HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCC 08-18 Affordable Health Coverage
SPONSOR(S): Healthcare Council; Bean
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Healthcare Council	10 Y, 6 N	Calamas/Massengale	Gormley
1)			
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

PCB 08-18 focuses on the issue of the uninsured in Florida and promotes affordable access to healthcare for Floridians. In doing so, the bill amends the health flex program by increasing the income eligibility restrictions to 300 percent of the federal poverty level and, subject to certain limitations, allows access by employers even if all employees do not meet the income eligibility restrictions. The bill also and specifies situations in which individuals can enroll in health flex plans despite having health coverage within the last 6 months or having lost eligibility for Medicaid or Kidcare due to income restrictions 90 days prior to enrolling in the plan. Further, the bill allows for direct payment of premiums for children qualified for Kidcare to be paid to employer sponsored group family plans in certain situations.

The bill extends current limitations on dependent health care coverage to provide coverage up to the age of 30, and specifies limitations and requirements for extending such coverage. The bill also empowers employers, at their option, to make employment conditioned upon an employee's acceptance of health coverage and to make coverage automatic for eligible employees and their dependents unless an employee expressly opts out of coverage. These requirements apply to certain health insurers and HMOs. Additionally, the bill redefines "basic services" to include limited hospital inpatient services, which may include hospital inpatient services, up to a maximum coverage benefit of five days and a maximum dollar amount of coverage of $15,000 per calendar year. The bill also creates an exemption from the Florida Insurance Code for nonprofit religious cost sharing organizations meet certain requirements.

The bill creates a new section of law s. 408.910, F. S. as the Florida Health Choices Program and establishes a competitive market for purchasing health insurance and health services. The program, which is purely voluntary, utilizes employer sponsored insurance but reduces employer administration, and provides individual choice in manner and amount of health care coverage. This new program creates a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care. These products include health insurance plans, HMOs, prepaid services, service contracts, and flexible spending accounts. The bill creates the Florida Health Choices, Inc., to administer the newly-created program.

The bill creates a new section of law s. 408.9091, F. S., as the Cover Florida Health Care Access Act, which is designed to provide affordable healthcare options for uninsured residents by providing non-catstrophic coverage supplemental insurance and discount medical plan options to enrollees. The plan may also provide catastrophic coverage. The plan, which is subject to several exceptions, is available to Floridians ages 19 to 64 who are not covered by private insurance, or eligible for public insurance and have been uninsured at least the prior six months. The provider entities shall be competitively procured by the Agency for Health Care Administration and the Office of Insurance Regulation. The bill amends s. 112.363, F.S., by providing that coverage under this program is considered health insurance for purposes of the retiree health insurance subsidy.

The bill has a fiscal impact (see fiscal comments section), and is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited government – Creates greater access through a free-market approach to providing health coverage.

Empower families – Families will benefit from the availability of greater access to health care through more affordable health coverage options.

Promote personal responsibility – Employers and individuals, who have previously elected not to secure health care coverage, will be empowered to do so through increased access.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

Financial Basis of Health Care

In 2006, 60 percent of all health care services and supplies were purchased with private funds and 40 percent were government sponsored.[1] Of the health expenditures made with private funds, 25 percent were made by businesses (largely employer contributions to health coverage) and 31 percent were made by households (including private insurance, Medicare payroll taxes and out-of-pocket spending).[2] The largest share of government spending occurs through Medicare and Medicaid.[3] State and local governments pay 17 percent of all health expenditures.[4]

Health care can be bought directly or through a third party such as an insurer or a managed care organization. Insurance is the way most people purchase health care. Third party coverage provides several benefits:

- Risk shifting: to prevent or limit financial loss due to unexpected events;
- Risk pooling: to decrease the variance of risk within a population;
- Pre-packaged bundles of services and established service networks: to compensate for differences in information between buyers and sellers;
- Bargaining: to enable access to price discounts;
- Pre-payment: to spread ordinary expenditures over time;
- Subsidy: to assist purchase of services for very high risk individuals.

Most Americans obtain health insurance through their employer. There are at least two important reasons for this: tax policy favors this method and employment groups provide a large and stable basis for pooling risk. Both of these factors make health insurance more affordable when acquired as an employment benefit.

As a result of the reliance on insurance, the costs even for routine medical encounters are invisible to most consumers. Individuals bear the cost of 31 percent of health expenditures, but more than half of this spending is through taxes or insurance premiums. Out-of-pocket spending for direct purchase of medical goods or services accounts for only 13 cents of every dollar devoted to health care.[5] Decisions to initiate care do not impart factual information to the consumer—demanding a dollar's worth of

[1] Aaron Catlin, et al, "National Health Spending in 2006: A Year of Change for Prescription Drugs", 27 *Health Affairs* 1, 2008 at 20.
[2] *Id.* at 23, Exhibit 6.
[3] *Id.*
[4] *Id.*
[5] *Id.*

services seems like spending 13 cents. At this price, consumers make rational choices to use more care. Of course, not all costs are based on money. Consumers also spend time and effort to use resources and as these requirements increase, utilization may decline.

