HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 811 CS Employee Health Care Access Act; List Billing by Employers
SPONSOR(S): Kreegel and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1660

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee	19 Y, 0 N, w/CS	Tinney	Cooper
2) Health Care General Committee	8 Y, 1 N, w/CS	Schiefelbein	Brown-Barrios
3) Commerce Council			
4)			
5)			

SUMMARY ANALYSIS

The bill amends the Employee Health Care Access Act (the Act), popularly referred to as Florida's Small Group law. Under the bill, a small employer is authorized to collect a health insurance premium from the salary or wages of an employee and to pay the premium to an individual health insurer on behalf of the employee as long as the employer does not contribute toward the premium or otherwise facilitate health insurance coverage. The practice of payroll deduction for an individual health insurance premium is not currently authorized by law.

The practice of payroll deduction for individual employee health insurance policies is known as "list billing"; the term derives from the payment of a single premium on behalf of numerous, i.e., a list of, policyholders. According to the Office of Insurance Regulation (OIR), several insurers, including such companies as Blue Cross Blue Shield of Florida, Assurant, Golden Rule, Medical Savings Insurance Company, and Humana, among others, may solicit premium payments through the list billing authority granted by the bill.

The applicability and scope of the Act is further amended by the bill in s. 627.6699(4), F.S., to specify that a health insurance carrier may offer an individual health insurance policy to an employee of a small employer without complying with the provisions of the Act if the employer has not offered its employees a group health benefit plan within the previous 6 months. The exemption provided by the bill, allowing an insurer to offer an individual policy without complying with the provisions of the Employee Health Care Access Act, means that an insurer is not required to offer the policy on a guaranteed-issue basis, is not required to offer the policy to any employee who works 25 or more hours per week, or offer a policy with coverage for the dependents of an employee.

Additionally, the bill authorizes a small employer regardless of whether the employer offers a health benefit plan to collect individual health policy premiums through payroll deduction from an employee who is not eligible to participate in the employer's group health plan.

The bill requires carriers that offer list-billing coverage to part-time employees to provide a termination notice at least ten days prior to termination to the employee.

The bill authorizes an employer with 50 or fewer employees to collect from an employee an amount sufficient to pay an insurer the individual health insurance premium due from the employee's wages or salary, even if the employer does not contribute any portion of the premium. An employer who elects to provide this service to its employees may incur some administrative costs to provide the service, although the amount of the administrative costs is indeterminate. It seems unlikely that the administrative costs to a single small employer for facilitating the payment of an employee's health insurance premiums would be material.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Safeguard Individual Liberty and Promote Personal Responsibility—The bill authorizes an employer to collect from an employee's salary or wages an amount sufficient to pay an employee's non-group, individually purchased, health insurance premium. Current law, s. 627.6699, F.S., governing small group health insurance, is designed to facilitate the pooling of small groups into larger groups, so an employer is not authorized to collect, though payroll deduction, a premium for an individual health policy.

B. EFFECT OF PROPOSED CHANGES:

Background: Employment-Based Health Insurance in the U.S.

In February 2004, the Florida House of Representatives Select Committee on Affordable Health Care for Floridians issued its final report, including the findings and recommendations of the Select Committee. The report traced the history of health insurance benefits in the U.S. According to the report, health benefits in the U.S. became closely linked to employment during the 1940s. The final report states that during World War II (WWII), wages in the civilian job market were frozen by the National War Labor Board to prevent inflation due to the shortage of workers. As a result, U.S. employers began offering health insurance as an employee benefit in an effort to attract scarce workers.

During the same period, the final report indicates that many western nations began consolidating and centralizing their health care systems. This trend occurred, particularly in Europe, in an effort to make the best use of scarce resources and to respond efficiently to the need for primary care and emergency services that resulted because so many of the battles in WWII took place in European countries.

The trend for U.S. employers to offer health insurance as a benefit served to help recruit and retain workers during the labor shortage of WWII. The close association between health insurance and the American workplace became more entrenched as labor unions embraced employment-based health insurance and because worker health benefits were not subject to income tax or Social Security payroll taxes as were cash wages.

Following WWII, much of the world suffered depressed economies as countries recovered from the privations and other effects of the war. In contrast, the U.S. economy grew very quickly during the late 1940s and through the 1950s, particularly in the manufacturing sector. The high growth in the American economy following the war enabled employers to continue offering health insurance as a benefit to attract workers. In contrast, many other western nations converted their centralized emergency health care systems into national health systems.

