HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 53 Health Insurance
SPONSOR(S): Sorensen & others
TIED BILLS: None **IDEN./SIM. BILLS:** SB 454

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Access & Financing (Sub)	7 Y, 0 N	Tinney	Cooper
2) Insurance			
3) Commerce & Local Affairs Approp. (Sub)			
4) Appropriations			
5)			

SUMMARY ANALYSIS

In the private health insurance market, there are two basic types of insurance coverage: managed care and more traditional health indemnity plans. Managed care organizations include entities such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). HMOs and PPOs are regulated both by the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR) of the Financial Services Commission.

In order to offer services within Florida, a managed care organization must first receive a health care provider certificate from AHCA under the provisions of part III of chapter 641, F.S. Upon receipt of a health care provider certificate from AHCA, a managed care organization may apply for a certificate of authority from OIR to sell insurance products in the state as specified in part I of chapter 641, F.S. DFS is assigned by law to examine the fiscal resources of a managed care organization, including cash reserves, liabilities, and other similar information. The law assigns AHCA to examine a managed care organization's service offerings, provider network, patient contracts, and other information related to the delivery of patient care and services. AHCA must ensure that a managed care organization's service offerings are sufficient to serve the geographic region targeted by the organization.

An insurer who offers health insurance for sale in Florida is required by the bill to offer health insurance within all 67 counties in the state, rather than in only one or a few counties. If an insurer offers health insurance in fewer than all counties in the state, the insurer will be prohibited from continuing to sell its insurance within the state.

OIR of the Financial Services Commission, i.e., the Governor and Cabinet members, will monitor the sales of health insurers in Florida to ensure that the insurers comply with the requirement to offer health insurance policies in every county in Florida. OIR also is directed by the bill to enforce the requirement that a health insurer sell health insurance policies throughout Florida, or be prohibited from selling such insurance anywhere in the state.

If the bill affects only insurers who offer health indemnity policies, there is minimal fiscal impact associated with the bill. If the bill affects HMOs and PPOs, as well as insurers offering health indemnity policies, both AHCA and OIR predict costs associated with implementation of the bill, however, the costs are indeterminate.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[x]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[]	N/A[x]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[]	No[]	N/A[x]

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

Reduce government:n The bill imposes additional requirements upon insurers who offer health insurance policies and services within the state.

B. EFFECT OF PROPOSED CHANGES:

HEALTH INSURANCE BACKGROUND

General Information

In the private health insurance market, there are two basic types of insurance coverage: managed care and more traditional health indemnity plans. Managed care organizations include entities such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). HMOs and PPOs are regulated both by the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR) of the Financial Services Commission.

In order to offer services within Florida, a managed care organization must first receive a health care provider certificate from AHCA under the provisions of part III of chapter 641, F.S. Upon receipt of a health care provider certificate from AHCA, a managed care organization may apply for a certificate of authority from OIR to sell insurance products in the state as specified in part I of chapter 641, F.S. OIR is assigned by law to examine the fiscal resources of a managed care organization, including cash reserves, liabilities, and other similar information.

The law assigns AHCA to examine a managed care organization's service offerings, provider network, patient contracts, and other information related to the delivery of patient care and services. AHCA examines a managed care organization's network of service providers to ensure there are sufficient providers and specialists available to serve the subscribers of a managed care organization. The law specifically assigns AHCA in ss. 641.49, 641.495, and 641.54, F.S., to examine a managed care organization's service plan for sufficiency of providers within the geographic region to be served by the provider.

AHCA reports that the provider networks of most managed care organizations typically serve a specific geographic region of the state because it is more efficient, and typically easier, to aggregate services, health care institutions, and providers within defined geographic boundaries. The geographic area served by a typical managed care organization frequently crosses city limit boundaries and county lines based upon the location of service providers and the number and location of members who subscribe to the organization.

Managed Care

Managed care refers to a variety of methods of financing and organizing the delivery of comprehensive health care in which an attempt is made to control costs and improve quality by controlling the provision of services. Managed care, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians, hospitals, and other health care providers that provide comprehensive health services to enrolled members for a predetermined monthly premium. The selected providers form a managed care network.

All forms of managed care represent attempts to control costs by modifying the behavior of physicians and other health care providers who prescribe treatment. Most managed care providers also restrict the access of their insured populations to physicians and other health care providers who are not affiliated with the provider's network. A key cost containment feature for many contracts between HMOs and health care providers is a fixed, per-patient fee, regardless of the services provided, referred to as a per-capita fee arrangement. This provides an economic incentive to a health care provider to limit services to those that are medically necessary.

Health Maintenance Organizations

HMOs, considered the prototype managed care organization, are entities that first must receive a health care provider certificate from AHCA and a certificate of authority for offering insurance products by OIR. Section 641.315, F.S., establishes requirements for HMO contracts with health care providers. This section mandates a number of provisions for HMO contracts with health care providers, including requirements that each contract be in writing, contain notice and cancellation provisions, and contain procedures for granting authorization for utilization of health care services, among other provisions.

