable to these plans in law. For the period ending December 31, 1998, these 2 plan types accounted for only $139 million in earned premium or just over 8 percent of the more than $1.7 billion in premium earned for all small employer group plans, according to figures provided by the Department of Insurance. According to the Department of Insurance Small Employer Enrollment Report for the period ending June 30, 1999, the number of lives covered under a basic or standard plan was 276,000 of over 1.7 million individuals covered under a small employer group plan.

It is not always apparent in statute which health plans are subject to which state-mandated health benefits. The statutes can be inconsistent and confusing. For instance, the statute may refer to "an insurer" but then in describing those covered refer to "subscriber," a term associated with HMOs.

Availability of Generally-Comparable Benefits

Although mandated health benefits apply only to private insurer and HMO health plans, committee staff found in many instances Floridians are receiving comparable benefits either under an exempt self-funded ERISA plan, or through Medicaid or Medicare.[1] However, these plans are either paid for by the general public, as in the case of Medicaid and Medicare, or funded voluntarily by those with the freedom to design a plan with benefits they are willing to purchase, such as an employer with a self-funded plan. In contrast, insurer and HMO plans are paid for by those securing the coverage, regardless of whether or not they want to purchase all of the mandated benefits.

The Cost of Mandated Health Benefits

The Legislature has recognized in legislative intent that "most mandates contribute to the increasing cost of health insurance premiums." Insurers and HMOs contend mandated benefits increase costs by: increasing utilization of health care services; giving providers of certain benefits pricing leverage; and by requiring insurers and HMOs to include additional benefits.

By stating that "most" mandates increase costs, that same legislative intent recognizes that some mandates may not increase premium costs. These could be of at least two types: a preventative care mandate, such as mammogram screening or well-child care; and a mandated treatment or provider substituting for a more expensive alternative. Certain mandated benefits may not necessarily reduce premium costs but may reduce the costs borne by the general public.

Calculating the cost of mandated health benefits can be difficult. Cost determinations are complicated by a lack of reported data, difficulty in calculating costs avoided, and failure to account for the cost of mandated benefits which would today be provided in the absence of a specific mandate.

Studies of the Cost of Mandated Health Benefits

Florida

Staff could not identify any comprehensive study of the cumulative cost of mandated health benefits in Florida.

Other States

Several states have calculated the costs of mandated health benefits. In 1996, the U.S. General Accounting Office published a report on claims costs in 6 states. According to the

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[1] Note: The actual terms of the coverage may vary. Committee staff did not analyze the details of the specific coverages or compare deductibles or co-payments, or determine the extent to which the coverages meet the letter of the benefit mandated on insurers and HMOs operating in the private marketplace. This information should therefore be considered only as a starting point in any comparison of benefits among the different sources of coverage.

report, studies as far back as 1988 reveal claims costs ranging from 5.4 percent in Iowa to 22 percent in Maryland. Costs vary based on the number and type of mandated benefits.

In Virginia, a state with extensive cost reporting requirements for insurers and HMOs, the average claim cost per group certificate for the 1997 reporting period was $263, accounting for 16.62 percent of total claims costs. The premium impact on group certificates for family coverage was 29.17 percent of overall average premium on a full cost (as opposed to marginal cost) basis. Virginia had 33 mandated benefits according to the 1998 Blue Cross/Blue Shield Association report.

In Maryland, mandates were priced on a full cost and marginal cost basis. On a full cost basis, the estimated annual cost per policy for a group insurance policy was $604. The marginal cost came in at $148. This represents 15.4 percent and 3.8 percent of the average premium per policy. Maryland has 47 mandated benefits according to the 1998 Blue Cross/Blue Shield Association report.

Maine calculates the cost impact of proposed mandated health benefits and also determines the cumulative costs of mandated benefits. As part of a December 22, 1999, report, the Maine Bureau of Insurance estimated the cumulative premium impact of 19 currently mandated benefits on group policies covering more than 20 employees to be 7.54 percent for fee-for-service plans, and 7.12 percent for managed care plans. For comparison purposes, the 1998 Blue Cross/ Blue Shield Association report showed Maine with 31 mandated benefits.

Mandated Benefits Review Process

Florida

In s. 624.215, F.S., the Legislature has established requirements specific to consideration of legislation proposing mandated health benefits.[2] Proponents of a particular mandated health benefit must prepare a report assessing the social and financial impacts of the proposal and submit the report to the Agency for Health Care Administration and the relevant legislative committees. These include an assessment of the extent to which:

- The treatment or service is used by a significant portion of the population;
- The insurance coverage is generally available;
- Any general lack of availability of coverage causes persons to forego necessary treatment;
- Any general lack of availability of coverage results in unreasonable financial hardship;
- There is public demand for the treatment or service;
- The coverage is included in collective bargaining negotiations;
- Cost increase or decrease results from the treatment or service;
- Coverage will increase the appropriate uses of the treatment or service;
- The coverage will be a substitute for a more expensive treatment or service;

[2] With other types of legislation, special constitutional or statutory requirements exist. These include legislation proposing changes in the state retirement system, creation of a public records exemption or specialty license plate, and approval of a local bill or local government mandate. The Legislature uses an estimating conference to consider fiscal impacts on the state employees group health plan. Both the Senate and the House of Representatives adopt rules, jointly and separately, defining the process for considering certain types of legislation--for example, legislation affecting appropriations--or conducting other legislative business. Special requirements can also be found in policy statements of several standing committees specific to legislative consideration of certain types of legislation.

