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 Health Policy

BILL: SPB 7014

INTRODUCER: For Consideration by Health Policy Committee

SUBJECT: Health Flex Plans

DATE: February 11, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall		**Submitted as Committee Bill**
2.				
3.				
4.				
5.				
6.				

I. Summary:

SPB 7014 extends the termination date of the Health Flex program to January 1, 2014 or upon the availability of qualified health plans through an exchange, whichever occurs later. Without legislative action, the Health Flex program will sunset on July 1, 2013.

This proposed 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 rate was reported as 16.8%, or 2.1 million while for those under 150% of the federal poverty level (FPL) the rate was reported at 34%.[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

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

[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.

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 cover 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% 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 six months;
- If a person did have coverage in the past six months under an individual health maintenance organization (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;
- 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,

[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] s. 408.909(1), F.S.
[8] s. 408.909(4), F.S., *supra at n. 2.*
[9] *Supra,* note 5 at 5-6.
[10] *Supra,* note 5, at p. 2-3.

- 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 six 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.

Responsibility for the Health Flex program resides with both the Agency for Health Care Administration (Agency) and the Office of Insurance Regulation (Office). The Agency and Office 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 Office is responsible for monitoring the financial viability of each plan.

In March 2010, Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).[11] 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.[12] 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 their dependants.[13] New 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.[14] These premium assistance measures assist individuals at varying levels from 100% FPL up to 400% FPL ($45,960 for an individual in 2013).[15]

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% FPL.[16] The state may also elect to extend Medicaid eligibility to adults up to 133% FPL.[17, 18]

Under PPACA, a state could opt to run its own exchange, partner with the federal government or default to a federal exchange.[19] 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

[11]Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).
[12]*Id.*
[13]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).
[14]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 Feb. 13, 2013).
[15]78 FR 5182 (5182-5183), January 24, 2013.
[16]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 Feb. 11, 2013).
[17]*Supra, Note 10.*
[18]*National Federal of Independent Business (NFIB) et al v. Sebelius,* 567 U.S., ___(2012).
[19]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 Feb. 11, 2013).

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.[20]

The essential health benefits requirement does not apply to all plans, including certain current self-insured group plans, health insurance coverage offered in the large group market, and grandfathered health plans. However, non-grandfathered plans that will be offered in 2014 and later both in the new exchanges and outside the exchanges must cover these essential health benefits.[21]

A grandfathered health plan is a plan that existed on March 23, 2010, the date that PPACA was enacted, and that at least one person had been continuously covered for one year.[22] Some consumer protection elements do not apply to grandfathered plans that were part of PPACA but others are applicable, regardless of the type of plan.[23] Providing the essential health benefits are also not required of grandfathered health plans.[24] Additionally, a grandfathered plan can lose its status if significant changes to benefits or cost sharing changes are made to the plan since attaining its grandfathered status.[25] Grandfathered plans are required to disclose their status to their enrollees every time plan materials are distributed and to identify the consumer protections that are not available as a grandfathered plan.[26]

Individuals that do not maintain coverage that meets the PPACA minimum requirements and cannot show a hardship will be subject to a penalty.[27] 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.[28]

Under the federal definitions of health insurance coverage and health insurance issuer, coverage includes medical and hospital benefits that are offered by an issuer that is licensed in the state and whose coverage is regulated by that state.[29] Some health coverage may also meet the definition of excepted benefits which would not qualify as minimum essential coverage for the

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[20] Healthcare.gov., http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html, (last visited Feb. 11, 2013).
[21] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin (December 16, 2011), http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf,* (last visited Feb. 11, 2013).
[22] Healthcare.gov, *Grandfathered Health Plans, http://www.healthcare.gov/law/features/rights/grandfathered-plans/index.html* (Last visited Feb.11, 2013).
[23] Healthcare.gov., http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html, (last visited Feb. 11, 2013).
[24] Sarah Barr, *FAQ: Grandfathered Health Plans* (Dec. 2012), http://www.kaiserhealthnews.org/stories/2012/december/17/grandfathered-plans-faq.aspx (last visited Feb. 12, 2013).
[25] Healthcare.gov, *Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered Health Plans* (June 14, 2010), http://www.healthcare.gov/news/factsheets/2010/06/keeping-the-health-plan-you-have-grandfathered.html (last visited Feb. 12, 2013).
[26] *Id.*
[27] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).
[28] Chaikind, *supra* Note 13 at 3.
[29] 42 U.S.C. s.300gg-91(b).

individual mandate.[30] Examples of excepted benefits would include coverage limited to dental or on-site medical clinics.[31]

Under s. 409.909(4), F.S., the Health Flex plans are not currently subject to the Florida Insurance Code and are not considered an insured product. 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 incorporate all ten essential health benefit categories based on a review of the web based marketing materials for the three plans.[32]

III. Effect of Proposed Changes:

The bill modifies subsection (10) of s. 409.909, F.S. in order to extend the expiration date for Health Flex plans from June 30, 2013, to January 1, 2014, or upon availability of qualified health plans through an exchange, whichever occurs later. This date extension corresponds to the implementation date of the major components of the Patient Protection and Affordable Care Act (PPACA) relating to exchanges and the individual mandate for insurance coverage.

Given that varying levels of subsidies, advance payment of premium tax credits and other cost sharing limitations are available for individuals up to 400% FPL and those served by the Health Flex program are under 300% FPL, coverage options should be available for most individuals currently under the Health Flex program in the Exchange.

Other Potential Implications:

Open enrollment for the exchanges begins October 1, 2013, for January 1, 2014, enrollment. Participants in the Health Flex program should be given ample notice by their respective plan of the impending termination of their coverage to allow sufficient application and transition time to other coverage.

Should Florida elect not to expand Medicaid for adults to 133% FPL, there would be a gap in subsidized coverage options for individuals under 100% FPL.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

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[30]Chaikind, *supra* note 13, at 1-2.
[31]42 U.S.C. s. 300gg-91(c)
[32]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 Feb. 11, 2013).

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private sector employers may participate in the Health Flex program and can contribute towards the cost of their employees' health coverage. Other options for contributing towards the cost of employees' health coverage will be available in the Exchange.

With the termination of the Health Flex program, enrollees would likely transition into the exchanges to access premium subsidies or Medicaid, if Florida extends eligibility to the adult population, as appropriate to their income level.

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.[33] Upon termination of this program, the District would be able to redirect these funds.

With the termination of the Health Flex program, enrollees would likely transition into the exchanges to access premium subsidies or Medicaid, if Florida extends eligibility to the adult population, as appropriate to their income level.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The exchanges under PPACA are scheduled to hold their first open enrollment period starting October 1, 2013, for effective dates as early as January 1, 2014. The Agency, Office and the Health Care District of Palm Beach County which is the plan with the largest Health Flex plan enrollment, have expressed concern as to whether or not existing Health Flex plan members will successfully transition during the inaugural open enrollment period. These entities have suggested an additional extension beyond January 1, 2014, may be necessary to ensure enrollees have sufficient time to find other coverage.

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

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.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.