FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 497	**COMPANION BILL:** SB 480 (DiCeglie)
TITLE: Health Coverage by Nonprofit Agricultural Organizations	**LINKED BILLS:** None
SPONSOR(S): Grow	**RELATED BILLS:** None

Committee References

Insurance & Banking
16 Y, 0 N, As CS
➤ Health Care Facilities & Systems
➤ Commerce

SUMMARY

Effect of the Bill:

The bill establishes a framework allowing nonprofit agricultural organizations to offer medical benefit plans to their members. To qualify, an organization must:

- Be based in Florida;
- Be tax-exempt under s. 501(c)(3) of the Internal Revenue Code;
- Be focused on supporting rural communities and farmers;
- Collect annual dues;
- Have existed since before 1945; and
- Have members across most of the state.

The bill specifies that these medical benefit plans are not considered insurance under the Florida Insurance Code and requires organizations offering such plans to include a disclaimer on all applications and marketing materials.

The bill prohibits the sale or marketing of these plans through licensed insurance agents and mandates an annual financial audit conducted by an independent certified public accountant, which must be publicly accessible.

Fiscal or Economic Impact:

The bill may have a negative fiscal impact on state government revenues. It has no fiscal impact on state government expenses or local government revenues or expenses. It may have a positive economic impact on the private sector.

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ANALYSIS

EFFECT OF THE BILL:

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- Be tax-exempt under s. 501(c)(3) of the Internal Revenue Code;
- Be focused on supporting rural communities and farmers;
- Collect annual dues;
- Have existed since before 1945; and
- Have members across most of the state. (Section 1)

The bill specifies that these medical benefit plans are not considered insurance under the Florida Insurance Code and requires organizations offering such plans to include a disclaimer on all applications and marketing materials. (Section 1).

The bill prohibits the sale or marketing of these plans through licensed insurance agents and mandates an annual financial audit conducted by an independent certified public accountant, which must be publicly accessible. (Section 1).

The bill takes effect on July 1, 2025. (Section 2).

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

Insurance premium tax revenues may be reduced to the extent that purchasers of health coverage shift their business from health insurance to the exempt health coverage proposed by the bill.

PRIVATE SECTOR:

Members of eligible nonprofit agricultural organizations may realize savings on health coverage to the extent that health coverage products offered by such organizations are priced lower that insurance products that they may already purchase.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Health Insurance

Health insurance is the insurance of human beings against bodily injury or disablement by accident or sickness, including the expenses associated with such injury, disablement, or sickness.[1] Individuals purchase health insurance coverage with the purpose of managing anticipated expenses related to health or protecting themselves from unexpected medical bills or large health care costs. Managed care is the most common delivery system for medical care today by health insurers.[2] Managed care systems combine the delivery and financing of health care services by limiting the choice of doctors and hospitals.[3] In return for this limited choice, however, medical care is less costly due to the managed care network's ability to control health care services. Some common forms of managed care are preferred provider organizations[4] (PPO) and health maintenance organizations[5] (HMO).

Office of Insurance Regulation

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[6] The Financial Services Commission (FSC), composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as the OIR agency head for purposes of rulemaking. Further, the FSC appoints the OIR Commissioner.

As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.[7] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[8] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[9] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code (FIC).[10]

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[1] S. 624.603, F.S.
[2] Florida Department of Financial Services, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers,* available at: https://www.myfloridacfo.com/docs-sf/consumer-services-libraries/ (last visited Feb. 26, 2025).
[3] *Id.*
[4] S. 627.6471, F.S.
[5] Part I of ch. 641, F.S.
[6] S. 20.121(3)(a), F.S.
[7] S. 624.418, F.S.
[8] s. 624.316(1)(a), F.S.
[9] S. 624.318(2), F.S.
[10] *See* S. 624.3161, F.S. The Code is comprised of chs. 624-632, 634-636, 641, 642, 648, and 651, F.S. S. 624.01, F.S.

