FINAL BILL ANALYSIS

BILL #: *CS/CS/HB 445*

FINAL HOUSE FLOOR ACTION:
115 Y's *0 N's*

SPONSOR: *Rep. Ingram*

GOVERNOR'S ACTION: Approved

COMPANION BILLS: *CS/CS/SB 1522*

SUMMARY ANALYSIS

CS/CS/HB 445 passed the House on April 29, 2011, and subsequently passed the Senate on May 3, 2011. The bill was approved by the Governor on June 17, 2011, chapter 2011-167, Laws of Florida, and takes effect July 1, 2011.

The Health Insurance Portability and Accountability Act of 1996 generally prohibits group health plans from charging similarly situated individuals different premiums or requiring other additional payments on the basis of a health factor. An exception exists for plans that offer rewards or incentives for member participation in health or wellness programs under specified circumstances.

Health insurers and health maintenance organizations (HMOs) are permitted to provide for a rebate of premiums paid on an individual health insurance policy when a covered individual enrolls in and maintains participation in a health wellness, maintenance or improvement program approved by the insurer. The premium rebate is effective for the covered individual on an annual basis.

For group health plans, a rebate of premiums paid during the preceding year is provided to members of the plan when the majority of members have enrolled in and maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan.

Evidence of maintenance or improvement of the enrollees' health status is achieved through assessment of health status indicators.

CS/CS/HB 445 permits group or individual health insurers and HMOs to offer a voluntary health or wellness improvement program to insureds. The bill also permits rewards and incentives to be offered for participation in the program. Those rewards and incentives may include, but are not limited to, merchandise, premium discounts, and modifications to copayment, deductible, or coinsurance amounts. The bill does not prohibit the offering of rewards and incentives that may otherwise be permitted by law. A reward or incentive offered by an insurer or HMO, pursuant to this bill, must be disclosed in the policy or certificate of coverage.

The bill allows insurers and HMOs to request verification of a member's inability to participate in a voluntary health or wellness improvement program due to a medical condition. Verification may be in the form of a statement from the member's treating physician concluding that it is difficult or inadvisable for the member to participate in a health or wellness improvement program.

The bill could have a positive fiscal impact on the private sector. It does not have a direct fiscal impact on state and local governments.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Current Situation

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) generally prohibits group health plans from charging similarly situated individuals different premiums or requiring other additional payments on the basis of a health factor. An exception exists for plans that offer rewards or incentives for member participation in health or wellness programs. If the receipt of a reward or incentive is not conditioned on the individual satisfying a standard related to a health factor, or if no reward or incentive is offered for participation, then the health or wellness program satisfies the nondiscrimination provisions of HIPAA. However, if the group health plan offers a reward or incentive for member participation in a health or wellness program that is based on the individual satisfying a health factor standard, then the program must meet five requirements. These are:

- The total reward or incentive is limited, generally to no more than 20% of the cost of coverage under the plan to the individual or family;
- The program must be reasonably designed to promote health and prevent disease;
- The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year;
- The reward or incentive must be available to all individuals similarly situated and must allow a reasonable alternative standard for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the standard; and
- The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard.

If the plan's program does not base any reward on outcome, it is permitted under the HIPAA nondiscrimination provisions without being subject to the five requirements above.[1]

Chapters 626 and 627, F.S., contain provisions relating to health insurers and health insurance policies in Florida. Chapter 641, Part I, F.S., provides for regulation of HMOs. The Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including HMOs, authorized under the Florida Insurance Code.[2, 3]

Under current law, insurers are permitted to provide for a rebate of premiums paid on an individual health insurance policy when a covered individual enrolls in and maintains participation in a health wellness, maintenance or improvement program approved by the insurer.[4] To qualify for any rebate offered by the insurer, a covered individual must provide evidence of improvement in his or her health status.[5] The measurement of improvement in health status is accomplished by assessing health status indicators, agreed upon in advance by the individual and the insurer, such as weight loss, decrease in body mass index, and smoking

