The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL:	CS/SB 1922
INTRODUCER:	Banking and Insurance Committee and Senator Garcia
SUBJECT:	Health and Human Services
DATE:	April 25, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Fav/CS**
2.			HR	
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

In 2008, the Florida Legislature created the Florida Health Choices Program (program). The program is designed to provide a centralized marketplace for the sale and purchase of health care products. These products would include, but are not limited to health insurance plans, health maintenance organizations (HMOs) plans, prepaid services, service contracts, and flexible spending accounts. The bill makes the following changes to the program:

- Expands the products, vendors, employers, and individuals that may participate in the program;
- Streamlines and clarifies the process by which new products are approved and offered; and
- Requires the Office of Insurance Regulation (OIR) to approve risk-bearing products.

The bill also exempts specified Medicaid psychiatric facilities from the certificate-of-need review provisions if certain conditions are met.

This bill amends the following sections of the Florida Statutes: 409.821, 409.912, and 408.910.

II. Present Situation:

Florida Health Choices Program

In 2008, the Florida Legislature created the Florida Health Choices Inc., as a not-for-profit corporation. The corporation is responsible for administering the program and functioning like a third-party administrator for employers participating in the program. Products sold as part of the program are exempt from regulation under the Insurance Code and laws governing health maintenance organizations.

Administration of the Program

The corporation is governed by a 15-member board, four members appointed by the Governor, four members appointed by the Senate President, four members appointed by the Speaker of the House of Representatives, and three non-voting members from the following agencies: Agency for Health Care Administration, Department of Management Services, and the Office of Insurance Regulation (OIR). The board members may not include insurers, health insurance agents, health care providers, HMOs, prepaid service providers, or any other entity or affiliate of eligible vendors.

The board may secure staff and consultant services necessary to the operation of the program. The Legislature appropriated $1.5 million in non-recurring funds in 2008 to finance the program.[1] The program is authorized to assess an annual surcharge for each premium or price set by a participating vendor of not more than 2.5 percent of the price to fund administrative services and payments to buyers' representatives or agents.

In the summer of 2011, phase one of the program will be operational. It will offer a central web portal to access and compare multiple insurance products.[2] The initial web-based portal will support a limited number of medical plans and permit a comparison of benefits and costs. The program expects to implement additional features in late 2011 and 2012, including the offering of life insurance and other products.

Eligibility and Enrollment

Small employers (1-50 employees), certain eligible individuals, cities with a population of less than 50,000, fiscally constrained counties, school districts in fiscally constrained counties, and statutory rural hospitals are eligible to enroll. Eligible individuals include individual employees of enrolled employers, state employees ineligible for the state group insurance plan, state retirees, and Medicaid participants who opt-out of the reform program.

Employers are required to establish section 125 plans in order to participate in, and allow their employees to enroll in, the program. This allows both employers and employees to purchase insurance coverage through the program using pre-tax dollars.[3]

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[1] Chapter 2008-32, L.O.F.

[2] See http://myfloridachoices.org/about/ (last viewed March 21, 2011).

[3] Section 125 of the Internal Revenue Code (IRC) allows employers to offer a cafeteria plan to employees for payment of qualified benefits. A cafeteria plan is a separate written plan maintained by an employer for employees meeting the specific requirements of section 125. It provides participants an opportunity to receive certain benefits on a pretax basis. Participants in a cafeteria plan must be permitted to choose among at least one taxable benefit (such as cash) and one qualified benefit. A qualified benefit is a benefit that does not defer compensation and is excludable from an employee's gross income under a

Authorized Vendors

The corporation must certify vendors and ensure the validity of their offerings. The following entities are authorized to be eligible vendors of the products and plans:

- Insurers authorized under ch. 624, F.S.,
- HMOs authorized under ch. 641, F.S.,
- Prepaid health clinics licensed under part II of ch. 641, F.S.,
- Health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers,
- Provider organizations, including services networks, group practices, and professional associations, and
- Corporate entities providing specific health services.

Vendors may not sell products that provide risk-bearing coverage unless those vendors are authorized under a certification of authority issued by the OIR under the Florida Insurance Code. Vendors are required to make all risk-bearing products offered through the program guaranteed-issue policies, subject to preexisting condition exclusions established by the corporation.