The insulation from ordinary expenses distorts the normal interaction of supply and demand that typically generate an efficient allocation of resources. As David Gratzer observes, "health care is so expensive because it is so cheap."[6] But health care is not cheap. As of 2006, health care expenditures totaled over $2 trillion and accounted for 16 percent of the gross domestic product. Spending for health care amounts to an average of $7,026 per person per year, though the distribution of these resources is neither efficient nor equitable.

Access To Health Care

The number of Floridians with private health insurance is estimated to include 11.3 million residents.[7] More than half of these (58%[8]) are covered through self-insured plans with the remainder receiving coverage through carriers that are regulated or monitored by the Office of Insurance Regulation (OIR). In 2006, OIR reported activity for 140 carriers of major medical lines. Of these, 25 carriers earned premiums in the small group market; 80 carriers reported activity for individual plans.[9] Despite the number of participating carriers, market share is highly concentrated—just three companies account for nearly 70% of the small group market. The table below presents additional data from OIR regarding the overall size of the small and individual markets in Florida.

CY2006 Accident and Health Report: Summary by Major Medical Lines of Business[10]

Line of Business	Premiums New/Renewal	Losses Incurred	Employer Groups	Primary Insureds	Covered Lives
Instate Individual	$971,267,393	$627,135,429		318,586	479,550
Instate Self-Employed	$168,488,242	$144,585,527	18,830	18,830	32,330
Instate 2-5 Member Groups	$720,398,361	$537,063,636	43,065	122,891	200,253
Instate 6-50 Member Groups	$2,998,464,292	$2,173,105,057	72,733	550,501	892,326
Total	$4,858,618,288	$3,481,889,649	134,628	1,010,808	1,604,459

Over the years, Florida has launched numerous initiatives to try to increase access for groups and individual health insurance coverage. Examples include guarantee-issue, limits on individual underwriting practices, and protections for continued coverage. These efforts produce mixed results because while extending protections to certain individuals, they also can drive up costs and increasing cost is the primary reason that employers and individuals drop coverage.[11]

The Florida Health Insurance Study (FHIS) of 2004[12] found that about 19.2 percent of non-elderly Floridians are uninsured. The number of uninsured varies with the time period considered. Estimates of uninsured at a point in time, like FHIS, tend to be higher than counts of people uninsured year-round

[6] David Gratzer, "What's Wrong with American Health Care?", http://www.freemarketcure.com/whatswrongwithushealthcare.php.
[7] America's Health Insurance Plans, "Health Insurance: Overview and Economic Impact in the States" November, 2007, at13 *available at* http://www.ahipresearch.org/PDFs/StateData/StateDataFullReport.pdf.
[8] *Id.*
[9] Florida Office of Insurance Regulation, CY 2006 Gross Annual Premium and Enrollment; Accident and Health Markets, July 2007 *available at* www.fdhc.state.fl.us/SCHS/doc/2006-7-19/TAB_E2.doc.
[10] *Id.* at 1.
[11] Mark V. Pauly and Len Nichols, "The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes", *Health Affairs Web Exclusive*, Oct. 2002 at 327-328, 338, http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w2.325.
[12] *Id*

but lower than the number ever uninsured during the year.[13] About 75 percent of non-elderly Floridians were insured the entire year, while 14 percent were uninsured the entire year, and 11 percent were uninsured part of the year.[14] The primary reason employers do not offer health insurance or employees do not take health insurance when it is offered is cost.[15]

The FHIS evaluated levels of insurance coverage based on both employment status of the individual, and on the size of the firm. The study revealed that obstacles to employer-provided health insurance are greatest for the smallest firms, with the rate of uninsured employees at firms having less than five employees being 36.3 percent, versus 35.2 percent for employees at firms with five to nine employees, 31.8 percent of employees at firms with 10 to 24 employees, 22.7 percent at firms with 25 to 49 employees, and 16 percent at firms with 50 to 99 employees.[16]

Among uninsured employed adults, the reasons for lacking coverage vary. A majority (69.2 percent) report that the employer does not offer insurance. For 13.6 percent, the employer offers insurance but the employee is ineligible for coverage; for 12.7 percent, the employer offers insurance but the cost sharing for the employee is too high; and for 4.5 percent the employer offers insurance, but the employee declined coverage for other reasons.[17]

Cost of Insurance

Costs of insurance in Florida average $10,848 per year for a family in the small group market. This amount is somewhat higher than the national average of $9,768.[18] Florida's minimum wage (as of January, 2008) is $6.79 per hour. A full-time minimum wage employee would earn $14,123 annually. Average costs of family coverage constitute 77% of the minimum wage worker's annual earnings. Even with employer contributions to reduce the burden on the individual, health costs are likely to be too expensive for low-wage workers. For those employers who do offer health coverage and contribute to the premium, those benefits drain resources away from higher wages.