The 2004 final report of the select committee notes that the employment-based health system became further rooted in the U.S. when the federal tax code began authorizing employers to deduct insurance premiums paid on behalf of employees from the employers' tax liability. A similar change to the tax code excluded health benefits, without limit, from a worker's taxable income, thus recognizing the trend for an employee to expect health benefits as part of a worker's benefit and compensation package.

Group Health Insurance Benefits

It is efficient for employers and other health care consumers to participate in groups because the health issues and health care needs of the group members are spread or divided among all group members, even those members who are young or healthy or who rarely use medical services. This means that a participant in a group health policy who is relatively healthy or who rarely uses medical services helps

subsidize the cost of unhealthy group members, those with serious or chronic illnesses, and other group members who use health services more frequently. Because group rate premiums are determined on an aggregate basis, by dividing cost and claims among all group members, it is more desirable to participate in a policy that serves a large group, with members of various ages and health histories.

In the private market, insurance companies determine premiums by assessing the various risks associated with each member who participates in a group policy. Thus, premiums differ from group to group, based upon total members in the group, age and health status of group members, and the past claims experience of the group members. The smaller a group that participates in a group policy, the fewer members there are among whom to apportion costs and claims. As a result, Florida's Small Group law, s. 627.6699(6), F.S., requires that a carrier pool the experience of all small groups together when calculating premiums. After pooling the experience of all its small groups, the law authorizes a carrier to vary the actual charge (i.e., premium) charged to an individual employer by up to 15 percent from the carrier's approved rate.

Reliance in the U.S. on an employment-based health insurance system typically excludes the unemployed and those workers who are self-employed. Similarly, many low-skilled workers are unable to afford any contribution to a health insurance premium or may be unable to qualify for a job that offers health insurance as a benefit. A worker who is single may also feel at a disadvantage if an employer provides single and family health benefits to its employees because a premium paid on behalf of a married employee who has a family typically is substantially higher than the premium paid for a single employee, even if both employees perform the same duties.

Population Statistics

At the end of 2004, the total population of the United States was estimated at 283.7 million citizens. For the same period, Florida, the fourth most populous state, was estimated by the Legislature's Office of Economic and Demographic Research to have a population of 17.52 million citizens. At the end of 2004, California had an estimated population of 36 million residents; Texas had approximately 22.5 million citizens; and New York was estimated to have 19.2 million citizens. The U.S. Census Bureau estimates that Florida will rank third in population, surpassing New York, between 2015 and 2020.

Health Insurance Availability

The Commonwealth Fund, a private foundation based in New York City (www.cmwf.org) supports independent research on health and social issues and makes grants to improve the practice of health care and health care policy. In February 2005, the Commonwealth Fund updated a 2004 study relating to the uninsured in the U.S.

The updated study found that approximately 18 percent of the U.S. population under the age of 65 currently has no health insurance. Further, the study indicates that approximately 63 percent of non-elderly Americans (an estimated 163 million Americans) who are employed receive health insurance through their employers; those employers currently spend in excess of $400 billion annually for employee health benefits. The Commonwealth Fund data does not specify whether those Americans who receive health insurance though their employers participate in health plans that are paid fully, partially, or not at all by their employers.

The Uninsured in Florida

The Agency for Health Care Administration (AHCA) is created in s. 20.42, F.S., and is directed by law to serve as the state's chief health policy and planning entity. In 1998, the Legislature directed AHCA to gather data for the then newly-created Florida Health Insurance Study (FHIS) to provide reliable data regarding the number of Floridians who were not covered by health insurance. The initial FHIS was completed in 1999; last year, AHCA received a grant to update the 1999 study.

Typically, data collected regarding the uninsured population in the U.S. counts citizens under the age of 65. According to AHCA, most Americans aged 65 or older "have some health coverage through Medicare." As a result, surveys of Americans relating to health insurance generally query Americans under age 65. Data in the FHIS are collected from Florida citizens under age 65.

