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HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
FISCAL POLICY AND RESOURCES
ANALYSIS

BILL #: HB 111

RELATING TO: Health Flex Plans

SPONSOR(S): Representative Murman and others

TIED BILL(S):

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

(1) HEALTH PROMOTION YEAS 10 NAYS 0
(2) FISCAL POLICY AND RESOURCES
(3) COUNCIL FOR HEALTHY COMMUNITIES
(4)
(5)

I. SUMMARY:

HB 111 creates a pilot program, designated health flex plans, to provide health care coverage for uninsured persons under the oversight of the Agency for Health Care Administration (agency) and the Department of Insurance (department). The bill:

- Provides legislative intent;
- Defines relevant terms;
- Creates a pilot program in three areas of the state having the highest number of uninsured residents;
- Provides for plan approval, or withdrawal of approval, by joint decision of the agency and the department based on specified criteria;
- Provides that such plans are not subject to licensing requirements of the Florida Insurance Code or Chapter 641, F.S., relating to health care programs, unless expressly made applicable;
- Provides that such plans are considered insurance subject to applicable provisions relating to prohibiting unfair trade practices;
- Provides eligibility criteria for enrollment;
- Provides record keeping requirements to enable both the agency and department to make determinations related to the financial viability of the plan;
- Provides notice requirements for denial, nonrenewal, or cancellation of coverage by a health plan entity;
- Specifies that coverage under an approved health flex plan is not an entitlement; and
- Authorizes, in addition to specified administrative actions, that the agency is authorized to seek certain civil remedies, under certain circumstances.

The bill takes effect July 1, 2002.

On November 27, 2001, the Committee on Health Promotion adopted a "strike-everything" amendment. See Section VI of this analysis for a detailed explanation of the amendment, which is traveling with the bill.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

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

Less Government: The bill creates a new pilot program that requires the Agency for Health Care Administration and the Department of Insurance to jointly approve or disapprove health flex plans that provide health care coverage for eligible participants residing in the three areas of the state having the highest number of uninsured residents, as determined by the agency.

B. PRESENT SITUATION:

The Florida Health Insurance Study

In 1998, the Legislature created the Florida Health Insurance Study (FHIS) to be conducted by the Agency for Health Care Administration and the University of Florida. This multi-year project was intended to provide a detailed understanding of the exceedingly complex issues of uninsurance and health insurance coverage.

In its first year the study was composed of three major elements. The primary focus was a large-scale telephone survey of Floridians under the age of 65. From March to September of 1999, the research team surveyed over 14,000 households representing more than 37,000 individuals. The interviews emphasized health insurance coverage, health care utilization, employment, income, family structure, and demographic characteristics. In addition to the telephone survey, the first year, the FHIS included: a study to determine the number, location, and characteristics of community subsidized safety net organizations that provide health care to people without insurance; and 1,000 in-person interviews conducted in communities that are economically disadvantaged and known to have incomplete telephone coverage.

In 1999, the Legislature continued to build on the initial research generated by the FHIS by commissioning additional research. The FHIS was directed to evaluate the impact of welfare reform and the WAGES (Work and Gain Economic Self-Sufficiency) program on the number of medically indigent individuals in Florida. The FHIS team was asked to estimate or identify:

- The number of individuals who will lose their Medicaid coverage as they transition from welfare to work;
- The number of former welfare recipients who will lose their Medicaid coverage and fail to obtain adequate health insurance for themselves and/or their families; and
- The major barriers preventing these individuals from obtaining health insurance coverage, and make recommendations to address these issues including, but not limited to, the feasibility of implementing a Medicaid buy-in program.

On March 23, 2000, the agency released the results of one of the FHIS studies. This was the first such state-level study conducted in the nation to pinpoint who is not covered by health insurance. The FHIS study revealed that 2.1 million people in the state did not have health insurance in 1999, identified those areas of the state where there is a need for such coverage, and showed a significant decrease in the number of the non-insured population.

The two-phase study, which involved extensive data interpretation, culminated an extensive effort to pinpoint the uninsured population according to income, employment status, ethnicity, and region of the state, as well as the impact of the WAGES program on the uninsured. Of Florida's major metropolitan areas, Tampa, Orlando, Jacksonville, Palm Beach, and Ft. Lauderdale, were all identified as below the statewide average of uninsured. Rural areas, especially around Lake Okeechobee and Immokalee, and metropolitan Dade County, where over 450,000 residents are not insured, were also identified as an area of concern.