Mandated health benefits reflect an interest in guaranteeing access to certain types of health services. A mandated health benefit must be either provided or offered. Florida has one of the nation's most extensive set of coverage requirements. According to a report prepared by the House of Representatives staff for the Committee on Insurance in 2000,[19] Florida has a total of 51 mandated health benefits applicable either to private insurers or HMO health plans. Additional mandates pertain to the regulatory requirements placed on insurers. Florida's mandates only apply to those insurers that are not exempt under federal law. Exempt insurers are those plans that are self-insured. The non-exempt insurers—those plans subject to state mandates and other regulation—account for about 42 percent of all Floridians with health insurance.

Hospitals and other providers deliver a substantial amount of services without compensation to people who are uninsured or underinsured. For Florida's 289 hospitals, the cost of uncompensated care was

[13] Economic Research Initiative on the Uninsured, "Counting the Uninsured by Reference Period" *available at* http://eriu.sph.umich.edu/fastfacts/counting.html.
[14] Florida Center for Medicaid and the Uninsured, Florida Health Insurance Study, Insurance Coverage Updates, Fact Sheet No. 3, "Gaps in Coverage: Uninsured Part of the Year" 2005 at 1, *available at* *http://ahca.myflorida.com/Medicaid/quality_management/mrp/Projects/fhis2004/reports.shtml*.
[15] The Henry J. Kaiser Family Foundation, Employee Health Benefits: 2007 Annual Survey, 41 Exhibit 2.8, *available at* http://www.org/insurance/7672/index.cfm; Florida Center for Medicaid and the Uninsured, Highlights from the Florida Health Insurance Study, 2004 at 1, 12, *available at* http://ahca.myflorida.com/Medicaid/quality_management/mrp/Projects/fhis2004/reports.shtml.
[16] Agency for Health Care Administration; 2004 Florida Health Insurance Study; available at http://ahca.myflorida.com/Medicaid/quality_management/mrp/Projects/fhis2004/.
[17] *Id*.
[18] *See* America's Health Insurance Plans, supra note 19 at 13.
[19] Committee on Insurance, Fla. House of Representatives, "Managing Mandated Health Benefits: Policy Options for Consideration" (2000) available at http://www.fdhc.state.fl.us/docs/USG/Meeting2/FloridaStudy.pdf.

estimated at $1.9 billion.[20] Hospitals are required by federal law to provide screening, treatment within their capabilities, or transfer if necessary to any patient presenting with an immediate medical need. Emergency department physicians are also affected by these federal requirements and in 2005, ED physicians provided at least $131 million worth of uncompensated care.[21] Estimates of amounts and costs of uncompensated care for community physicians are harder to come by, however, a study in the early 1990s estimated that at least 10 percent of all physician charges were unresolved with self-pay patients accounting for at least half of these amounts.[22]

Quality

The primary criticism about the quality of health care in the U.S. is not that the system cannot produce good outcomes, but rather that the results are inconsistent, unpredictable and undependable. Researchers including John Wennberg, the Institute of Medicine, the Institute for Health Improvement and many others have documented the variations in practice patterns and medical outcomes. The common observation among these studies is that the failure is systemic. Even skilled professionals can be stymied by inadequate information, fragmented care, and unreliable supports. Dr. John Wennberg was one of the first to suggest that more care is not always better care. For example, his research reveals that Medicare spends 2.5 time as much on its Miami enrollees as it does on those in Minneapolis. The outcomes in Miami are worse, despite the additional costs to Medicare of $50,000 per enrollee.[23]

Health Flex Plans

In 2002 the Legislature established the Health Flex Plan Program recognizing that a significant portion of Florida residents are unable to afford health insurance coverage.[24] The Health Flex Plan Program was established as a pilot program in an effort to offer basic affordable health care services to low-income uninsured state residents, "by encouraging health insurers, health maintenance organizations, healthcare-provider-sponsored organizations to develop alternative approaches to traditional health insurance, which emphasize coverage for basic and preventative care services."[25] The Agency for Health Care Administration (AHCA) is directed by law to administer the Health Flex Plan Program.[26] In 2004, the Legislature expanded Health Flex plans to all 67 counties.[27] The program is scheduled to sunset July 1, 2008.[28]

Health Flex Plans can be offered by licensed insurers, HMOs, health care providers, local governments, health care districts, or other public or private organizations, and through small employers' business purchasing arrangements sponsored by local government. Currently eligibility to enroll in the Health Flex Plan is limited to individuals who:

- Are residents of this state;
- Are 64 years of age or younger;
- Have family income equal to or less than 200 percent of the federal poverty level (currently $42,400 for a family of four)[29];

[20] Florida Hospital Association, Facts About Florida's Health Care System, tbl. Community Hospital Finances – 2005 *available at* http://www.fha.org/facts.html#health/expen.
[21] Barbara Langland-Orban, et al, "Uncompensated Care Provided by Emergency Physicians in Florida Emergency Departments", Health Care Management Review Oct.-Dec. 2005 at 317.
[22] Kerry Kilpatrick, et al, "Uncompensated Care Provided by Private Physicians in Florida", 26 Health Services Research 3 Aug. 1991 at 285.
[23] *See* To Improve Health and Health Care, (Stephen L. Isaacs and James R. Knickman, eds., Robert Wood Johnson Foundation, Volume X) (2007).
[24] ch. 2002-389, Laws of Florida; s. 408.909(1), F.S.
[25] s. 408.909(1), F.S.
[26] s. 408.909, F.S.
[27] ch. 2004-297, Laws of Florida; s. 408.909(3), F.S.
[28] s. 408.909(10), F.S.
[29] 73 Fed. Reg. 15, 1371-72 (Jan. 23, 2008)

