

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 Health and Human Services Appropriations Committee

BILL: CS/CS/SB 2534
 INTRODUCER: Committee on Health and Human Services Appropriations, Banking and Insurance Committee, Senator Peadar, and Senator Gaetz
 SUBJECT: Health Insurance
 DATE: April 2, 2008 REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	Fav/CS
2.	Peters	Peters	HA	Fav/CS
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE..... Statement of Substantial Changes
 B. AMENDMENTS..... Technical amendments were recommended
 Amendments were recommended
 Significant amendments were recommended

I. Summary:

According to the 2005 U.S. Census, Florida has the third highest uninsured rate in the nation at 20.2 percent. The bill provides mechanisms for increasing affordable coverage to the uninsured in Florida by revising eligibility for certain private and public health care coverage.

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 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, subject to exclusions for pre-existing conditions approved by the agency and the office.
- Plans are portable, regardless of employment status.
- 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.

Cover Florida plans are not subject to the Florida Insurance Code and ch. 641, relating to HMOs. However, these plans are considered to be insurance subject to the Unfair Insurance Trade Practices in Part IX of ch. 626, F.S.

Retiree Health Insurance Subsidy

Coverage provided through Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy.

Health Flex Plan Program

The Health Flex Plan Program was established to offer basic affordable health care services to low-income, uninsured residents. The bill provides the following changes to the program:

- Expands the population eligible to purchase health flex plans by raising the family income limit from 200 to 300 percent of the federal poverty level. Based on the 2008 Federal Poverty Guidelines, 200 percent of the federal poverty level is \$42,400 for a family of four, and 300 percent of the federal poverty level is \$63,600 for a family of four.
- Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

Insurance Coverage for Dependent Children

Requires group health insurers to offer policyholders and certificateholders (parents) the option to continue coverage for their children on their family policy until age 30. Current law is maintained that requires coverage for dependent children until age 25. In addition, a group insurer would be required to offer the parent the option to continue coverage for a (non-dependent) child until age 30, if the child is unmarried with no dependents, a resident of Florida or a full time-or part-time student, and does not have insurance coverage under any other private plan or is not entitled to benefits under Title XVII of the Social Security Act.

This bill substantially amends the following sections of the Florida Statutes: 112.363, 408.909, and 627.6562.

The bill creates the following section of the Florida Statutes: 408.9091.

II. Present Situation:

The Uninsured in Florida

As of 2006, there were an estimated 3,686,676 uninsured nonelderly people in Florida. Children, age 18 and under, comprised 22 percent (816,979) of the nonelderly uninsured in Florida. The remaining 78 percent (2,868,697) consisted of adults, ages 19 to 64.¹ Approximately 43 percent of persons age 18 to 34 were uninsured.²

Health insurance coverage for adults, age 19 to 64, was primarily provided through the employer, as indicated in the chart below. The uninsured rate for this age group was 27 percent. In contrast, the national uninsured rate was 20 percent.³

	FL #	FL %	US #	US %
Employer	6,232,130	58%	114,883,073	63%
Individual	672,057	6%	10,677,488	6%
Medicaid	603,749	6%	14,244,607	8%
Other Public	398,415	4%	5,000,512	3%
Uninsured	2,868,697	27%	37,011,340	20%
Total	10,775,048	100%	181,817,020	100%

The costs of uncompensated care in Florida are significant. In 2004 and 2005, these costs were \$2,110,518,208 and \$2,352,544,130, respectively. For fiscal year 2006, the uninsured represented 8.6 per cent of all inpatient admissions, according to the Florida Hospital Association.

¹ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the U.S. Census Bureau's March 2006 and 2007 Current Population Survey (CPS Annual Social and Economic Supplements).

² Florida Health Insurance Study, 2004, Profile of the Uninsured, Agency for Health Care Administration

³ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the U.S. Census Bureau's March 2006 and 2007 Current Population Survey (CPS Annual Social and Economic Supplements).

Florida Health Flex Plan Program

In 2002 the Legislature established the Health Flex Plan Program as a mechanism to provide basic affordable health care services to low-income, uninsured residents. Health Flex was designed to encourage health insurers, health maintenance organizations, and health care providers to develop alternative approaches to traditional health insurance, which emphasize coverage for basic and preventative care services. The agency administers the Health Flex Plan Program.

Health Flex Plans can be offered by licensed insurers, HMOs, health care providers, local governmental entities, health care districts, or other public or private organizations, and through small employers' business purchasing arrangements sponsored by local governmental entities. These entities must meet quality of care and financial guidelines jointly developed by the agency and the Office of Insurance Regulation.

Currently, eligibility to enroll in the Health Flex Plan is limited to individuals who meet the following requirements:

- residents of Florida;
- age 64 years of age or younger;
- family income equal to or less than 200 percent of the federal poverty level; uninsured status for at least 6 months prior to enrollment; and
- not covered by a private insurance policy and are not eligible for coverage by a public health program.

According to the agency, as of January 2008, there were five active Health Flex Plan providers that had enrolled a total of 2,232 beneficiaries. For the prior year, 2007, there were four health flex plans covering 1,776 members.⁴

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.

⁴ Health Flex Plan Program Annual Report, January 2007, by the Agency for Health Care Administration and the Office of Insurance Regulation.

Coverage for Dependent Children

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. (s. 627.6562, F.S.)