The general findings of the study included:

- Uninsured - The number of uninsured Floridians in 1999 was placed at 2.1 million, down 560,000 from 1993 when a previous survey was taken. The state's population grew by nearly 2 million people during the same time.
- Income - Nearly half (938,527) of the uninsured earn less than 150 percent of the Federal Poverty Level (FPL), which currently is $26,475 for a family of four.
- Employment Status – 50 percent of the uninsured work full or part-time and 62 percent of Floridians gain access to health insurance through their employer. A majority of the working uninsured (89 percent) says they do not have health insurance because their employer does not offer it, or they are not eligible, or they cannot afford it.
- Size of employer - Employers with one to nine employees have the highest rate of uninsured (24.6 percent), compared to companies with 100 or more employees (4.78 percent).
- Ethnicity - Hispanics make up nearly one-fourth (492,154) of Florida's uninsured population. The rate of non-insurance for Hispanics (28.59 percent) is more than twice the rate of white non-Hispanics (13.2 percent) and almost 50 percent greater than the rate of African Americans (19.6 percent).
- Regional difference - The rates of uninsurance vary widely across the state, ranging from a high of 25.5 percent in District 13 (DeSoto, Glades, Hardee, Hendry, Highlands, Okeechobee, and Monroe counties) and 24.6 percent in District 17 (Dade County), to a low of 11.8 percent in District 6 (Lake, Osceola and Seminole counties) and 12.1 percent in District 4 (Duval County).

Governor's Health Care Summit

On September 21-22, 2000, a conference entitled, "The Florida Governor's Summit on Health Care: Solutions for the Uninsured," was held in Miami Beach, Florida. The summit was hosted by the Agency for Health Care Administration, with primary funding from the Robert Wood Johnson Foundation, as part of an existing grant to the state in support of the development and analysis of insurance coverage expansion proposals, and in response to the Florida Health Insurance Study. The purpose of the summit was to stimulate thinking about Florida's options for health care policy, especially concerning methods to improve access, affordability, and availability of health coverage. A variety of national speakers, representing a variety of perspectives, addressed the several hundred people in attendance at the conference.

As a keynote speaker at the conference, Governor Jeb Bush highlighted health care accomplishments of this administration to date. He also identified specific issues of concern,

including: too many uninsured forced to access the health care system in inappropriate ways, such as emergency room use; eroding quality of care; issues regarding who are the uninsured, and who needs access to care (based on Florida Health Insurance Study)--specific rural communities, especially around Lake Okeechobee, Hispanics and African Americans, and employees of small businesses. He also identified guiding principles to be followed in crafting solutions, including: recognizing, and not forgetting, that 17 percent of the uninsured will not opt into health insurance, even when available; avoiding harm and unintended consequences; striking a delicate balance between access, affordability, and quality; rewarding personal initiative (financial incentives); and recognition that basic insurance is better than no insurance (flexibility in coverage).

Among the major challenges identified by the Governor were making an affordable insurance product available for targeted groups, and enhancing the state's health care safety net. Specific issues of note included recognition that the uninsured need to seek care at more appropriate times and places, not the emergency room, and the fact that the insurance cost of Florida's 51 mandated health benefits adds 15-20 percent to the cost of health insurance.

The Governor indicated his desire to look at the uninsured and structure a basic insurance product that meets their needs on a geographic specific basis—which he referred to as "health flex communities." Such products would be:

- Free of mandates;
- A basic flexible policy for the uninsured in a community with a large volume of uninsured;
- Subject to minimum regulation;
- Offered by insurers recruited, or provider service networks specifically recruited, to offer this flexible product; and
- Catastrophic coverage, with some primary care coverage as a coverage option.

