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:	SB 1922
INTRODUCER:	Senator Garcia
SUBJECT:	Health Insurance
DATE:	April 19, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Pre-meeting**
2.			HR	
3.			BC	
4.				
5.				
6.				

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 categories of employees and employers eligible for enrollment;
- Streamlines and clarifies the process by which new products are approved and offered;
- Authorizes HMOs to sell contracts under the program; and
- Requires the Office of Insurance Regulation (OIR) to approve risk-bearing products that are sold by insurers and HMOs.

This bill amends the following sections of the Florida Statutes: 409.821 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 (TPA) 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. A total of $1.5 million in non-recurring funds was appropriated in 2008 from the General Revenue Fund to finance the program. 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.[1] 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.[2]

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.,

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

[2] 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 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).

- 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.

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.[3] 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.[4] 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.[5]

III. Effect of Proposed Changes:

Section 1 amends section 408.910(2), F.S., relating to Florida Health Choices, Inc.

Definitions
The bill creates definitions for the following terms:

- "Corporation's marketplace" means a single, centralized market established by the program to facilitate the purchase of products certified by the corporation.
- "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plans contract, or HMO contract.

[3] 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.).
[4] Case No. 11-11021-HH.
[5] 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).

- Small employer" means an employer with an average of not more than 50 employees during the preceding calendar year;
  - All employees are counted, including part-time and those not eligible for coverage through the employer;
  - A newly existing employer is allowed to base eligibility on a reasonably expected number of employees; and
  - A small employer is allowed to maintain coverage if his or her number of employees exceed 50.

Eligibility and Administration of the Program
The bill revises the eligibility and enrollment provisions in the following manner:

- Remove 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 all Medicaid recipients who opt-out of Medicaid to participate in the program rather than only Medicaid reform participants;
- Requires the OIR to approve risk-bearing products that are regulated under ch. 624 or part I of ch. 641, F.S., and are available through the program;
- Clarifies that s. 408.910, F.S., does not preempt the authority of the OIR to regulate the business of insurance in Florida;
- Provides that any non-risk-bearing products other than those specifically subject to OIR's regulation must be approved by the corporation;
- Removes the requirement that the program develop a methodology by which it will evaluate the actuarial soundness of the products and premiums offered by the plan and eliminates the process for the program seek guidance from OIR regarding the approval or denial of inclusion of a plan or product;
- Requires the program to operate a toll-free hotline that will assist enrollees, prospective enrollees, vendors, and other participants;
- 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 operation of a toll-free hotline

The bill provides technical, conforming changes, such as including HMOs and their products.

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 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:

In 2008, the Legislature appropriated $1,000,000 in non-recurring General Revenue to the Florida Health Choices, Inc., to implement the program. 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 requirement that the program operate a toll-free hotline to respond to requests for assistance regarding the marketplace 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.

B. Private Sector Impact:

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

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The bill provides a definition of the term, "small employer," that differs substantially with the definition of a small employer as provided in the Insurance Code. Small employer is defined in s. 627.6699(3)(v), F.S., to mean, in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year the majority of whom were employed in this state, employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of eligible employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single employer. For purposes of this

section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.

The bill provides a definition of "health benefit plan" that differs substantially from the definition in the Insurance Code. The term "health benefit plan" is defined for small group coverage in s. 627.6699(3)(k), F.S., to means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

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.)

None.

B. Amendments:

None.