The Florida Senate

HOUSE MESSAGE SUMMARY

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BILL:	CS/CS/SB 2534
INTRODUCER:	Health and Human Services Appropriations, Banking and Insurance Committee, and Senator Peaden
SUBJECT:	Affordable Health Coverage
DATE:	April 24, 2008

I. Amendments Contained in Message:

House Amendment 1 – 364545 (title)

II. Summary of Amendments Contained in Message:

Similar or Identical Provisions Contained in House Amendment and CS/CS/SB 2534
The House delete-all amendment has the following provisions that are currently included in CS/CS/SB 2534, as passed by the Senate:

Cover Florida Health Care Access Program
Creates the Cover Florida Health Access Program, which is designed to provide affordable health care options for uninsured residents of Florida between the ages of 19-64 who meet certain other criteria. A Cover Florida plan entity must provide non-catastrophic coverage and may provide catastrophic coverage, supplemental insurance, prepaid health clinics, and discount medical plan product options to enrollees. The Agency for Health Care Administration (agency) and the Office of Insurance Regulation (office) are responsible for jointly establishing and administering the Cover Florida Program. The agency and the office are required to issue an invitation to negotiate no later than July 1, 2008, to health insurers, health maintenance organizations (HMO), health care provider-sponsored organizations, and health care districts. The agency and the office are required to approve at least one Cover Florida plan entity having an existing statewide provider network and may approve at least one regional network plan in each Medicaid area.

Dependent Coverage
The Senate Bill and the House amendment continue the current law for dependent coverage until age 25. Eligibility for coverage until age 25 requires the child to be dependent upon the parent for support and living in the household of the parent, or is a full-time or part-time student.

The House amendment and the Senate Bill require group health insurers to offer policyholders and certificate holders (parents) the option to continue coverage of their children on their family

policy until age 30, if the child is: (1) unmarried with no dependents; (2) a resident of Florida or a full-time or part-time student; and (3) does not have insurance coverage under any private or public plan.

Health Flex Plan Program

The Health Flex Plan Program was established to offer basic affordable health care services to low-income, uninsured residents. The bill provides the following changes to the program:

- Expands the population eligible to purchase health flex plans by raising the family income limit from 200 to 300 percent of the federal poverty level (FPL).
- Allows a person who is covered under a subsidized Medicaid or KidCare coverage and lost eligibility due to the income limits to apply for coverage without a lapse in coverage if all other requirements are met.
- Expands the population eligible for health flex plans by allowing individuals that are covered under an individual contract issued by an HMO that has an approved health flex plan, as of October 1, 2008, to enroll in the HMO's health flex plan. These individuals would not be subject to the current requirement of being uninsured for the prior 6-months. Currently, three of the health flex plan providers are authorized as Medicaid HMOs. Persons no longer eligible for the HMO coverage would be able to obtain coverage in a health flex plan and avoid a gap in coverage.
- Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

Provisions Not Included from CS/CS/SB 2534

CS/CS/SB 2534 Bill has the following provisions that are <u>not</u> contained in the House amendment:

1. KidCare

- Expands eligibility and enrollment for the KidCare program by eliminating the 10 percent cap on enrollment for MediKids (ages 1-5) and Healthy Kids (ages 6-19) enrollees who have a family income of greater than 200 percent of the federal poverty level and pay full premiums. These enrollees must pay the full cost of the premium (unsubsidized).
- Requires Healthy Kids Corp. to submit a report to the Legislature and Governor, by February 1, 2009, on the premium impact to the subsidized portion of KidCare from the inclusion of the full-pay program, and recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.

2. Small Employer Group Coverage

The Senate Bill revises the definition of small employer for group coverage to provide that, for purposes of calculating the numbers of employees, companies that are affiliated groups, as defined in s. 1504(a) of the Internal Revenue Code, are considered one employer. This change conforms the statutory definition of "small employer," to the definition contained in the NAIC Model Act and ensures that the majority of the employees of an employer work in Florida and that a company is not formed primarily for buying health insurance. The result will be that certain companies that are currently considered small employers will no longer be entitled to guarantee issue and modified community rating since they will no longer be deemed small employers.

Provisions Not Included in CS/CS/SB 2534
The House amendment includes the following provisions, which are not in CS/CS/SB 2534:

1. Cover Florida Health Care Access Program
The House amendment contains the Cover Florida provisions found in the Senate Bill and also requires a disclosure to be signed by all consumers purchasing program options or insurance coverage through the program, which provides that the program is or isn't an insurance program and the benefits are limited to benefits provided under s. 408.9091, F.S., and that such coverage is an alternative to coverage without such limitations.