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) in Florida operate within a regulatory framework overseen by OIR. To offer health insurance plans in Florida, HMOs must obtain a license from the OIR.[11] Managed care plans are the primary offerings of HMOs in Florida. These plans provide comprehensive healthcare services to members for a fixed monthly premium.[12] Members typically select a primary care physician from within the HMO's network, who serves as the main point of contact for all healthcare needs and referrals to specialists.[13]

HMOs maintain networks of healthcare providers, including primary care physicians, specialists, hospitals, and other healthcare facilities.[14] Members are generally required to receive care from within the HMO's network, with exceptions for emergencies or authorized out-of-network care.[15]

Florida law provides various consumer protections for individuals enrolled in HMO plans, including guaranteed access to emergency services, coverage for essential health benefits mandated by the Affordable Care Act, and the right to appeal coverage decisions made by the HMO.[16]

Association Health Plans (AHPs)

An association health plan (AHP) is a group purchasing arrangement in which members of a trade group or professional association jointly obtain health insurance for employees. These arrangements differ from traditional group insurance by their unique structure, since they involve the purchase of insurance products across multiple employers.

On June 21, 2018, the Employee Benefits Security Administration within the federal Department of Labor (DOL) issued a final rule amending the parameters for association health plans (AHPs),[17] consistent with the directives of a 2017 Presidential Executive Order.[18] The revised regulations were intended to give an employer greater flexibility to participate in an AHP. The new federal rule, among other things, permitted establishing an AHP for the explicit purpose of providing health coverage, so long as the association has another legitimate purpose for members and allowed the self-employed and sole proprietors to participate in an AHP.[19] Overall, the federal rule was designed to offer an expanded pathway for the establishment of an AHP.

In July 2018, eleven states[20] and the District of Columbia sued the DOL, alleging the final rule, and particularly the rule's provisions on bona fide association and working owner provisions, conflicted with the text and purpose of Employee Retirement Income Security Act (ERISA) and Patient Portability and Affordable Care Act (PPACA), and exceeded DOL's statutory authority.[21] On March 28, 2019, the U.S. District Court for the District of Columbia agreed with the states, finding that the DOL unreasonably expanded ERISA's definition of "employers" as an end run around the requirements of PPACA.[22] The court struck down the portions of the DOL's AHP rule that expanded the ability of small businesses and owners to buy health insurance on the large group market that was not subject to PPACA requirements that apply to the small group market.[23]

State Regulation of AHPs

The regulatory oversight of health insurance is generally reserved to the states, except when explicitly preempted by federal law. In Florida, OIR is responsible for all activities concerning insurers and other risk bearing entities,

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[11] S. 641.21(1), F.S.
[12] Medicare, What's an HMO? https://www.medicare.gov/health-drug-plans/health-plans/. (last visited Feb. 26, 2025).
[13] *Id.*
[14] S. 641.19(12), F.S.
[15] Medicare, *What's an HMO?*, https://www.medicare.gov/health-drug-plans/health-plans/. (last visited Feb. 26, 2025).
[16] Consumer Services, *Health Insurance & HMO Overview*, https://www.myfloridacfo.com/division/consumers/understanding-insurance/health-insurance-and-hmo-overview (last visited Feb. 26, 2025).
[17] Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans, 83 FR 28912. June 21, 2018.
[18] Promoting Healthcare Choice and Competition Across the United States, 82 FR 48385. October 21, 2017.
[19] Milliman, Inc., *"Association health plans after the final rule"*, August 22, 2018, available at http://www.milliman.com/insight/2018/Association-health-plans-after-the-final-rule/ (last viewed on Feb. 26, 2025).
[20] California, Delaware, Kentucky, Maryland, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, Virginia, and Washington.
[21] State of New York, et al. v. U.S. Department of Labor, et al., No. 1:18-cv-01747 (D.D.C. Mar. 28, 2019).
[22] *Id.*
[23] *Id.*

including licensing, rates, policy forms, market conduct, claims, issuing certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the FIC.[24]