The 2004 update to FHIS included telephone interviews with 17,435 Florida households. The data in the 2004 FHIS represent an estimated 46,876 Florida citizens. The data that follow are contained in *Highlights from the 2004 Florida Health Insurance Study* available on the AHCA web site at: http://ahca.myflorida.com/Medicaid/Research/Projects/fhis2004/PDF/highlights_from_the_2004_fhis_1104.pdf

- From 1999 to 2004, the number of uninsured Floridians under age 65 rose from 16.8 percent to 19.2 percent;
- Miami-Dade County now has the highest rate of citizens without health insurance at 28.7 percent, an increase from 24.6 percent in 1999;
- Rates of uninsurance increased the most for middle-income families in the state; those with annual family incomes ranging from $15,000 to $45,000 per year;
- As in 1999, Hispanics have the highest rate of uninsurance at 31.8 percent; African Americans are uninsured at the rate of 22.6 percent; white, non-Hispanics are uninsured at the rate of 14.3 percent;
- Employment status has a high correlation to health insurance coverage: almost half, 48.1 percent of unemployed Florida citizens lack coverage; similarly, 32 percent of the self-employed lack health coverage. Full-time employees are uninsured at the rate of 15.7 percent;
- The size of an employer is a key factor in whether a Florida worker has health coverage. Among those in firms with fewer than 10 employees, more than 33 percent do not have health insurance, however, for employees in firms with 1,000 or more workers, only 5.2 percent lack health insurance;
- In describing the "main reason" they lack health insurance, 63 percent of the survey respondents cited cost as the primary factor; almost 10 percent indicated that their employers do not offer health insurance, and 3.7 percent of the respondents were unemployed at the time of the survey; and
- Of Floridians without health coverage, 54 percent have been without coverage for longer than 1 year and almost 19 percent have never had health insurance.

Florida's Current Health Insurance Market

In Florida, regulation of the insurance industry is shared by the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR). The state's Chief Financial Officer (CFO) heads DFS while the head of OIR is the Governor and Cabinet members sitting as the Financial Services Commission. Generally, OIR is responsible for granting a certificate of authority or license to an insurer; a domestic insurer, i.e., an insurer based in Florida, must possess a certificate of authority in order to conduct business in Florida. Similarly, many insurers are required by law to seek OIR approval for their rates, or the prices they charge for coverage, and approval of the insurance forms they use for issuing policies. The Office of Insurance Regulation investigates allegations of fraud against insurers and administers state laws governing the financial reserve requirements imposed on insurers. The regulation and licensure of insurance agents and agencies is the purview of DFS. Staff of DFS also provides consumer information and assistance through the Division of Consumer Services.

Various federal and state laws regulate the health insurance market in the state. The result of the various laws is that Florida's health insurance market is segmented into various groups, including self-insured groups or health plans, large groups of 51 or more participants, small groups ranging in size from 1 to 50 members, individual health policies, and out-of-state groups. Each segment of the market may be further divided into sub-groups, both in Florida, and in most other states, however, the Florida Insurance Code governs the activities, policies, and premiums of health insurance within the market segments identified herein.

Chapter 627, F.S., governs rates and contracts for all types of insurance available in Florida, including life, health, property, automobile, credit life and disability, workers' compensation, and title, among other types of policies. For example, part VI, chapter 627, F.S., governs health insurance policies, while part VII of chapter 627, F.S., governs group, blanket, and franchise health insurance policies.

Out-of-State Group Health Insurance

Some groups located in a state other than Florida may have members who reside or work in Florida. As a result, Florida law at s. 627.6515, F.S., recognizes out-of-state group health insurance and regulates same, although not to the degree that it regulates policies issued to groups in Florida. Rather, Florida law sets minimum policy standards for out-of-state group policies, but otherwise defers to regulations in the state where the policy is issued to establish the policy standards.

Based on the section of the Insurance Code that governs out-of-state groups, s. 627.515, F.S., many association groups have been established which offer their members, including those in Florida, health insurance coverage subject to a carrier's underwriting requirements for an individual policy. Figures provided by OIR indicate that in 2002, out-of-state groups accounted for an estimated 27 percent of Florida's health insurance issued to individuals.

Insurers that issue policies to groups or associations outside of Florida, but also sell and market the policies to individuals in Florida (who are issued "certificates"), are exempt from Florida's rate filing and approval requirements and therefore, may not include the consumer protections provided by Florida laws governing insurance rates and forms. The law requires that the group certificates issued in Florida be filed with OIR "for information purposes only" (s. 627.410(1), F.S.)