Prior to making a risk-bearing product available through the program, the corporation must provide information on the product to the OIR. The OIR has 30 days to review the product and to recommend that it should, or should not, be made available through the program. If the OIR recommends that a risk-bearing product should not be made available, the product may be offered only if a majority of the board vote to include the product.

Pricing; Risk Pooling

Prices for products sold through the program are underwritten based on age, gender, and location of participants. The corporation must develop a methodology for evaluating the actuarial soundness of the product and the methodology is subject to review by the OIR. The corporation must use the methodology to compare the expected costs and benefits of the products, which must be reported to individuals participating in the program. Prices must remain in force for at least one year. The corporation must add a surcharge not to exceed 2.5 percent for each premium or price set by the vendor to generate funding for administrative services provided by the corporation and payments to buyer's representatives (including insurance agents).

The program must utilize methods for pooling the risk of individual participants and preventing selection bias, including a post-enrollment risk adjustment of the premium payments to the vendors. Monthly distributions of payments to the vendors must be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

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specific provision of the IRC, without being subject to the principles of constructive receipt. Qualified benefits include but are not limited to accident and health benefits (but not Archer medical savings accounts or long-term care insurance); adoption assistance; dependent care assistance; group-term life insurance coverage; and health savings accounts. A section 125 plan is the only means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice causing the benefits to become taxable. A plan offering only a choice between taxable benefits is not a section 125 plan. *See* http://www.irs.gov/govt/fslg/article/0,,id=112720,00.html. (last viewed April 18, 2011).

The Federal Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, "PPACA," P.L. 111-148, as amended by the Reconciliation Act, P.L. 111-152. The PPACA is a broad-based, national approach to reform various aspects of the health care system. The PPACA requires most U.S. citizens and legal residents to obtain health insurance by January 1, 2014.

The PPACA also establishes new requirements on employers and health plans; restructures the private health insurance market; and creates exchanges for individuals and employers to obtain coverage. An exchange is not an insurer; however, it would provide eligible individuals and businesses with access to insurers' plans.

If a state decides to establish an exchange, such exchange must be a governmental agency or nonprofit entity. A state may establish a single exchange or multiple subsidiary exchanges if each serves a distinct geographic area. Exchanges may contract with entities in the individual and small group markets and in benefits coverage if the entity is not an insurer, or with the state Medicaid agency. By 2015, exchanges must be self-sufficient and may charge assessments or user fees. If the U.S. Health and Human Services (HHS) determines by January 1, 2013, that a state has opted out of operating an exchange or that it will not have an exchange operational by January 1, 2014, the HHS shall operate an exchange, either directly or through agreement with a non-profit entity.

Effective January 1, 2014, individual coverage will be available through an "American Health Benefit Exchange" and small businesses with 100 or fewer employees can purchase coverage through a "Small Business Health Options Program" (SHOP) exchange. However, a state may merge the individual and small business exchanges into a single exchange. Businesses with more than 100 employees can purchase coverage in an exchange beginning in 2017.

Florida and 25 other states brought an action in the United States District Court for the Northern District of Florida challenging the constitutionality of PPACA. On January 31, 2011, Judge Roger Vinson found the Act unconstitutional.[4] The court rejected the argument by the United States that the individual mandate is a tax and made it clear that he agreed with the plaintiff's argument that the power the individual mandate seeks to harness "is simply without precedent." On March 3, 2011, Judge Vinson granted a stay of his order on the condition that the federal government seek an immediate appeal and seek an expedited review. The federal government filed the appeal and motion for expedited review to the United State Court of Appeal for the Eleventh Circuit on March 8, 2011.[5] Florida and the other plaintiffs have filed a motion requesting a more condensed briefing and oral argument schedule than requested by the federal government. The Eleventh Circuit responded on March 11, 2011, setting the briefing schedule beginning on April 4, 2011, and ending May 25, 2011.[6]

[4] State of Florida, et al. v. United States Department of Health and Human Services, et al., --- F.Supp.2d ----, 2011 WL 285683 (N.D.Fla.).

[5] Case No. 11-11021-HH.

[6] State of Fla., et al. v. U.S. Dept. of Health & Human Serv., Nos. 11-11021-HH & 11-11067-HH, Order on Appellants' Mtn. to Expedite Appeal (11th Cir. March 11, 2011).