- Have been uninsured for at least 6 months prior to enrollment;
- Are not covered by a private insurance policy and are not eligible for coverage by a public health care program; and
- Have applied for health coverage through an approved health flex plan and have agreed to make payments pursuant to the plan[30]

Health Flex Plans are also available to individuals eligible under a federally approved Medicaid demonstration waiver and who reside in Palm Beach County or Miami-Dade County.[31] According to AHCA, although s. 408.909, F.S. was amended to allow Palm Beach County to develop a Health Flex Plan using Medicaid funds, the County opted instead to implement a Health Flex Plan without the use of such funds.[32] Additionally, Miami-Dade County opted to not implement a Health Flex Program.[33]

According to AHCA, as of December 2007, five health flex plans were operational in Florida, covering 2,232 employees.[34] One of the five plans, JaxCare, anticipated ending its pilot with the county on December 13, 2007 and, therefore, ceased accepting new enrollment applications after July 1, 2007.[35] JaxCare has decided to continue its plan until June 30, 2008, when it will then implement a new "Medical Home" program in its place.[36] The Annual Report noted that "JaxCare and business owners consider the 200 percent Federal Poverty Level [under current law] as too restrictive."[37]

For another of the four plans, the Report noted the plan's observation that "[l]ack of state funding to support expansion of benefits, the low income threshold, and the six months waiting period [are] significant barriers to expansion of the program."[38]

Retiree Health Insurance Subsidy

A Florida Retirement System (FRS) participant must have vested rights, that is, six years of service in the Pension Plan or one year of service in the Investment Plan, to be eligible for the HIS payment. The subsidy requires the applicant to demonstrate that there is an out-of-pocket post-retirement health insurance premium for the subsidy to apply. The participant must also separately apply for this additional benefit feature. An estimated 206,000 retirees or beneficiaries were receiving this benefit in March 2005. The benefit is paid by the imposition of an additional employer contribution rate of 1.11 percent, or 111 basis points, on the employer active payroll. The contribution rate is imposed uniformly on all FRS retirement classes. To effect payment of the subsidy the participant must be retired and have terminated employment. Participants in DROP are still actively employed, though retired, and do not receive this payment until cessation of all covered FRS employment and the receipt of a monthly benefit.[39]

Florida Kidcare Program

The Florida KidCare program provides health care coverage to over 1.4 million children in Florida. KidCare is an "umbrella" program that includes: Medicaid, Florida Healthy Kids Program, MediKids and the Children's Medical Services Network for children with special health care needs. Eligibility for the different program components is based on age, family income, and whether the child has a serious

[30] s. 408.909(5), F.S.
[31] s. 408.909(5)(c)
[32] Health Flex Plan Program Annual Report, January 2008, Agency for Healthcare Administration, available at http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/index.shtml; Agency for Health Care Administration 2008 Bill Analysis & Economic Impact Statement.
[33] Agency for Health Care Administration 2008 Bill Analysis & Economic Impact Statement.
[34] *Id.*
[35] Health Flex Plan Program Annual Report, January 2008, Agency for Healthcare Administration, available at http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/index.shtml
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] Senate April 2, 2008 Bill Analysis and Fiscal Impact Statement to CS/CS/SB 2534.

health condition. Florida KidCare primarily targets uninsured children under age 19 whose family income is at or below 200 percent of the federal poverty level ($40,000 for a family of four in 2006).

Nonprofit Religious Cost Sharing Organizations

As an alternative to traditional health insurance, not-for-profit, religious medical cost sharing organizations have formed. These organizations, which function similar to a cooperative, allow members to pay in to the organization what is generally a fraction of what they would pay for insurance premiums which, in return, provides a monthly share of the organization's cumulative needs. In general, organizations condition an individual's membership on his or her agreement to adopt a Christian lifestyle and abstain from high-risk health behavior, such as smoking, drinking alcohol or using illegal drugs. The type and amount of restrictions or conditions placed on members vary from organization to organization. Organizations also may opt to adopt other limitations as well, such as not providing cost-sharing for pre-existing conditions. Generally, members pay for their own cost of care up to a certain level, and then cost-sharing is capped at another level determined by the organization.[40]

Employee Election of Health Coverage

Current law is silent regarding as to how group health insurance coverage and coverage under health maintenance organization contracts is offered to an employee and his or her dependents by the employer. In fact, current law allows an employee's spouse or dependents to be insured by a group plan without the employee electing coverage.[41] In general, where group coverage or coverage under an HMO is available to employees, employees are provided with health insurance enrollment paperwork upon employment that the employees may fill out at their leisure and return to the employer to in order to obtain coverage. Acceptance of coverage is optional on the part of the employee.