All health insurance policies issued in Florida, with the exception of certain self-insured policies,[25] must meet certain requirements that are detailed throughout the FIC. Ch. 627, F.S., sets parameters and requirements for health insurance policies and ch. 641, F.S., provides requirements for health plans issued by HMOs. At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[26]

Florida Life and Health Insurance Guaranty Association

A guaranty association is typically a nonprofit corporation established by law to safeguard policyholders against financial losses and delays in claim payment and settlement resulting from the insolvency of an insurance company. In the event of an insolvency of a member, the guaranty association takes over the servicing of claims on eligible policies. Authorized insurers in Florida are typically required to participate in the applicable guaranty association for the relevant line of insurance as a condition of eligibility to transact insurance in the state.

Section 631.715, F.S., establishes the Florida Life and Health Insurance Guaranty Association (FLHIGA). Every insurer licensed to sell direct life insurance policies, health insurance policies, annuity contracts, and supplemental contracts in the state must participate in FLHIGA as a requirement for conducting business in Florida.[27] FLHIGA functions as a nonprofit corporation, governed by a Board of Directors consisting of nine to eleven members appointed by member insurers.[28]

Health Coverage or Services Exempt from Florida's Insurance Code

Florida law exempts nonprofit religious organizations,[29] commonly known as health care sharing ministries (HCSMs), from the regulatory requirements and consumer protections of the Florida Insurance Code if they meet the following criteria:

- Qualify as a tax-exempt organization under s. 501 of the Internal Revenue Code of 1986, as amended.[30]
- Limit participation to individuals who share a common set of ethical or religious beliefs.[31]
- Act as a facilitator among participants to assist those with financial, physical, or medical needs according to criteria established by the organization.[32]
- Provide for participants' financial or medical needs through voluntary contributions from other participants or direct payments between participants.[33]
- Establish contribution amounts for participants without assuming risk or making a promise to pay among participants or by the organization itself.[34]
- Provide monthly accounting reports to participants detailing the total amount of qualified needs shared in the previous month.[35]
- Conduct an annual financial audit performed by an independent certified public accountant, in accordance with generally accepted accounting principles (GAAP), and make it publicly available upon request or by posting it on the organization's website.[36]

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[24] s. 20.121(3)(a)(1), F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[25] 29 U.S.C. 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida. These plans cannot be regulated by state law.
[26] S. 627.413(1)(d), F.S.
[27] s. 631.716(1), F.S.
[28] *Id.*
[29] S. 624.1265, F.S., refers to health care sharing ministries as "nonprofit religious organizations." A health care sharing ministry is an organization that facilitates the sharing of health care expenses among individuals with similar and sincerely held beliefs. These organizations resemble insurance in that members generally pay monthly membership fees and submit claims when they incur medical bills.
[30] S. 624.1265(1)(a), F.S.
[31] S. 624.1265(1)(b), F.S.
[32] S. 624.1265(1)(c), F.S.
[33] S. 624.1265(1)(d), F.S.
[34] S. 624.1265(1)(e), F.S.
[35] S. 624.1265(1)(f), F.S.
[36] S. 624.1265(1)(g), F.S.

- Do not market or sell health plans through insurance agents licensed by the Department of Financial Services under ch. 626, F.S.[37]

Nonprofit religious organizations must include a written disclaimer in all applications and guideline materials. The disclaimer must state:

"Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Membership is not offered through an insurance company, and the organization is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant is compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payments for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills."[38]

Under the Insurance Code, these requirements do not prevent:
- A participant from limiting the financial or medical needs eligible for payment.[39]
- The nonprofit religious organization from canceling a participant's membership if they fail to meet membership conditions for more than 60 days.[40]

Health Care Sharing Ministries Nationwide
Approximately 30 states have explicitly exempted health care sharing ministries (HCSMs) from insurance regulation.[41] Members of an HCSM typically contribute a monthly payment to cover the medical expenses of other members. HCSMs either match paying members with those in need or pool contributions and distribute payments directly.[42]

