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 Committee on Community Affairs

BILL:	CS/SB 1128
INTRODUCER:	Banking and Insurance Committee and Health Policy Committee
SUBJECT:	Health Flex Plans
DATE:	April 12, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall		**hp SB 7014 as introduced**
2.	Johnson	Burgess	BI	**Fav/CS**
3.	Toman	Yeatman	CA	**Pre-meeting**
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:

CS/SB 1128 eliminates the repeal of the Health Flex Program, which is designed to provide affordable, alternative health care coverage for low-income individuals. Without legislative action, the Health Flex program would sunset on July 1, 2013. The bill also allows Health Flex plans coverage to include excepted benefits, such as hospital indemnity or other fixed indemnity insurance, and limited scope dental or vision effective January 1, 2014. Currently, such coverage is health care services that are covered as benefits provided under an approved Health Flex plan or otherwise provided either directly or through arrangements with other persons, via a Health Flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

This bill substantially amends section 408.909, Florida Statutes.

II. Present Situation:

The Health Flex program was created by the 2002 Legislature to address the health insurance needs of Florida's lower income uninsured adult population.[1] At the time, Florida's uninsured

[1] SB 46-E (2003-E Session).

rate was reported as 16.8 percent, or 2.1 million while for those under 150 percent of the federal poverty level (FPL) the rate was reported at 34 percent.[2] Initially launched as a pilot program limited to three areas of the state with the highest incidences of uninsured adults and Indian River County, the program had an original expiration date of July 2004.[3]

Subsequent legislative acts removed the limited geographic reach of the project extending the scope statewide as well as modified the expiration date multiple times until it reached its current expiration date of June 30, 2013.[4] Plans are currently available in six counties: Broward, Hillsborough, Miami-Dade, Palm Beach, Polk, and St. Lucie.[5]

The enacting legislation's intent emphasized alternative approaches for affordable health care options over traditional insurance coverage for the uninsured. Products offered as Health Flex plans were to include basic and preventive health care services and to coordinate with local service programs.[6]

Health Flex plans can be offered through a variety of means, including by licensed insurers, health maintenance organizations (HMOs), health care providers, local governments, health care districts or other public or private organizations.[7] Products sold under the program are not subject to the Florida Insurance Code.[8] As of September 30, 2012, three plans covered 12,127 members.[9]

Plan Name	Enrollment – September 30, 2012
American Care, Inc.	347
Preferred Medical Plan, Inc.	1,630
Vita Health Plan, Inc.	10,150
Total Enrollment:	**12,127**

Eligibility for the program has also been modified multiple times since inception. Today, an individual must meet the following requirements:[10]

- Be a resident of the state;
- Have a family income equal to or less than 300 percent FPL ($69,150 for a family of four based on 2012 federal guidelines);
- Not be covered by a private insurance policy and not be eligible for public coverage such as Medicare, Medicaid, or KidCare, or have not been covered at anytime in the last 6 months;

[2] Analysis for SB 46-E by the Senate Committee on Health, Aging and Long Term Care (April 30, 2002), *available at http://archive.flsenate.gov/data/session/2002E/Senate/bills/analysis/pdf/2002s0046E.hc.pdf (*last visited Feb. 11, 2013).
[3] Id.
[4] *See Chapter Law 2003-405, Chapter Law 2004-270, Chapter Law 2005-231, Chapter Law 2008-32, Chapter Law 2011-195.*
[5] Florida Agency for Health Care Administration and Florida Office of Insurance Regulation, *Health Flex Plan Program, Annual Report,* 3-5, (January 2013).
[6] SB 46-E (2003-E Session).
[7] Section 408.909(1), F.S.
[8] Section 408.909(4), F.S., *supra at n. 2.*
[9] *Supra,* note 5 at 5-6.
[10] *Supra,* note 5, at p. 2-3.

- Have applied for health care coverage through an approved Health Flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or,
- Be part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the Health Flex plan entity is a health insurer, health plan or HMO, only 50 percent of the employees must meet the income requirement.