Dependent Coverage

Under current law, a group health insurance policy must insure a dependent child until the end of the calendar year in which the child reaches age 25, if the child is dependent upon the parent for support and is either living in the household of the parent or is a full-time or part-time student.[42] These provisions do not apply to self-insured employers

Limited Benefit Plans

Part II, Chapter 641 authorizes prepaid health clinics as an option for health care coverage in Florida. Prepaid health clinics provide basic services to clients, which includes emergency care, physician care other than hospital inpatient physician services, ambulatory diagnostic treatment, and preventative health care services as part of their limited benefit plans. As limited benefit plans, these plans do not currently provide catastrophic or hospital coverage to insureds. As of September 2007, there were 5 licensed entities in Florida operating as prepaid health clinics.

Effect of Proposed Changes

House Bill 7081 provides for the following additions and amendments to current law:

Retiree Health Insurance Subsidy

The bill amends s. 112.363, F.S., by providing that coverage issued pursuant to the Cover Florida Health Access Program Act is considered health insurance for purposes of the retiree health insurance subsidy.

Health Flex Plans

[40] *See, e.g.*, Medi-Share at http://www.medi-share.org/index.aspx; Samaritan Ministries at http://www.samaritanministries.org/info/html/faq.html; Christian Healthcare Ministries at http://www.chministries.org/howitworks.asp; all viewed on April 8, 2008.
[41] s. 627.653, F.S.
[42] s. 627.6562, F.S.

The bill expands the population eligible to purchase health flex plans by raising the income limit to 300 percent of the federal poverty level, which is $63,600 for a family of four,[43] and removes obsolete eligibility provisions. Moreover, the bill provides that individuals who were covered under an individual HMO contract issued by an HMO that was also an approved health flex plan as of October 1, 2008, may apply for coverage in the same HMO health flex plan without a lapse in coverage if all other eligibility requirements are met. Further, the bill allows individuals who lose Medicaid or Kidcare subsidy eligibility due to income restrictions to be eligible for health flex coverage within 90 days prior to enrolling for such coverage.

Additionally, the bill removes the expiration date of the health flex program, which is scheduled to expire on July 1, 2008.

The bill additionally expands the population eligible to purchase health flex plans by allowing all employees of a business to qualify if at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level. The bill specifies that if the health flex plan is a licensed insurer, health plan, or health maintenance organization, only 50 percent of the employees have to have an income level up to 300 percent of the federal guidelines in order for the entire employee group to qualify.

Kidcare Program

Premium assistance in the KidCare program is the amount paid by AHCA toward health insurance premiums on behalf of each child in the program whose family income is under 200 percent of the federal poverty level. These children are eligible for federal Title XXI and state funding assistance to participate in the program. This bill amends the definition of premium assistance in s. 409.811(22), F.S., to allow the premium assistance paid by AHCA on behalf of children in KidCare to be used to help purchase insurance for a child from an employer sponsored group family plan. The bill language would allow this as long as the assistance amount paid to the employer sponsored plan does not exceed the amount that would be paid if the child were enrolled in KidCare. The effect of this change would allow additional choices beyond Florida KidCare, for families to purchase healthcare insurance for their children. This would also help support employer sponsored health insurance plans. A federal waiver may be required to use the federal Title XXI funding towards payment for an employee sponsored group family plan.

Cover Florida Health Access Program Act

The bill creates the "Cover Florida Health Access Program Act," which is designed to provide affordable health care options for uninsured residents. A Cover Florida plan entity must provide non-catastrophic coverage and may provide catastrophic coverage, supplemental insurance, and discount medical plan product options to enrollees. The enrollee must meet the following eligibility requirements:

- Resident of Florida;
- Ages 19 to 64;
- Not covered by private insurance or eligible for public insurance, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements; and
- Uninsured for at least the prior 6 months, with exceptions for persons who lose coverage within the past 6 months under certain conditions.

The Agency for Health Care Administration (agency) and the Office of Insurance Regulation (office) are responsible for jointly establishing and administering the program. The agency and the office are required to issue an invitation to negotiate no later than July 1, 2008, to health insurers, health maintenance organizations (HMOs), health care provider-sponsored organizations, and health care districts ("Cover Florida plan entities"). The agency and the office are required to approve at least one

[43] *See* supra, Note 6.

Cover Florida plan entity having an existing statewide provider network, and may approve at least one regional network plan in each Medicaid area.

The Cover Florida general plan must include the following components:

- Guaranteed issue to enrollees.
- Plans are portable
- Plans can require limits on the number of services, caps on benefit payments, and copayments.
- Plans must provide information on coverage, benefit limits, cost-sharing, and exclusions in the enrollment materials.
- Plans must offer prescription drug benefit coverage or use a prescription drug manager.
- Plan entities are required to develop two benefit plans having different cost and benefit levels.