Health Indemnity Contracts

A health indemnity contract or policy is governed by OIR within the Financial Services Commission and parts VI and VII of chapter 627, F.S. A traditional indemnity policy is typically more expensive than an HMO or PPO contract because the indemnity policy is not restricted to a specific network of service providers or to service providers within a designated geographic area. Rather, an indemnity policy offers services, or at least partial reimbursement for services, from most health care service providers. The general reimbursement or payment structure of an indemnity policy specifies that 20 percent of the insurer's allowable fee per service is paid by the policyholder while the insurer pays or reimburses up to 80 percent of the allowable fees. Indemnity policies generally require the policyholder to pay a predefined deductible amount annually, along with the co-payment for each service the policyholder receives. Indemnity policies may exclude payment for specified services and medications altogether, as may HMO and PPO plans.

OIR reports that all of its licensees who offer health indemnity policies must offer such policies and their attendant benefits throughout the state. An insurer who offers an indemnity policy may not offer such a policy only in the parts of Florida where the company may wish to conduct business. OIR is granted statutory authority by s. 626.9541(1)(x)2., F.S., relating to unfair methods of competition, to require an insurer to offer indemnity policies throughout the state.

Availability of Health Services in Florida

Both AHCA and the Department of Health collect data from health service providers relating to the availability of such services and providers throughout Florida. Both agencies indicate there are regions throughout Florida, especially in areas that are still largely rural, where both general and specialty health care services remain largely unavailable to many citizens. In rural areas, the demographics of the population, particularly with respect to household income, may inhibit the availability of medical services and providers. Rural areas typically contain smaller population centers than do urban areas. Smaller populations also discourage the proliferation of medical services and providers.

There are other areas of the state, for example the Florida Keys, that also suffer from a shortage of health care providers. Although most of the population in the Keys is generally more affluent than in most rural areas, the Keys are geographically isolated and small in terms of overall population. In some communities, where only one or two small hospitals exist, there is little impetus for the available service providers to discount their service costs in order to participate in a managed care network. AHCA reports that a concentration of service providers within a geographic location encourages the available providers to compete with respect to fees for services, thus enhancing the opportunity for service providers to participate in a network associated with a managed care organization.

EFFECTS OF THE BILL

An insurer that sells health insurance policies in Florida is prohibited by the bill from limiting insurance coverage to only specific counties in Florida. The bill requires a health insurer to make health insurance coverage available in all 67 Florida counties. A health insurer that attempts to limit the geographic scope of its services is prohibited by the bill from selling health insurance in Florida.

OIR is directed by the bill to monitor each health insurer that offers health insurance policies in Florida to ensure the insurer offers its policies throughout the state. OIR also is directed to prohibit an insurer from continuing to offer health policies in Florida if the insurer fails to offer such policies throughout the state.

C. SECTION DIRECTORY:

Section 1. Specifies that an insurer authorized to sell health insurance in Florida may not limit its products to a specific geographic region or county of the state. An authorized insurer is required bythe bill to make its products and policies available in all 67 Florida counties. OIR is directed to monitor health insurers to assure that the insurers comply with the provisions of the bill.

Section 2. Provides that the bill takes effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate. Neither AHCA nor OIR anticipates incurring expenses resulting from the bill if the bill affects only authorized insurers who offer health indemnity coverage. If the bill applies to HMOs and PPOs, as well as indemnity policies, both agencies predict they will incur additional costs to implement the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If the bill is successful in making health insurance options more widely available throughout Florida, the impact could be to increase the choices for health care coverage to the general public.

If the bill affects health insurance coverage offered by licensed HMOs and PPOs, however, AHCA predicts that such organizations will offer fewer services in Florida and indicates that some providers may leave the Florida market entirely. The availability of fewer health care providers in Florida likely will negatively impact the availability of health insurance coverage to Florida consumers, although the costs associated with such a decrease are not quantifiable.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No rulemaking authority is granted either to AHCA or DFS by the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill requires an insurer who offers health insurance policies within Florida to offer the policies in all 67 Florida counties. No definition is provided for “an insurer which sells or offers for sale . . . policies of health insurance” (lines 17 and 18). As a result, it is unclear whether the bill affects only insurers who offer health indemnity policies or HMOs and PPOs as well as indemnity policy providers. If the intent of the bill is to require indemnity policies, HMOs, and PPOs to offer their policies and services throughout Florida, a definition stating such intent likely is needed.

If a definition is added to the bill specifying that HMOs, PPOs, and indemnity policies all must conform to the bill, current laws governing the activities of HMOs and PPOs may be in conflict with the bill. Current laws governing managed care organizations specify that AHCA must consider whether the organization’s network of providers is sufficient to serve the geographic area targeted by the managed care organization. The bill requires a health insurer to make its services and benefits available throughout the state, rather than allowing such services and benefits to target only specific geographic regions within Florida.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On April 13, 2004, the Subcommittee on Health Access & Financing adopted an amendment that authorizes a pilot program to be established in Monroe County under the Rural County Health Networks created in s. 381.0406, F.S. The Rural Health Network of Monroe County, an existing governmental entity, may establish a self-insurance plan through a non-profit corporation. The self-insurance plan will be subject to approval by the Office of Insurance Regulation, in consultation with the Department of Health. The self-insurance plan must be

actuarially sound and may charge premiums to its participants. The non-profit corporation that oversees the self-insurance plan will provide a report of its activities, along with recommendations for the future of the program by January 1, 2006.