Some individuals choose HCSMs due to their lower upfront costs compared to Patient Protection and Affordable Care Act (PPACA)-compliant plans.[43] However, HCSMs are not insurance and cannot guarantee payment of claims. While they may distribute funds to members with medical needs, they are not legally required to do so and do not have to comply with state or federal insurance regulations or consumer protections.[44]

Farm Bureau Health Plan
In a number of states, Farm Bureau Plans (FBPs) have been provided an exemption from regulation by the state's insurance regulatory authority to provide health coverage that is not regulated as an insurance product. The FBPs operate as healthcare options provided by a state's Farm Bureau to its members, typically catering to individuals and families within rural communities, including farmers and agricultural workers. To access FBPs, individuals must join their state's Farm Bureau organization. Membership often entails paying dues to support the Farm Bureau's advocacy and community initiatives. FBPs operate under a unique exemption from state insurance regulations, distinguishing them from traditional health insurance offerings. This exemption allows FBPs to be considered separately from standard health insurance products.

Unlike typical health insurance, FBPs, which predate the Affordable Care Act (ACA), utilize medical underwriting and are not subject to state or federal insurance mandates. Consequently, they can decline applicants based on medical history or impose waiting periods for pre-existing conditions without having to comply with essential health benefit requirements or maximum out-of-pocket limits mandated for ACA-compliant plans. While FBPs aren't classified as insurance, they still provide comprehensive benefits. In every state with FBPs, they typically

[37] S. 624.1265(1)(h), F.S.
[38] S. 624.1265(2)(b)(3), F.S.
[39] S. 624.1265(2)(a), F.S.,
[40] S. 624.1265(2)(b), F.S.
[41] National Association of Insurance Commissioners, What you should know about health care sharing ministries, discount plans, and risk sharing plans, (Dec. 13, 2023), https://content.naic.org/article/what-you-should-know-about-health-care-sharing-ministries-discount-plans-and-risk-sharing-plans (last visited March. 5, 2025).
[42] *Id.*
[43] *Id.*
[44] *Id.*

offer options for comprehensive coverage at reasonable monthly costs, including free or low-cost preventative care, prescription drug coverage, telehealth services, dental and vision care options, and health savings accounts for qualified High Deductible Health Plans, with most plans having no annual or lifetime limits. Unlike individual market plans, participants can enroll in FBPs at any time. [45]

OTHER RESOURCES:

Health Insurance and Health Maintenance Organizations Consumer Guide
Health Insurance & HMO Overview
Association Health Plans After the Final Rule
Farm Bureau Health Coverage Plans

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Insurance & Banking Subcommittee	16 Y, 0 N, As CS	03/5/25	Lloyd	Herrera
THE CHANGES ADOPTED BY THE COMMITTEE:	• Replaces all existing provisions with a new framework for nonprofit agricultural organizations to offer medical benefit plans rather than general health coverage. • Establishes a new statute (s. 624.4032, F.S.) to regulate nonprofit agricultural organization medical benefit plans modeled after the Church Benefit Plan Statute. • Modifies the organization's definition, now requiring 501(c)(3) tax-exempt status instead of 501(c)(5). • Requires a disclaimer on applications and marketing materials, informing consumers that the plan is not insurance, not subject to state insurance regulations or consumer protections. • Prohibits marketing through licensed insurance agents to differentiate these plans from regulated insurance products. • Mandates annual financial audits by an independent CPA, ensuring transparency and public access to financial information which must be provided on request.			
Health Care Facilities & Systems Subcommittee				
Commerce Committee				

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.

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[45] The states are Tennessee, Iowa, Kansas, Indiana, and Texas. The Foundation for Government Accountability, *Farm Bureau Health Coverage Plans*, https://thefga.org/wp-content/uploads/2021/01/Farm-Bureau-Plans-FAQ.pdf (last visited Feb. 26, 2025).