Plans without catastrophic coverage must provide:

- Preventative health services
- Incentives for routine preventive care
- Office visits for the diagnosis and treatment of illness or injury
- Office surgery
- Services related to Behavioral Health Services
- Durable medical equipment and prosthesis
- Diabetic supplies

Cover Florida plans are not subject to the Florida Insurance Code and chapter 641, relating to HMOs. However, these plans are considered to be insurance subject to the Unfair Insurance Trade Practices in Part IX of chapter 626, F.S. Moreover, coverage provided through the program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy.

General components of the Cover Florida Program plans include that the plans are portable, guarantee issue, and may provide for cost containment through limits on the number of services, caps on benefit payments, and copayments for services. Moreover, the health plan must make all plan benefit and marketing materials available in both English and Spanish, and the program must provide a disclosure to consumers to ensure consumers are aware of any benefit limitations and can make informed choices. The Executive Office of the Governor, OIR and AHCA shall develop a statewide public awareness and incentive campaign for promotion of the program.

Nonprofit Religious Cost Sharing Organizations

The bill creates an exemption from the Florida Insurance Code for nonprofit religious organizations that qualify under Title 26, s. 501 of the IRS Code. In order to meet this exemption, the nonprofit religious organization must:

- Limit its membership to members of the same religion
- Act as an organizational clearinghouse for information between participants who have financial, physical, or medical needs and those with the ability to pay for the benefit of those members in need
- Provide for medical or financial needs of participants through payments directly from one participant to another
- Suggest amounts that participants may voluntarily give with no assumption of risk or promise to pay either among the participants or between the participants

Organizations are authorized to establish qualifications of participation relating to the health of a prospective participant, prevent a participant from limiting the financial or medical needs that may be eligible for payment, or to cancel the membership of a participant when the participant fails to make a

payment to another participant for a period of more than 60 days. Further, the organization is required to provide all prospective participants with written notice that the organization is not an insurance company, that membership is not offered through an insurance company, and that the organization is not subject to the regulatory requirements and consumer protections afforded under the Florida Insurance Code.

Coverage for Employees

The bill provides that, unless employers choose otherwise, for all policies issued after October 1, 2008, eligible employees and their dependents will be automatically enrolled for coverage under the employer's plan unless the employee provides written notice opting out of such coverage. The written notice must include information about why the coverage as declined or whether the employee has coverage under another plan, and must be retained in the employee's employment file. Furthermore, the bill allows employers to require employees to be covered as a condition of employment. This applies to both employee group and HMO coverage.

Coverage of Dependents

The bill amends current law concerning dependent coverage for health insurers providing group, blanket, or franchise health insurance, as well as HMOs, by increasing the age limit for dependent coverage from 25 to 30 if the dependent is:

- Unmarried and without dependents
- Is a resident of this state
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person in any other group, blanket, franchise health policy, HMO, individual health benefits plan, or entities to public benefits pursuant to the Social Security Act.
- Is not eligible for coverage as an employee under an employer sponsored health plan.

The bill provides that these changes do not:

- Affect or preempt an insurer's right to medically underwrite or charge an appropriate premium
- Require coverage for services provided prior to Oct 1, 2008 to a dependent
- Require that an employer pay all or part of the cost of coverage provided for a dependent
- Prohibit an insurer or HMO from increasing the limiting age for dependent coverage to age 30 in policies and contracts issued or renewed prior to this act's effective date

Until April 1, 2009, a dependent child who qualifies for dependent coverage under subsection (1) but whose coverage terminated may make a written election to reinstate coverage, without proof of insurability. All other dependent children shall be automatically covered until the end of the calendar year in which the child reached the age of 30, unless other limitations apply. The plan may require the payment of a premium by the covered person or dependent child, subject to approval of OIR, for any period of coverage relating to a dependent's written election for reinstatement of coverage, and notice of reinstatement must be provided to a covered person in the covered person's certificate of coverage or by his or her employer. Such notice must be given as soon as practicable after July 1, 2008, and may be given through the group policyholder. The bill states that this section does not apply to accident only, specified-disease, disability income, Medicare supplement, or long-term care insurance policies.

Limited Benefit Plans

The bill amends current law by allowing prepaid clinic plans to provide limited hospital inpatient coverage, which may include hospital inpatient physician services, up to a maximum of five days and a maximum dollar amount of $15,000 per calendar year.

The Florida Health Choices Program

The bill creates the Florida Health Choices Program as a single, centralized marketplace for the sale and purchase of various products that enable individuals to pay for health care. The bill establishes the Florida Health Choices Corporation to administer the program.

Several types of employers are eligible to use the marketplace as their employer-sponsored health plan:

- Employers with 1-50 employees;
- Fiscally constrained counties;
- Municipalities with populations less than 50,000; and
- School districts in fiscally constrained counties.

The bill directs the establishment of procedures for employer participation, including compliance with Sec. 125 of the Internal Revenue Code regarding cafeteria plans and enabling the employers' contributions and the employees' contributions to be made using pre-tax dollars.[44] Employers must also designate the Corporation as the third party administrator for the employer's health plan, establish payroll deduction, and arrange for employer contribution payments.