Generally, an out-of-state group health policy is more similar to an individual policy than to a group policy. This means that the insurer may refuse to cover preexisting conditions, an applicant is not afforded guaranteed-issue protection, and coverage for the policyholder's dependents is not required. In some cases, an insurer forms the group or association, then, as long as the carrier is licensed in Florida, the insurer may issue certificates to Florida citizens and add those policies to the group organized under another state's laws.

Under s. 627.6515, F.S., which was strengthened in 2003, health policies for which a certificate is issued to the policyholder now are required to provide strong disclosure information specified in law to a consumer at time of application. The law also requires any insured that terminates membership in a group to notify the insurer and requires the carrier to offer the insured a conversion policy. The law states that any rate escalations caused by segmenting healthy and unhealthy lives resulting in an ultimate pool of primarily less healthy policyholders (i.e., a "death spiral") to be predatory pricing, constituting unfair discrimination, i.e., an unfair trade practice.

Health Insurance and Small Employers

As indicated in the 2004 update to the FHIS, persons who are unemployed or employed by small employers, i.e., those with 50 or fewer employees, are the most likely to lack health insurance. The Legislature has recognized this problem and has created numerous programs over the past 15+ years to encourage small employers to make health insurance available to their employees.

For example, in 1993, the Legislature created Community Health Purchasing Alliances (CHPAs) under AHCA. The intent of CHPAs was to encourage small employers within relatively close geographic proximity, to create larger insurance purchasing groups. The Legislature hoped that by facilitating the creation of larger groups for small employers, health insurance rates would be more affordable due to the pooling of risk and claims experience among participants.

Florida's current laws governing small group health benefits, s. 627.6699, F.S., The Employee Health Care Access Act or Small Group law, require insurance carriers to pool or aggregate all of their small groups into a single rating group or pool when apportioning costs and estimating premiums. This

requirement regarding small group premiums addressed many of the issues the creation of CHPAs was designed to address, thus, the Legislature repealed laws authorizing CHPAs in 2000.

In 2002, the Legislature authorized several projects under what was named the Health Flex Plan Pilot Project, provisions for which are found in s. 408.909, F.S. The 2002 legislation recognized that many Floridians did not have health coverage because of the cost. The Health Flex Plan was designed to encourage health insurers, health maintenance organizations, provider-sponsored organizations, local governments, health care districts, and other public and private entities to develop alternative approaches to traditional health insurance. This goal was to be accomplished by allowing program participants to emphasize coverage for basic and preventive services rather than offering full, traditional insurance coverage, including coverage for mandated services. To date, although the original health flex plan was authorized for expansion throughout the state in 2004, participation in health flex plans remains relatively low.

Last year, the Legislature adopted several reforms to the various provisions of law that govern health insurance and the provision of health care services in chapter 2004-297, Laws of Florida, entitled "The 2004 Affordable Health Care for Floridians Act". Among the provisions of the 2004 law was the creation of s. 627.6699(15), F.S., entitled The Small Employers Access Program.

The Small Employers Access Program states that the purpose of s. 627.6699(15), F.S., is to facilitate the ability of small employers "to provide health care benefits to their employees at an affordable cost through the creation of purchasing pools for employers with up to 25 employees, and rural hospital employers and nursing home employers regardless of the number of employees."

The Employee Health Care Access Act, s. 627.6699, F.S.

Under the Employee Health Care Access Act (the Act), a "small employer" is defined in s. 627.6699(3)(v), F.S., as any person, sole proprietor, self-employed person, independent contractor, firm, association, or other business entity that is based in Florida, actively engaged in business, with at least one, and no more than 50 employees. The Act applies to a health benefit plan providing coverage to a Florida-based small employer, unless the policy is marketed directly to an individual employee whose employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy.

The Act defines a carrier as a person or entity who provides health benefit plans in Florida, including an authorized insurer, a health maintenance organization, and a multiple-employer welfare plan, i.e., a self-insurance plan, unless the self-insurance plan existed in 1992 or earlier. Under the definitions provided in s. 627.6699(3), F.S., an "eligible employee," i.e., an employee who may participate in a group benefit plan, is an employee who works full time, including a normal workweek of 25+ hours. An "eligible employee" includes a sole proprietor, a self-employed person, or a partner.