[1] http://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html (Last viewed on March 15, 2011)
[2] S. 20.121(3)(a)1., F.S.
[3] Chs. 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code".
[4] S. 627.6402(1), F.S.
[5] *Id.*

cessation.[6] The premium rebate is effective for the covered individual on an annual basis, unless the individual fails to maintain his or her health status while participating in the wellness program, or evidence shows that the individual is no longer enrolled in the approved wellness program.[7]

For group health plans offered by insurers, an appropriate rebate of premiums paid during the preceding year, not to exceed 10 percent of paid premiums, is provided to members of the plan when the majority of members have enrolled in and maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan.[8] Evidence of maintenance or improvement of the enrollees' health status is achieved through assessment of health status indicators similar to those included for individual health policies.[9] The group or health insurer may contract with a third party administrator to gather the necessary information regarding enrollees' health status and provide the necessary report to the insurer.[10] The premium rebate is effective for an insured on an annual basis unless the number of participating members in the health wellness, maintenance or improvement program becomes less than the majority of total members eligible for participation in the program.[11]

Any group rate, rating schedule, or rating manual for an HMO policy which provides creditable coverage must provide for an appropriate rebate of premiums paid in the last year when the majority of members under the policy are enrolled in and have maintained participation in any health wellness or improvement program offered by the group contract holder.[12] Premium rebates are also permissible for individual contracts.[13]

Unfair methods of competition and deceptive acts or practices in the sale of insurance policies and the operation of insurance companies are defined by statute.[14] Certain acts are prohibited, including, but not limited to, the following:

- Unlawful rebates;
- Misrepresentations and false advertising of insurance policies;
- Defamation;
- Boycott, coercion and intimidation;
- Unfair claim settlement practices;
- Illegal dealings in premiums, including excess or reduced charges for insurance;
- Refusal to insure on the basis of race, color, creed, marital status, or sex; and
- Misrepresentation of agent qualifications.

Except as provided for in ch. 641, F.S., HMOs are exempt from all other provisions of the Florida Insurance Code. Unfair methods of competition and unfair or deceptive acts or practices, as they relate to an HMO, are addressed in ss. 641.3901 and 641.3903, F.S.

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[6] *Id.*
[7] S. 627.6402(2), F.S.
[8] S. 627.65626(1), F.S.
[9] *Id.*
[10] *Id.*
[11] S. 627.65626(2), F.S.
[12] S. 641.31(40)(a), F.S.
[13] S. 641.31(40)(c), F.S.
[14] S. 626.9541, F.S.

Effect of Changes

To encourage participation in the wellness or health improvement program, the bill permits a health insurer or an HMO to offer incentives or rewards, such as merchandise, premium rebates or savings, or modifications to copayment, deductible, or coinsurance amounts. The bill does not limit other forms of incentives or rewards that may be offered to health plan members for adherence to a wellness or health improvement program that may otherwise be permitted by state or federal law. Any reward or incentive offered by an insurer or HMO must be disclosed in the policy or certificate of coverage. The bill expressly states that the incentives and rewards offered to enrollees in wellness or health improvement programs do not constitute unfair methods of competition or deceptive acts or practices and do not, therefore, violate s. 626.9541, F.S., or s. 641.3903, F.S.

The bill makes clear that a health insurer or an HMO may request documentation from a health plan member to verify that the member has a medical condition that makes it difficult or inadvisable for the member to participate in a voluntary wellness or health improvement program. Documentation may be in the form of a statement from the member's treating physician.

Health insurers and HMOs are not required by the bill to offer wellness or health improvement programs. The decision to do so is voluntary. Participation in a wellness or health improvement program by a health plan member is also voluntary. The bill does not penalize a health plan member for non-participation in a wellness or health improvement program.

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:

See Fiscal Comments.

D. FISCAL COMMENTS:

Voluntary participants could financially benefit from premium discounts or rebates, contributions to a member's health savings account, or modifications to copayment, deductible, or coinsurance amounts allowed as incentives or rewards by this bill. If the health status of participants improves, or health risks, with accompanying medical costs, are avoided, the result could be a positive fiscal impact on the cost of health care for the participants, co-workers, and employers.