Several types of individuals are eligible to purchase health care products and coverage in the marketplace:

- Employees of employers choosing the marketplace as the employer-sponsored health plan;
- State employees not eligible for state employee health benefits;
- State retirees;
- Medicaid reform participants who select the opt-out provision of reform; and
- Employees of statutory rural hospitals.

The bill requires individual participants to select a product within 60 days of the date the individual's employer qualifies for participation. Individuals failing to select a product in the Program will be limited to participation in flexible spending account services until the next annual enrollment period. Changes in product selection are limited to the annual enrollment period. The bill establishes portability of products by allowing individuals to voluntarily continue participation in the Program regardless of changes in job status. The bill establishes procedures for portable participation by individuals, who must make arrangement for payment (such as changing payroll deduction with a change in employer, or arranging for the contribution formerly made by an employer to be made by the individual).

The marketplace model encourages diversity of price and benefit packages. Many types of products provided by many types of vendors may be available in the marketplace.

- Licensed insurers may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.
- Licensed health maintenance organizations (HMOs) may sell health insurance policies, limited benefit policies, other risk-bearing products, and other products or services.
- Licensed prepaid clinic service providers may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.
- Out-of-state insurers may sell health insurance policies, limited benefit policies, other risk-bearing products, and other products or services.
- Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell

[44] Section 125 allows employers to offer employees a choice between cash salary and a variety of nontaxable (qualified) benefits. A qualified benefit is one that does not defer compensation and is excludable from an employee's gross income under a specific provision of the IRS Code, without being subject to the principles of constructive receipt. Qualified benefits include health care, vision and dental care, group-term life insurance, disability, adoption assistance and certain other benefits.

non-risk-bearing service contracts and other arrangements for a specified amount and type of health services or treatments.

- Provider organizations including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell non-risk-bearing service contracts, and arrangements for a specified amount and type of health services or treatments.
- Corporate entities providing specific health services in accordance with applicable state laws, may sell service contracts, and arrangements for a specified amount and type of health services or treatments.

The bill provides that these products are not subject to the licensing requirements or mandated coverage or offering requirements of chapter 641, part VI of chapter 627 or chapter 641. However, only licensed vendors may offer risk-bearing products.

The bill provides for the exclusion of vendors for deceptive or predatory practices, financial insolvency, and failure to comply with program standards set by the Corporation. The bill establishes procedures for participation by vendors, which must submit complete descriptions of the products offered, including information on the provider network, set product prices based on the basic risk adjustment factors of age, gender and location of the individual participant, participate in ongoing reporting as required by the Corporation, and establish grievance procedures. In addition, vendors must agree to make all the products they offer available to all individual participants in the Program.

The bill provides that licensed health insurance agents may voluntarily participate as buyers' representatives to act on behalf of individual purchasers and provide information about the products and services sold. Such agents would receive compensation from the Corporation for performing this function. The bill requires such agents to receive training and disclose relationships with vendors.

As additional tools for helping consumers make informed decisions, the bill requires the Program to enable purchasing through an interactive website, and to make information about the products and services available on the website and through other means. Moreover, the bill requires a disclosure to consumers to ensure consumers are aware of any benefit limitations and can make informed choices.

The bill establishes the Corporation, and provides for its powers and duties. The bill provides that the Corporation shall be governed by a 15-member board of directors who serve for terms of 3 years. Five members are appointed by the Governor: the AHCA Secretary or designee with relevant expertise, the Department of Management Services Secretary or designee with relevant expertise, and 3 representatives of eligible public employers. Five members are appointed by the President of the Senate, which are representatives of employers, insurers, health care providers, health insurance agents and individual participants. Five members are appointed by the Speaker of the House of Representatives, which are representatives of employers, insurers, health care providers, health insurance agents and individual participants. All appointees serve at the pleasure of the appointing officer. The bill provides for no compensation, but allows for reimbursement of per diem and travel expenses. The bill provides immunity from liability to board members, and Corporation employees and agents for actions taken in the performance of duties under this section.

The Corporation will establish the marketplace and perform several functions to administer it. The Corporation is required to establish procedures to determine the eligibility of employers, vendors, individuals and agents, and develop criteria for the exclusion of vendors. The Corporation must collect individual and employer contributions and pay them out to vendors. The Corporation must establish procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education. The bill gives the Corporation strong authority to establish qualifying criteria and certification procedures for vendors, including requiring performance bonds, to monitor vendors' performance, and enforce the terms of agreements with vendors.

To avoid selection bias in the distribution of consumers among available products, the bill directs the Corporation to employ a variety of risk-pooling techniques. Most notably, these measures will include the ability to re-allocate a portion of the premium paid for risk-bearing products through a post-

enrollment risk adjustment. This adjustment process will be applied monthly based on data reported by the vendors about their enrollees.

C. SECTION DIRECTORY:

Section 1. Amends s. 112.363, F.S.; relating to retiree health insurance subsidy.

Section 2. Amends s. 408.909, F.S.; relating to health flex plans.

Section 3. Creates s. 408.9091, F.S.; relating to the Cover Florida Health Care Access Act.