- The coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders; and
- The coverage will impact the total cost of health care.

Although the Legislature has enacted approximately 35 mandated benefits since 1987, House Insurance Committee staff could only identify 4 reports submitted for mandated health benefits enacted since that time.

<u>Other States</u>

A survey conducted by the committee staff found 20 states have special statutory provisions for managing mandated benefits legislation and 28 do not.

Impact analyses

The most common response of states has been to have an impact analysis conducted to assess the financial impact, social impact, and/or medical efficacy of the proposal. This is the case in 18 states. States typically require either a designated state agency or special review panel to conduct the review. In Maine, the review panel may contract with a private actuarial firm to complete the analysis. However, 7 states, including Florida, direct the proponents or sponsor of a mandates proposal to complete the analysis. One state, Pennsylvania, permits both proponents and opponents to submit information. Two states, Louisiana and Tennessee, direct fiscal committee staff to conduct the review. For the most part, states call for a similar impact analysis. All include a financial component. Fourteen, including Florida, must include an analysis of the social impact of the proposal. Seven require the analysis to consider the medical efficacy of the mandate as well. Virtually all states include a laundry list of specific criteria to examine in conducting the analysis.

Time frames for submitting an impact analysis vary among states: at the time the proposal is filed (e.g., Oregon); within 30 days after analysis is requested (e.g., South Carolina); 90 days prior to session (e.g., Washington); timely manner (e.g., Maine); or before being heard or before final passage by committee (e.g., Kentucky).

Only 5 states directly attempt to limit the prerogative of the Legislature to act on mandates legislation based on whether or not an impact analysis has been submitted. Maine is the most direct: "a proposed mandate may not be enacted into law unless [the] review and evaluation . . . [have] been completed."

Review entities

Only 11 of the 48 states responding reported having either an ongoing permanent body or a state agency specifically charged with reviewing proposed mandated benefits.

Virginia and Maryland have standing commissions; Pennsylvania's Health Care Cost Containment Council must convene a Mandated Benefits Review Panel of 4 senior researchers to develop independently certified documentation for proposed mandates. The remaining states designate a state agency such as the Department of Insurance to review a proposed mandate if requested by either the appropriate legislative committee or, in some states, by the Governor's office. In Georgia, the Clerk of the House and the Secretary of the Senate must deliver any health insurance mandates bills to the Insurance Commissioner for a fiscal review within 5 days after first reading. Several state legislatures, Texas for one, have enacted legislation creating a temporary committee to

study the costs and benefits of proposed mandated benefits. Missouri, likewise, approved legislation for a one-time study of mandated benefits.

Limitations on enactment

Maryland and Oregon are 2 states with distinct limitations on legislative approval of mandated benefits legislation.

Maryland, at least in the small group market, is the only state staff could identify that has attempted to limit the cumulative cost of all mandated benefits to a specific dollar amount. In Maryland, insurance carriers can only sell one insurance product to small employers--the product developed by the Health Care Access and Cost Commission (HCACC). In 1993, the Maryland General Assembly enacted an "affordability" cap on mandates costs for the small group plan. The cap is set at 12 percent of the average wage in the state. If the HCACC finds the cumulative cost of approved mandates exceeds this amount, the HCACC must adjust the level of benefits or cost sharing arrangements under the plan so the cap is not exceeded in the future.

In 1999, the Maryland General Assembly considered a similar approach for the large group market by requiring a comparison of mandates costs to the average annual wage in Maryland and to health insurance premiums. However, an actual cap was not imposed and there was no provision for benefits adjustments. Instead, the calculations are used as the basis for triggering further review by the HCACC. If the HCACC finds the full cost of mandated benefits exceeds 2.2 percent of the average wage in the state, then it must evaluate the social, medical, and financial impacts of each existing mandated benefit and report its findings to the General Assembly. The General Assembly can then use this information to decide whether or not to enact proposed mandates or repeal existing mandates.

The Oregon Legislature appears to be the only state which sunsets mandated benefits. Since 1985, Oregon law has provided for the automatic repeal of mandated benefits statutes 6 years from the effective date of the particular mandate. According to Oregon legislative staff, several mandates have expired under this law.

C. EFFECT OF PROPOSED CHANGES:

HB 2061 creates the Advisory Commission on Mandated Health Benefits to review legislation proposing mandated health benefits and manage the cumulative impact of mandated health benefits. The commission is made up of 6 members--3 of whom are members of the Senate appointed by the President of the Senate and 3 of whom are members of the House of Representatives, appointed by the Speaker of the House of Representatives. One of the appointed members of each body must be a member of the minority party. The bill authorizes the commission to, among other responsibilities:

- Compile an inventory of mandated health benefits;
- Complete a baseline cost impact assessment of existing mandated health benefits through contract;
- Conduct the required impact assessments of proposed mandated benefits;
- Adopt rules governing commission operations; and
- As warranted, recommend legislation to manage the cumulative effects of mandated health benefits, resolve statutory ambiguities or inconsistencies creating interpretative differences over the application of particular mandated health benefits, and recommend

limits on the percentage of total premium costs that mandated health benefits may represent.