In addition, if a person did have coverage in the past 6 months under an individual HMO contract licensed in the Florida which was also a licensed Health Flex plan on October 1, 2008, the individual may apply for coverage under that same Health Flex plan without a lapse in coverage if all other eligibility requirements are met. If a person was covered under Medicaid or KidCare and lost eligibility for Medicaid or KidCare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved Health Flex plan, the individual may apply for coverage in a Health Flex plan without a lapse in coverage if all other eligibility requirements are met.

Responsibility for the Health Flex program resides with both the Agency for Health Care Administration (Agency) and the Office of Insurance Regulation (OIR). The Agency and the OIR jointly review applications for Health Flex plans, develop necessary rules, evaluate the program, and produce an annual report. The Agency has primary responsibility for reviewing Health Flex applications and determining whether plans meet quality of care standards and follow standard grievance procedures. The OIR is responsible for monitoring the financial condition of each plan.

Under s. 408.909(4), F.S., the Health Flex plans are not subject to the licensing requirements of the Florida Insurance Code or ch. 641, F.S., relating to HMOs, unless expressly made applicable. However, for the purpose of prohibiting unfair trade practices, Health Flex plans are considered insurance subject to the applicable provisions of part IX of chapter 626, F.S., except as otherwise provided. The plans are not required to cover Florida's mandated benefits or meet solvency requirements. Neither do the current benefits schedules of the Health Flex plans comply with the essential health coverage as the packages do not offer all ten essential health benefit categories based on a review of the web-based marketing materials for the three plans.[11]

In March 2010, Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).[12] Beginning January 1, 2014, the federal government and some states plan to launch one of the largest components of the PPACA legislation, health benefits exchanges.[13] The exchange implementation coincides with the requirement that, with few exceptions, all individuals must maintain a minimum level of health insurance coverage for themselves and

[11] Websites for three Health Flex plans reviewed on February 12, 2013: American Care Plans, *Health Flex Plans*, *http://www.healthflex.org/files/HealthFlexBrochure.pdf*, Preferred Medical Plan, Medi-Flex Plan, https://www.pmphmo.com/plans.php, and Vita Health Plan, http://www.vitahealth.org/index.aspx?page=453, (last visited Apr. 12, 2013).
[12] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).
[13] *Id.*

their dependants.[14] Subsidies, advanced premium tax credits, and out of pocket cost sharing maximums become effective at the same time to assist lower income enrollees with the cost of that coverage.[15] These premium assistance measures assist individuals at varying levels from 100 percent FPL up to 400 percent FPL ($45,960 for an individual in 2013).[16]

Health care coverage will be available through Medicaid or the Children's Health Insurance Program (CHIP) for the lowest income individuals. Children are covered under Medicaid or CHIP in Florida currently up to 200 percent FPL.[17] The state may also elect to extend Medicaid eligibility to adults up to 133 percent FPL.[18, 19]

Under PPACA, a state may operate its own exchange, partner with the federal government, or default to a federal exchange.[20] Regardless of the option selected by a state, individuals will have a choice of qualified health plans that meet established standards and offer the minimum set of essential health benefits. In order to be offered on the exchanges, a health plan has to offer the benefits in ten categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.[21]

The essential health benefits requirement does not apply to all plans, including certain self-insured group plans, health insurance coverage offered in the large group market, and grandfathered health plans.[22] Individuals who do not maintain health insurance coverage that meets the PPACA minimum requirements and cannot show a hardship or meet some other allowable exemption, will be subject to a tax penalty.[23] To qualify for the hardship exemption, an individual who is not eligible for Medicaid and who is above the filing threshold for income taxes must show that the cost of his or her contribution towards self-only coverage for a calendar year will exceed 8 percent of household income.[24]