Medicaid Health Care Facilities/Certificate of Need
Pursuant to the Medicaid provisions of s. 409.912, F.S., the Agency for Health Care Administration (agency) is responsible for the procurement of goods and services for Medicaid recipients in Florida. Section 409.912(41), F.S., requires the agency to provide for the development of a demonstration project in Miami-Dade County of a long-term care facility to improve the access to health care and to evaluate alternatives to nursing home care and general acute care for such population. The establishment of this project is exempt from the certificate-of-need review provisions of ss. 408.036 and 408.039, F.S.

III. Effect of Proposed Changes:

Section 1 amends various provisions of s. 408.910, F.S., relating to Florida Health Choices, Inc. The bill defines the term, "corporation's marketplace" to mean a single, centralized market established by the program to facilitate the purchase of products certified by the corporation. The bill expands the definition of the term, "insurer," to include health maintenance organizations, prepaid limited health services organizations, and discount medical plan organizations.

The bill revises the eligibility and enrollment provisions in the following manner:

- Removes the eligibility restriction for employers to have 1 to 50 employees, and allows the employers to meet the criteria as established by the corporation and elect to make their employees to be eligible for more than one or more health plans offered;
- Allows any Medicaid recipient who opts-out of Medicaid to participate in the program rather than only Medicaid reform participants;
- Expands the vendors that may offer products through the program to include health maintenance organizations, prepaid limited health service organizations, and discount medical plan organizations;
- Requires the OIR to approve risk-bearing products and their rates; thereby eliminating the need for the program to develop a methodology to evaluate the actuarial soundness of the premiums;
- Provides that any non-risk-bearing products must be approved by the corporation;
- Authorizes the program to establish product price based on age, gender, family composition, location of the individual participant, which may include medical underwriting;
- Eliminates the requirement that all risk-bearing products must be offered on a guaranteed-issue basis;
- Requires the program to operate a toll-free hotline that will assist enrollees, prospective enrollees, vendors, and other participants;
- Authorizes the program to provide specified enrollment periods;
- Authorizes the program to establish options for employer participation, which may conform to common insurance practices;
- Eliminates the plan for tax credits to be made available to participating employers;
- Deletes the one-year enrollment requirement for all types of products; and
- Requires the program to operate a toll-free hotline.

The bill also provides technical and conforming changes.

Section 2 amends s. 409.821, F.S., to require the disclosure of personal identifying information about a Florida Kidcare Program applicant or enrollee to the program by the Agency for Health Care Administration, the Department of Children and Families, the Department of Health, or the Florida Healthy Kids Corporation for administration of the program.

Section 3 amends s. 409.912, F.S., relating to Medicaid goods and services, to exempt specified Medicaid psychiatric facilities from the certificate-of-need provisions of ss. 408.036 and 408.039, F.S., if certain conditions are met. Currently, long-term care facilities meeting specified criteria are exempt from such certificate-of-need provisions.

Section 4 provides that the bill will take effect July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill expands the pool of eligible individuals and employers that would have access to a variety of products offered by the program.

In 2008, the Legislature appropriated $1.5 million in non-recurring funds to Florida Health Choices, Inc., to implement the program. Under current law, the program is authorized to assess an annual surcharge for each premium or price set by a participating vendor of not more than 2.5 percent of the price to fund administrative services and payments to buyers' representatives or agents. The implementation of a toll-free hotline carries an indeterminate, and possibly significant, fiscal impact. The program will need to purchase hardware and software to establish, operate, and maintain the hotline. Additional staff will also need to be hired and trained. If the program chooses to outsource the operation of the hotline, that action will also carry a fiscal impact on the corporation.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Banking and Insurance Committee on April 25, 2011:

The bill provides the following changes relating to the Florida Health Choices program:

- Expands the products, vendors, employers, and individuals that may participate in the program;
- Requires the OIR to approve risk-bearing products offered through the program;
- Eliminates the requirement that all risk-bearing products must be offered on a guaranteed-issue basis;
- Authorizes the program to establish options for employer participation that may conform to common insurance practices.
- Eliminates the plan for tax credits to be made available to participating employers;
- Requires the program to establish a toll-free hotline; and
- Authorizes specified enrollment periods.

The bill also exempts specified Medicaid psychiatric facilities from the certificate-of-need review provisions if certain conditions are met.

B. Amendments:

None.