Health Insurance Regulation

A person or entity must obtain a certificate of authority (COA) from the Department of Insurance (department) in order to transact health insurance in this state. The department may not grant a COA if it finds the management, officers, or directors to be incompetent or untrustworthy or so lacking in insurance company managerial experience as to make the proposed operation hazardous to the insurance-buying public; or so lacking in insurance experience, ability, and standing as to jeopardize the reasonable promise of successful operation; or which it has good reason to believe are affiliated with any person whose business operations are to the detriment of policyholders, stockholders, investors, or of the public, by manipulation of assets, accounts, or reinsurance, or by bad faith. The department may deny a COA if any person who exercises or has the ability to exercise effective control of the insurer, or who has the ability to influence the transaction of the business of the insurer, has been found guilty of, or has pleaded guilty or nolo contendere to, any felony. In addition, the following conditions must be met:

- Before an insurer may be issued an original COA, it must maintain a minimum of surplus as to policyholders, equivalent to a net worth requirement. [s. 624.407, F.S.]
- The maximum amount of insurance that an insurer may write is controlled by its surplus as to policyholders. [s. 624.4095, F.S.]
- Insurers that issue health insurance policies in Florida are required to file their forms and rates for approval with the Department of Insurance, subject to specified conditions. [ss. 627.410 and 627.411, F.S.] [Note: These requirements apply to individual and group health insurance policies, Medicare Supplement policies, and long-term care policies.
- Certain rating laws are designed to prohibit so-called "death spiral" rating practices. [s. 627.410(6)(d)-(e), F.S.]

- Health insurers must make an annual rate filing demonstrating the reasonableness of its premium rates in relation to benefits. [s. 627.410(7), F.S.]
- An insurer that issues individual health insurance policies is permitted to use a loss ratio guarantee as an alternative method for meeting rate filing and approval requirements. [s. 627.410(8), F.S.]
- The primary grounds for disapproval for health insurance rates are if the policy "provides benefits which are unreasonable in relation to the premium charged, contains provisions which are unfair or inequitable or contrary to the public policy of this state or which encourage misrepresentation, or which apply rating practices which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices." [s. 627.411(1)(e), F.S.]

In addition, the department has adopted rules that establish minimum loss ratio requirements for all types of health insurance policy forms. [4-149, F.A.C.]

Health Maintenance Organization Regulation

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. Such organizations stress preventive care and make efforts to avoid unnecessary hospitalization and expensive tertiary care. Subscribers must surrender certain freedom of choice selections of health care providers and health care related services. Subscriber choice is typically restricted to a "gatekeeper" physician (primary care physician) or other health care professional that is either an employee of, or has contracted to provide professional services on behalf of, the subscriber's HMO. Furthermore, subscribers are restricted in their choice of hospitals and other health care delivery facilities that they may utilize.

Under present law, the Department of Insurance regulates HMO finances, contracting, and marketing activities under part I of ch. 641, F.S., while the Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a COA from the department, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate under part III of chapter 641 and that is otherwise in compliance with the licensure provisions under part I, may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.

For HMO contracts, the department may disapprove rates that are excessive, inadequate, or unfairly discriminatory, which may be defined by rule of the department, in accordance with generally accepted actuarial practice as applied by HMOs. The department may also disapprove a rate if the rating methodology followed by the HMO is determined by the department to be inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding. [s. 641.31(2), F.S.]

HMO subscribers are statutorily provided certain subscriber protections as specified in s. 641.185, F.S., as follows:

- Access to health care services under reasonable standards of quality of care that are, at a minimum, consistent with the prevailing standards or medical practice in the community [ss.641.495(1) and 641.51, F.S.];
- Access to quality health care from a broad panel of providers, including referrals, preventative care, emergency screening and services, and second opinions [ss. 641.402(1), 641.31(12), 641.51, and 641.513, F.S.];