The Act requires an insurer to offer group health benefits on a guaranteed-issue basis. The term "guaranteed-issue basis" is defined as an insurance policy that must be offered to an employer, employee, or to a dependent of an employee, regardless of health status, previous claims experience, or preexisting condition. A policy offered as a guaranteed issue also must provide all the coverage mandated by state law, including coverage for such services as mammograms, diabetes education and treatment, treatment for cleft lip and cleft palate, among other required benefits.

Changes Proposed by the Bill

The Employee Health Care Access Act is amended by the bill to allow a small employer to collect a health insurance premium from the salary or wages of an employee and to pay the premium to an individual health insurer on behalf of the employee as long as the employer does not contribute toward the premium or otherwise facilitate health insurance coverage. The practice of payroll deduction for an individual health insurance premium is not currently authorized by law.

The practice of payroll deduction for individual employee health insurance policies is known as "list billing;" the term derives from the payment of a single premium on behalf of numerous, i.e., a list of, policyholders. According to OIR, several insurers, including such companies as Blue Cross Blue Shield of Florida, Assurant, Golden Rule, Medical Savings Insurance Company, and Humana, among others, may solicit premium payments through the list billing authority granted by the bill.

The applicability and scope of the Act is further amended by the bill in s. 627.6699(4), F.S., to specify that a health insurance carrier may offer an individual health insurance policy to an employee of a small employer without complying with the provisions of the Act if the employer has not offered its employees a group health benefit plan within the previous 6 months. The bill specifies that only a carrier authorized by law to offer a group or individual health plan may offer an individual health policy to the employee of a small group employer.

The exemption provided by the bill, allowing an insurer to offer an individual policy without complying with the provisions of the Employee Health Care Access Act, means that an insurer is not required to offer the policy on a guaranteed-issue basis, is not required to offer the policy to any employee who works 25 or more hours per week, or offer a policy with coverage for the dependents of an employee.

Additionally, the bill authorizes a small employer which offers a group health benefit plan to collect individual health policy premiums through payroll deduction from an employee who is not eligible to participate in the employer's group health plan. Finally, the bill requires carriers that offer list-billing coverage to part-time employees to provide at least a ten-day termination notice to the employee.

C. SECTION DIRECTORY:

Section 1 amends s. 627.6699, F.S., the Employee Health Care Access Act, to authorize an employer to collect individual policy health insurance premiums from employees and to pay the premiums to an insurer, even if the employer does not contribute to the premium; provides list-billed coverage to part-time employees, regardless of whether or not the small employer has a group health benefit plan; requires carriers to provide at least a ten-day termination notice to the employee.

Section 2 provides an effective date of July 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill authorizes an employer with 50 or fewer employees to collect from an employee salary or wages an amount sufficient to pay an insurer the individual health insurance premium due from the employee, even if the employer does not contribute any portion of the premium. An employer who elects to provide this service to its employees may incur some administrative costs to provide the service, although the amount of the administrative costs is indeterminate. It seems unlikely that the administrative costs to a single small employer for facilitating the payment of an employee's health insurance premiums would be material.

D. FISCAL COMMENTS:

In its analysis of HB 811, OIR indicates that it cannot estimate the costs or benefits from the bill to small employers, i.e., those with 50 or fewer employees. The OIR analysis further states,

> However, if the legislation provides an incentive for small group employers to drop [health insurance] coverage for [6] months in order to qualify for the solicitation of individual coverage for the small employer workforce, there will be an increasing number of individuals joining the population of those who are uninsured—those employees who are today eligible for small group coverage, but who would fail to pass health underwriting criteria for the individual coverage provided for in this legislation.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 17, 2005 meeting, the Insurance Committee adopted three amendments to HB 811. The first amendment clarifies that only an insurance carrier *authorized by law to offer a group or individual health plan* may offer an individual health policy to the employee of a small-group employer.

The second and third amendments adopted change from 3 months to 6 months the period during which a small-group employer has not offered a health plan to its employees before the employer may begin list billing.

On March 31, 2005 meeting, the House Health Care General Committee adopted one amendment to HB 811. This amendment specified that carriers may offer list-billed coverage to employees not defined as “eligible employees” in the small group law, clarified that a carrier may offer coverage to part-time employees regardless of whether the small employer has a group health benefit plan, and requires carriers to provide a termination notice at least ten days prior to termination to the employee.

The committee passed the bill as a committee substitute.

This analysis is written to the committee substitute.