2. Florida Health Choices Program
The House amendment creates the Florida Health Choices Program. The program is designed to be a single, centralized market for the sale and purchase of health care products including, but not limited to, health insurance plans, HMO plans, prepaid services, service contracts, and flexible spending accounts. Policies sold as part of the program would be exempt from regulation under the Insurance Code and laws governing health maintenance organizations. The following entities are authorized to be eligible vendors of these products and plans: (1) insurers authorized under ch. 624, F.S., (2) HMOs authorized under ch. 641, F.S., (3) prepaid health clinics licensed under part II, ch. 641, F.S., (4) health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers, (5) provider organizations, including services networks, group practices, and professional associations, and (6) corporate entities providing specific health services.

The House amendment creates Florida Health Choice, Inc., as a not-for-profit corporation under ch. 617, F.S. The corporation would administer the program and function like a third-party administrator (TPA) for employers participating in the program. The corporation can collect premiums and other payments from employers. The corporation is not required to maintain any level of bonding. The corporation is responsible for certifying vendors and ensuring the validity of their offerings. The House amendment does not require or specify any type of independent actuarial or financial reporting by the vendors to the corporation or the submission of such reports or any marketing materials or forms to a regulator, such as the Office of Insurance Regulation or the Agency for Health Care Administration, for review, approval or denial.

The corporation is governed by a 15 member board, 5 members appointed by the Governor (agency representative, Department of Management Services representative, the Commissioner of the Office of Insurance Regulation, and two representatives of public employees), 5 members appointed by the Senate, and 5 members appointed by the House. The employees, officers, and directors of the Florida Health Choice, Inc., are not subject to the ethics (conflict of interest) requirements of s. 112.3145, F.S.. However, even though it is silent on the subject, it appears that the corporation is subject to the public records and meeting requirements under chs. 119 and 286, F.S., respectively.[1] However, medical information or other sensitive, personal information received by the corporation regarding employers and employees are not exempt from public records laws since ch. 119, F.S., does not provide such a general exemption. There is no public records exemption bill addressing the records of the corporation. The House amendment provides that the corporation will develop policies and procedures regarding

[1]Florida Office of the Attorney General, Government-in-the-Sunshine Manual, 2007 Edition. Pages 61-62.

conflicts of interest. The House amendment requires the corporation to submit an annual report on its activities to the Legislature and the Governor; however, it does not require an annual independent financial audit and actuarial report of the corporation or authorize the Auditor General to examine the books and records to determine compliance with the statutory requirements. The office and the agency are not authorized to review the books or records of the corporation or vendors.

The House amendment provides that there is no liability on the part of, and no cause of action can arise against, any member of the board or its employees or agents for any action taken by them in the performance of the powers and duties under this act. This provision may waive any liability and cause of action for misfeasance and malfeasance by the board or its employee or agents.

Eligibility and Enrollment-Employers (1-50 employees), certain eligible individuals, cities (population less than 50,000), fiscally constrained counties, vendors (insurers, HMOs, prepaid health clinic providers, out-of-state insurers, health care providers, provider organizations, and corporate entities providing specific services via service contracts), health insurance agents, statutory rural hospitals. Eligible individuals include individual employees of enrolled employers, state employees ineligible for the state group insurance plan, state retirees, and Medicaid reform participants who opt-out.

Health insurance agents serve as buyers' representatives, contingent upon completing specified training and participation agreements. Since an agent is not required to be appointed by an insurer or vendor, it is unclear whether a captive insurer could prohibit an agent from representing such entities.

A consumer purchasing program coverage is required to sign a disclosure regarding the nature of the product, whether it is insurance or not, and that the coverage is subject to certain limitations under the act. If the consumer signs the form, it is presumed that there was an informed, knowing acceptance of such limitations.

The initial enrollment period by an individual participant is a minimum of 12 months. The selection of products and services must be made by an individual participant within 60 days after the date the individual's employer qualified for participation. If an individual fails to enroll within 60 days, the individual is limited to participation in flexible spending account services until the next enrollment period. This provision could be a mandate on some small employer to establish a flexible spending account, resulting in additional administrative costs to the employer.

Pricing—Allows vendors to establish prices based on age, gender, and location of the participants. The corporation must analyze the prices and compare the costs in relationship to the price and provide such information to individuals participating. The Office of Insurance Regulation is authorized to "review" the methodology. However, the office cannot approve or deny such methodology that is used by the corporation. The corporation is authorized to make a post-enrollment risk adjustment of the premium payments to vendors. The corporation may charge a surcharge of 2.5 percent for administrative costs.