- Assurance that the HMO has been independently accredited by a national review organization and is financially secure as determined by the state [ss. 641.512, 641.221, 641.225, and 641.228, F.S.];
- Continuity of health care, even after the provider is no longer with the HMO [s. 641.51(8), F.S.];
- Access to timely, concise information regarding the HMO's reimbursement to providers and services [ss. 641.31 and 641.31015, F.S.];
- Flexibility to transfer to another Florida HMO regardless of health status [ss. 641.228, 641.3104, 641.3107, 641.3111, 641.3921, and 641.3922, F.S.];
- Eligibility for coverage without discrimination against individual participants and beneficiaries of group plans based on health status [s. 641.31073, F.S.];
- Coverage for preexisting conditions, guaranteed renewable of coverage, notice of cancellation, extension of benefits, conversion on termination of eligibility, and access to conversion contracts [ss. 641.31071, 641.31074, 641.3108, 641.3111, 641.3921, and 641.3922, F.S.];
- Receipt of timely and, if necessary, urgent grievances and appeals within the HMO [ss. 641.228, 641.31(5), 641.47, and 641.511, F.S.];
- Requires HMO to receive timely and, if necessary, urgent review by an independent state external review organization for unresolved grievances and appeals [ss. 641.228, 641.31(5), 641.47, and 641.511, F.S.];
- Written notice at least 30 days in advance of a rate change either by the HMO or the employer [s. 641.31(3)(b), F.S.]; and
- A copy of the applicable HMO contract, certificate, or member handbook specifying: all the provisions, disclosures, and limitations of HMO contract requirements; the covered services, including statutorily specified services, medical conditions, and providers; and where and in what manner services may be obtained [ss. 641.31(1) and (4), 641.31, 641.31094, 641.31095, 641.31096, 641.51(11), 641.513, and 641.31(4), F.S.]

Section 641.185, F.S., specifies that the section does not create a civil cause of action by any subscriber or provider against any HMO.

Florida Insurance Mandate Requirements

State laws frequently require private health insurance policies and health maintenance organization contracts to include specific coverage for particular treatments, conditions, persons, or providers. These are referred to as "mandated [health] benefits."

Recognizing that "most mandated benefits contribute to the increasing cost of health insurance premiums," while acknowledging the social and health benefits of many of the 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 thirteen years since, the Legislature has approved an additional 35-mandated benefits. With 51 mandated health benefits, 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 mandate benefit prior to consideration—is found in s. 624.215, F.S. [Source: House Committee on Insurance, Interim Project, "Managing Mandated Health Benefits: Policy Options for Consideration, January 28, 2000.]

According to the Associated Industries of Florida, of all insured Floridians, about 40 percent are covered by policies that carry mandated benefits. Although there has never been a study on the cumulative cost of mandated benefits in Florida, a 1998 Blue Cross/Blue Shield report studied the cumulative cost of mandated benefits in various states including Maryland (only Maryland had more

mandates than Florida — 47 at the time of the study, according to the report). According to the report, Maryland mandates are estimated to add $604, or 15.4 percent, to the average monthly premium for a group policy. In Maine, 19 of its 31 mandates were found to increase premium costs on groups of 21 or more by just over seven percent.

C. EFFECT OF PROPOSED CHANGES:

HB 111 provides the following:

- Legislative intent;
- Definitions for five key terms;
- Authorization for a pilot program for health flex plans for certain uninsured persons in the three areas of the state having the highest number of uninsured residents;
- Criteria for the plans;
- Exemption of approved plans from certain licensing requirements;
- Eligibility/enrollment criteria;
- Requirement for the plan to maintain certain records; and
- Provision for denial, nonrenewal, or cancellation of coverage.

The bill specifies that coverage under an approved plan is not an entitlement. The bill provides for actions against plan entities by the Agency for Health Care Administration uncertain circumstances.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Authorizes “health flex plans”, as follows:

Subsection (1) provides the Legislative intent for health flex plans, with an emphasis on:

- Affordability and availability of health care coverage;
- Alternative approaches to traditional health insurance;
- Basic and preventative health care services; and
- Coordination with existing local service programs.

Subsection (2) provides definitions for the terms: “agency”, “approved plan”, “enrollee”, “health care coverage”, and “health plan entity.”

Subsection (3) creates the pilot program. The Agency for Health Care Administration (agency) and the Department of Insurance (department), are directed to jointly approve or disapprove health flex plans which provide health care coverage for eligible participants residing in the three areas of the state having the highest number of uninsured residents, as determined by the agency. The plans are authorized to:

- Limit or exclude mandated benefits;
- Cap the annual total amounts of claims paid; or
- Limit enrollment.

The bill specifies that the agency and the department not approve or withdraw approval of plans that:

- Contain any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;

- Provide benefits that are unreasonable in relation to the premium charged, contains provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or
- Cannot demonstrate that the plan is financially sound and the applicant has the ability to underwrite or finance the benefits provided.