Section 4. Creates s. 408.910; relating to The Florida Health Choices Program.

Section 5. Amends s. 409.811, F.S.; relating to definitions pertaining to the Florida Kidcare Act.

Section 6. Creates s. 624.1265, F.S., relating to Nonprofit religious organizations exemption; authority; notice.

Section 7. Amends s. 627.602, F.S.; relating to scope; format of health insurance policies.

Section 8. Amends s. 627.653, F.S.; relating to employee group health insurance.

Section 9. Amends s. 627.6562, F.S.; relating to dependent health insurance coverage.

Section 10. Amends s. 627.6699, F.S.; relating to Employee Health Care Access Act.

Section 11. Amends s. 641.31, F.S.; relating to health maintenance contracts.

Section 12. Amends s. 641.402, F.S.; relating to definitions.

Section 13. Providing that the act shall take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill affords Floridians greater access to health care coverage.

D. FISCAL COMMENTS:

The bill creates the Florida Health Choices Program to expand opportunities for Floridians to purchase affordable health insurance and health services. The House proposed General Appropriations Act for Fiscal Year 2008-2009 contains funding for the initial program implementation in Specific Appropriation 185A. The appropriation provides $1,029,561 from the General Revenue Fund. The line item includes the following proviso language:

> *Funds in Specific Appropriation 185A are provided to expand opportunities for Floridians to purchase affordable health insurance and health services. The funds shall be used to create a competitive market for health care by prompting innovative arrangements for purchase of individual, portable health insurance and individual contracts for health services. Funds shall be used to contract with the corporation created by legislation authorizing and directing the implementation of the Florida Affordable Healthcare Program.*

The bill amends the definition of premium assistance in s. 409.811(22), F.S., to allow the premium assistance paid by AHCA on behalf of children in KidCare to be used to help purchase insurance for a child from an employer sponsored group family plan. The bill language would allow this as long as the assistance amount paid to the employer sponsored plan does not exceed the amount that would be paid if the child were enrolled in KidCare. The effect of this change would allow additional choices beyond Florida KidCare, for families to purchase healthcare insurance for their children. This would also help support employer sponsored health insurance plans. A federal waiver may be required to use the federal Title XXI funding towards payment for an employee sponsored group family plan.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

AHCA and the Financial Services Commission are granted sufficient rulemaking authority to implement the Cover Florida Health Access Program.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On April 8, 2008, the Healthcare Council adopted one strike-all amendment, and two amendments to the strike-all amendment, to the PCB.

The strike-all amendment (Amendment 1) makes the following changes to the PCB:

- Amends s. 112.363, F.S. in order to clarify that coverage under the Cover Florida Health Care Access Act is considered insurance for purposes of the retiree health insurance subsidy.
- Similar to the PCB, the strike-all amendment creates s. 408.9091, F.S., which establishes the Cover Florida Health Care Access Program. The amendment conforms the PCB to the Senate Bill, including removing the fiscal impact in the PCB. Moreover, language is added to clarify that the program must make disclosures to consumers so that consumers are aware of any benefit limitations and can make informed choices.
- Consistent with the PCB, the strike-all amendment establishes the Florida Health Choices Program in a new section of law, s. 408.910, F.S. The strike-all amendment provides for one substantive change to the program to require disclosure to consumers to ensure consumers are aware of any benefit limitations and can make informed choices, and makes several technical amendments.
- The strike-all removes provisions in the PCB that authorized AHCA to limit enrollment in Medikids and the board of directors of Healthy Kids to limit enrollment in the Florida Healthy Kids Program, which results in the removal of a corresponding fiscal impact.
- Similar to the PCB, the strike-all mends ss. 627.602 and 627.6562, by allowing insurance coverage of dependent children, under certain circumstances, up to the age of 30. The strike-all adds an additional exclusion to such coverage for dependent children who are eligible for coverage as an employee under an employer-sponsored health plan.
- The strike-all amends the effective date of the PCB to provide that it is effective upon becoming law.

The first amendment (Amendment 2) to the strike-all amendment amends health flex plan eligibility limitations, which currently preclude enrollment of individuals who have had health coverage within the past 6 months, by allowing individuals who were covered by an HMO contract issued by an HMO that was also approved as a health flex plan on October 1, 2008, to apply for coverage in the same HMOs health flex plan without a lapse in coverage if all other eligibility requirements are met. An exception is also provided for a person that was eligible for Medicaid or Kidcare subsidy and lost such eligibility due to income restrictions within 90 days prior to applying for health care coverage through an approved health flex plan.

The second amendment (Amendment 3) to the strike-all amendment creates s. 624.1265, F.S., relating to an exemption from the insurance code for nonprofit religious organizations that qualify under Title 26, s. 501 of the IRS Code of 1986. The amendment specifies requirements that must be met and allows the nonprofit religious organizations to establish qualifications of participation, prevent a participant from limiting the financial or medical needs that may be eligible for payment, or prevent the organization from cancelling the membership of a participant. Further, the amendment provides for specified disclosure requirements that must be made by the organization.

The PCB was reported favorably with the above amendments.