Liquidation or Dissolution—The Department of Financial Services would supervise any such action pursuant to the department's authority under the insurance code relating to liquidation and dissolution under ch. 631, F.S. However, some of these vendors are not insurance entities regulated under ch. 631, F.S., and would be subject to the federal bankruptcy laws. The bill does not expressly exempt these products or services from coverage under Florida Life and Health Insurance Guaranty Association or the Health Maintenance Organization Consumer Assistance Plan in the event of insolvency. The House amendment does not specify the distribution of assets in the event of dissolution of the corporation.

Oversight of Participating Vendors—The corporation may exclude vendors from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement. The amendment does not define financial solvency or require financial or actuarial reports from vendors to determine financial solvency or compliance with the participation agreements. The bill does not define deceptive practices or subject these insurer vendors to the unfair insurance trade practices under part IX of ch. 626, F.S., or non-insurer vendors to part II of ch. 501, F.S. (Florida Deceptive and Unfair Trade Practices Act). Disputes regarding the payment or denial of claims are not governed by the insurance code. Instead, the corporation is responsible for establishing grievance procedures and establishing terms for participation by vendors. It is unclear what recourse an enrollee would have in the event a claim was denied.

Applicability of the Insurance Code—Policies sold under program not subject to the insurance code, ch. 641, or the mandated offerings or coverage established in part VI of ch. 627 and ch. 641. The corporation, acting as TPA is not subject to the licensure requirements of part VII of ch. 626. The program is not subject to the Unfair Insurance Trade Practices Act under part IX of ch. 626, F.S.

Tax Credit—Requires the corporation to work with the Department of Revenue to establish tax credits or refunds for participating employers. A plan must be submitted to the Governor and the Legislature by 1/1/09.

The House proposed General Appropriations Act provides $1,029,561 in non-recurring General Revenue to initially implement the Florida Health Choices Program.

3. Health Flex Plans

The House amendment allows a person who is part of an employer group with at least 75 percent of the employees having income equal to or less than 300 FPL and not covered by private insurance during the last 6 months to be eligible for coverage. If the health flex is an insurer, only 50 percent of the employees must meet the income test.

4. KidCare Program

The House amendment authorizes the direct payment of premium for a qualifying child to be covered as a dependent under an employer family plan when such payment does not exceed the KidCare payment.

5. Dependent Coverage

The House Amendment also provides that until April 1, 2009, a dependent child who qualifies for dependent coverage under this act but whose coverage is terminated may make a written election to reinstate coverage, without proof of insurability. The House Amendment also provides that the changes to dependent coverage do not:

- Require coverage for services provided prior to October 1, 2008 to a dependent;
- Require that an employer pay all or part of the cost of coverage provided for a dependent;
- Prohibit an insurer or HMO from increasing the limiting age for dependent coverage to age 30 in policies and contracts issued or renewed prior to this act's effective date.

Until April 1, 2009, a dependent child who qualifies for dependent coverage (to age 25) but whose coverage terminated may make a written election to reinstate coverage, without proof of insurability. All other dependent children shall be automatically covered until the end of the calendar year in which the child reached the age of 30, unless other limitations apply. The plan may require the payment of a premium by the covered person or dependent child, subject to approval of the office, for any period of coverage relating to a dependent's written election for reinstatement of coverage, and notice of reinstatement must be provided to a covered person in the covered person's certificate of coverage or by his or her employer. Such notice must be given as soon as practicable after July 1, 2008, and may be given through the group policyholder. This provision applies to individual and group insurance policies and HMO contracts.

6. Insurance Code Exemption for Certain Religious Organizations

The House amendment creates an exemption from the Florida Insurance Code for nonprofit religious organizations that qualify under Title 26, s. 501 of the IRS Code. In order to meet this exemption, the nonprofit religious organization must:

- Limit its membership to members of the same religion;
- Act as an organizational clearinghouse for information between participants who have financial, physical, or medical needs and those with the ability to pay for the benefit of those members in need;
- Provide for medical or financial needs of participants through payments directly from one participant to another;
- Suggest amounts that participants may voluntarily give with no assumption of risk or promise to pay either among the participants or between the participants.

7. Prepaid Health Clinics

The House Amendment revises the term, "basic services," for purposes of a prepaid clinic services to include limited hospital inpatient services, which may include hospital inpatient services, up to a maximum coverage benefit of five days and a maximum dollar amount of coverage of $15,000 per calendar year.