The bill requires the Office of Economic and Demographic Research to develop and maintain a system and program of data collection to enable the commission to assess the cumulative impact of mandated health benefits on an ongoing basis and to assess the impact of legislation proposing mandated health benefits.

The bill incorporates several revisions into s. 624.215, F.S., relating to proposed health benefit mandates. The bill includes legislative findings regarding the health insurance mandates and provides legislative intent to conduct a review of current and proposed mandates, along with establishing a process for conducting such reviews. The bill provides a definition for “mandated health benefits” and requires every person or organization seeking mandated health benefits legislation to submit a report to the commission, along with an impact assessment containing certain specified information. The bill prohibits any committee in the Senate or the House of Representatives from considering any proposed health care mandate legislation until the commission has submitted its impact assessment to the presiding officers of the Legislature, except as otherwise provided in the joint rules adopted by the Legislature or in rule applicable to either the Senate or the House of Representatives.

The bill requires the automatic 5-year repeal of mandated health benefits enacted on or after July 1, 2000, unless otherwise re-enacted by the Legislature.

The bill provides for an appropriation from the Insurance Commission’s Regulatory Trust Fund of an amount sufficient to implement this act.

The bill provides for effect upon becoming a law.

D. SECTION-BY-SECTION ANALYSIS:

N/A

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   N/A

2. Expenditures:

   An as yet undetermined amount of funds would be appropriated from the Insurance Commissioner’s Regulatory Trust Fund to implement this act.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   N/A

2. Expenditures:

   N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Proponents of legislation proposing mandated health benefits might incur increased costs in preparing statutorily-required impact assessments with the addition of the requirement that they use certified actuaries.

D. FISCAL COMMENTS:

Office of Economic and Demographic Research (EDR)

According to the EDR, HB 2061 requires the EDR to serve as agent for the Advisory Commission on Mandated Health Benefits in contracting for actuarial services to:

1. Establish the costs of mandated health benefits as a percentage of premiums as of October 1, 2000; and

2. Calculate the impact of proposed changes in the mandated benefits.

Additionally, the bill requires EDR to establish and maintain a data base that will ultimately enable EDR to estimate the cost of mandated coverage and proposed changes to that coverage.

In the past, EDR has not been directly involved with the issue of mandated health insurance benefits and does not, for that reason, currently possess the in-house expertise to estimate the costs of existing or proposed mandates. Given time and funding for an additional position, that in-house expertise could be developed. In the interim, actuarial services could be purchased from a vendor as is done by the Division of Retirement and the State Board of Administration.

No explicit dollar denominated appropriation is made although Section 3 provides a general appropriation implying that the commission can take whatever amount, in its sole discretion, it believes it needs from the Insurance Commissioner’s Regulatory Trust Fund. Presumably, whenever the commission needed an analysis performed it would contact EDR who would, in turn, engage an actuarial consultant to perform the analysis and submit the bill to the commission to fund out of the Insurance Commissioner’s Regulatory Trust Fund. From EDR’s viewpoint, this arrangement would be feasible, however, it seems likely that the Insurance Commissioner would have a different view of such an open-ended commitment.

There is no way to reliably estimate the impact of this bill on the Insurance Commissioner’s Regulatory Trust Fund since the frequency and extent of the analyses that will be necessary is not known.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to expend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

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

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

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

V. <u>COMMENTS</u>:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

The bill grants the commission the authority to adopt procedural rules. The bill specifically exempts the commission from chapter 120.

C. OTHER COMMENTS:

None.

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

On March 30, 2000, the Committee on Health Care Services adopted a “strike-everything” amendment and an amendment to the amendment. The amended amendment differs from the bill, as follows:

- Provides a different definition of “mandated health benefits;”
- Replaces review of proposed mandates by a Legislative Commission with review by the Agency for Health Care Administration;
- Requires the agency to submit a report to the Legislature prepared by a certified actuary;
- Requires the agency to submit the report prior to the first day of the Legislative session, if the bill proposing a mandated health benefit was submitted to the agency prior to the first day in November preceding the Legislative session;
- Deletes reference to funding the review of proposed mandates from the Insurance Commissioner’s Regulatory Trust Fund; does not provide an identified funding source or amount to fund agency costs of preparing actuary-certified legislative reports; and

- No longer requires the Office of Economic and Demographic Research to develop and maintain a system and program of data collection to enable assessment of the cumulative costs of mandated health benefits on an ongoing basis.

[Note: There is debate on whether the amendment definition of "mandated health benefit", as amended, is as inclusive as the definition contained in the bill, as introduced.]

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Stephen T. Hogge	Stephen T. Hogge

AS REVISED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Tonya Sue Chavis, Esq.	Phil E. Williams