Subsection (4) provides that plans approved under this section are not subject to the licensing requirements of the Florida Insurance Code or chapter 641, F.S., relating to health maintenance organizations, unless expressly made applicable. Provides that for the purposes of prohibiting unfair trade practices, plans are considered insurance subject to the applicable provisions of part IX of chapter 626, F.S., except as otherwise provided in this section.

[Note: Insurance companies and self-insurance plans are governed by Chapters 624 through 632, 634, 635, 638, 642, 648 and 651 ("Florida Insurance Code") of the Florida Statutes. HMOs are governed by parts I and III or ch. 641 of the Florida Statutes and are exempt from the Florida Insurance Code, except for provisions specifically made applicable to HMOs. Insurance companies must be licensed by the department to do business in Florida. Self-insurance plans are not licensed by the department.**]**

Subsection (5) provides eligibility criteria. Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

- Are 64 years of age or younger;
- Have a family income equal to or less than 200 percent of the federal poverty level;
- Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program such as Medicare or Medicaid, or other public health care program, including, but not limited to, Kidcare; and have not been covered at any time during the past six months; and
- Have applied for health care benefits through an approved plan and agree to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

Subsection (6) provides requirements for record keeping. Every plan entity must maintain reasonable records of its loss, expense, and claims experience and is required to make such records reasonably available to enable the agency and the department to monitor and determine the financial viability of the plan, as necessary.

Subsection (7) provides notice requirements. The denial of coverage by a plan must be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation must be provided for with at least 45 days advance notice, except that 10 days' written notice must be given for cancellation due to nonpayment of premiums. Provides that if the plan fails to give the required notice the plan must remain in effect until notice is appropriately given.

Subsection (8) specifies that the coverage of a plan is not an entitlement and that no cause of action shall arise against the state, local governmental entity, or other political subdivision of this state, or the agency for the failure to make coverage available to eligible persons under this section.

Subsection (9) provides for civil remedies. Provides that in addition to an administrative action initiated under subsection (4), the agency may seek any remedy provided by law, including, but not limited to, the remedies provided in s. 812, 035, F.S., relating to civil remedies relating to theft,

robbery, and related crimes, if the agency finds that a plan has engaged in any act resulting in injury to an enrollee covered by a plan approved under this section.

Section 2. Provides that the bill take effect July 1, 2002.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None

2. Expenditures:

Implementation of this bill can be accomplished with existing staff and resources within the Agency for Health Care Administration and the Department of Insurance.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that hospitals, local community providers, and local government programs provide uncompensated care to low-income persons, such providers may see a decrease in demand for uncompensated care as a result of this pilot project.

These same local providers may seek to become health flex plan provider entities.

In addition, this bill has the potential to offer low-income individuals a lower cost health insurance alternative.

D. FISCAL COMMENTS:

None

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

A. APPLICABILITY OF THE MANDATES PROVISION:

The bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

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

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. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None

B. RULE-MAKING AUTHORITY:

None

C. OTHER COMMENTS:

None

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On November 27, 2001, the Committee on Health Promotion adopted a “strike-everything” amendment. The amendment makes the following changes:

- Adds a definition that “department” means the Department of Insurance;
- Specifies the designated pilot areas as the three service areas with the highest number of uninsured as identified in the Florida Health Insurance Study conducted by the agency;
- Clarifies that the agency and the department must develop guidelines for review of health flex plan applications and shall not approve, or withdraw approval of, plans that do not meet or no longer meet the minimum quality of care standards;
- Requires each health plan to maintain enrollment data;
- Requires plans to provide provider network and enrollment data to the agency biannually to enable the agency to monitor access to care;
- Deletes agency authorization to seek civil remedies upon finding a health plan entity has engaged in any act resulting in injury to an enrollee by a plan;
- Requires evaluation of the program, specifies the elements of the evaluation, and a report to the Governor, Senate President, and Speaker of the House of Representatives by January, 2004;
- Sunsets the pilot project on July 1, 2004, unless specifically reenacted by the Legislature; and
- Makes technical changes for consistency throughout the bill.

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

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Tonya Sue Chavis, J.D.

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AS REVISED BY THE COMMITTEE ON FISCAL POLICY AND RESOURCES:

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