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[14] Hinda Chaikind, *Individual Mandate and Related Information Requirements under PPACA*¸ Congressional Research Service, 1, (September 21, 2010), *http://www.ncsl.org/documents/health/Individual_Mandate_Under_PPACA_pdf.*, *(*last visited Feb. 11, 2013).
[15] Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Subsidies* (July 2012), http://www.kff.org/healthreform/upload/7962-02.pdf (last visited Apr. 12, 2013).
[16] 78 FR 5182 (5182-5183), January 24, 2013.
[17] State of Florida, Florida KidCare Program, Title XXI State Plan, *Amendment #22, (5),* http://www.fdhc.state.fl.us/medicaid/medikids/PDF/KidCare_Program_Amendment_21_to_Titlle_XXI_2012-07-01.pdf , (last visited Apr. 12, 2013).
[18] *Supra, Note 10.*
[19] *National Federal of Independent Business (NFIB) et al v. Sebelius,* 567 U.S., ___(2012).
[20] Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, *General Guidance on Federally-facilitated Exchanges*, (May 16, 2012), http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf (last visited Apr. 12, 2013).
[21] Healthcare.gov, http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html, (last visited Apr. 12, 2013).
[22] PPACA exempts "grandfathered health plan coverage" from many of its insurance requirements. For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. Grandfathered health plan coverage is tied to the individual or employer who obtained the coverage, not to the policy or contract form itself. PPACA s. 1251; 42 U.S.C. s. 18011; 45 C.F.R. s. 147.140.
[23] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).
[24] Chaikind, *supra* Note 14 at 3.

Under the federal definitions of health insurance coverage, coverage includes medical and hospital benefits that are offered by an issuer licensed in the state and whose coverage is regulated by that state.[25] Some insurance coverage may meet the definition of excepted benefits, which would not qualify as minimum essential coverage for the individual mandate.[26] Examples of excepted benefits would include coverage limited to dental or on-site medical clinics.[27] Excepted benefit plans are not required to provide the essential health benefits.

III. Effect of Proposed Changes:

The bill eliminates the repeal of the Health Flex program that was scheduled to be effective July 1, 2013. Instead, the bill eliminates any reference to a termination date. Effective January 1, 2014, the bill also allows Health Flex plans coverage to include excepted benefits (such as hospital indemnity or other fixed indemnity insurance, and limited scope dental or vision), as provided in s. 627.6561(5)(b),(c), and (d), F.S. Currently, coverage is health care services that are covered as benefits provided under an approved Health Flex plan or otherwise provided either directly or through arrangements with other persons, via a Health Flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

This act would take effect June 30, 2013.

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:

Currently, individuals eligible for enrollment in the Health Flex program are at or below 300 percent FPL. Under PPACA, premium tax credits, and subsidies would be available for qualified individuals between 100 FPL and 400 FPL who obtain coverage in the

[25] 42 U.S.C. s. 300gg-91(b).
[26] Chaikind, *supra* note 14, at 1-2.
[27] 42 U.S.C. s. 300gg-91(c)

exchange. It is anticipated that many individuals above 100 FPL may transition to the exchange.

However, individuals below 100 FPL are not eligible for premium tax credits or subsidies through an exchange. If Florida elects not to expand Medicaid for adults to 133 percent FPL, there may be a gap in subsidized coverage options for individuals under 100 percent FPL. The bill would continue access to affordable, alternative coverage through the Health Flex plan.

C. Government Sector Impact:

One plan, Vita offered by the Health Care District of Palm Beach County, offsets the cost of coverage. The Health Care District currently subsidizes approximately two thirds of the total premium with the enrollee paying the remaining one third of the total premium.[28] The estimated number of individuals that would transition from Health Flex plans to the exchange is indeterminate at this time. The fiscal impact on the District is unknown at this time.

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.)

CS by Banking and Insurance on April 9, 2013:
The CS eliminates the sunset date of the Health Flex program and also allows such coverage to include excepted benefits as well as current benefits specified in s. 408.909(2)(d), F.S.

B. Amendments:

None.

[28] *Supra,* Note 5, at 6.