III. Effect of Proposed Changes:

Retiree Health Insurance Subsidy (Section 1)

The bill specifies that coverage provided through Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy.

Health Flex Plan Program (Section 2)

the bill revises eligibility criteria for enrollment in the Health Flex Plan and participation as an entity eligible to offer the plan. The bill expands the population eligible to purchase health flex plans by raising the income limit from 200 to 300 percent of the federal poverty level. Based on the 2008 Poverty Guidelines of the U.S. Department of Health and Human Services, 200 percent of the federal poverty level is \$42,400 for a family of four, and 300 percent of the federal poverty level is \$63,600 for a family of four.⁵

The bill also extends the expiration date of the program from July 1, 2008 to July 1, 2013. In addition, the bill eliminates obsolete provisions related to a federally approved Medicaid demonstration waiver.

Cover Florida Health Access Program Act (Section 3)

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. To be eligible for the program, an enrollee must meet the following 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 requests; and
- Uninsured for at least the prior 6 months, with exceptions for persons who lose coverage within the past 6 months under certain conditions.

Administration of the Cover Florida Health Access Program:

The Agency for Health Care Administration (agency) and the Office of Insurance Regulation (agency) 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, health care provider-sponsored organizations, and health care districts ("Cover Florida plan entities"). The agency and the office are required to

⁵ <http://aspe.hhs.gov/poverty/>

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

Changes in plan benefits, premiums, and forms are subject to regulatory oversight by the agency and the office. The office and the agency are required to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the status of the program.

The Cover Florida general plan must include the following components:

- Guaranteed issue to enrollees, subject to exclusions for pre-existing conditions approved by the agency and the office.
- Plans are portable, regardless of employment status.
- Insurers 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.
- Insurers are required to develop two benefit plans having different cost and benefit levels.

Plans without catastrophic coverage are required to provide coverage options for certain services, including but not limited to:

- Preventive health services and screenings, annual assessments, cervical cancer screenings, mammograms, prostate screening, and immunizations.
- Office visits and surgery
- Behavioral health services
- Durable medical equipment and prosthetics
- Diabetic supplies

Plans providing catastrophic coverage must provide coverage for all of the services required for non-catastrophic coverage, above, as well as the following coverage:

- Inpatient hospital stays
- Hospital emergency care
- Urgent care services
- Outpatient services and surgery

Evaluation and Approval of Cover Florida Plans:

A plan must be disapproved or withdrawn if the plan:

- Contains ambiguous, inconsistent, or misleading provisions;
- Provides benefits that are unreasonable in relation to the premiums charged or result in unfair discrimination in sales practices;
- Fails to demonstrate that the plan is financially sound;

- Cannot demonstrate that the applicant and management meet general eligibility requirements for insurers and HMOs, which includes competency and trustworthiness; or
- Does not guarantee that enrollees may participate in the plan entity's network of providers.

Applicability of the Insurance Code and HMO Laws:

Cover Florida plans are not subject to the Florida Insurance Code and ch. 641, relating to HMOs. However, these plans are considered to be insurance subject to the Unfair Insurance Trade Practices in Part IX of ch. 626, F.S. In the event of the insolvency of a Florida plan entity, these plans would not be covered by an insurance or HMO guaranty association.

Coverage for Dependent Children (Section 4)

Requires group health insurers to offer policyholders and certificateholders (parents) the option to continue coverage for their children on their family policy until age 30. Current law is maintained that requires coverage for dependent children until age 25. In addition, a group insurer would be required to offer the parent the option to continue coverage for a (non-dependent) child until age 30, if the child is: (a) unmarried with no dependents, (b) a resident of Florida or a full-time-or part-time student, and (c) does not have insurance coverage under any other private plan or is not entitled to benefits under Title XVII of the Social Security Act.

Under current law (retained by the bill), the policy must insure a dependent child until age 25, if the child is dependent upon the parent for support and is living in the household of the parent or is a full-time or part-time student.

If a child is provided coverage under the parent's policy after the child reaches age 25 and the coverage for the child is subsequently terminated, the child is ineligible to be covered again under the parent's policy unless the child was continuously covered by other insurance coverage without a coverage gap of more than 63 days. This would address adverse selection issues relating to children (age 25-30) dropping off and coming back on the parent's policy, due to needed medical treatment or services.

These provisions would not apply to self-insured employers since the federal Employee Retirement Income Security Act (ERISA) preempts state laws affecting self-insured employer plans. Approximately 50 percent of the employers in Florida are self insured.

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:

See Private and Public Sector Impact, below, regarding federal tax issues.

B. Private Sector Impact:

The bill increase access and eligibility to health care services and coverage through the Health Flex Plan, Cover Florida Health Access, and the dependent coverage provided through group insurance policies.

Health Flex Plan Program

By broadening the income eligibility requirements for the Health Flex Plans for an individual from 200 to 300 percent of the federal poverty level, an indeterminate number of additional persons would be eligible to purchase this coverage. (See Effects of Proposed Changes for income levels.)

According to the agency, this change is also expected to provide an incentive to other health flex plan providers to implement a health flex program. The agency notes that existing health flex plan providers have contended that this change is needed to capture a larger number of individuals that are unable to afford health care premiums for commercial insurance products. Additionally, the expected increase in enrollment is needed to ensure the financial viability of the health flex programs.

Cover Florida Health Access Plans

The bill will allow insurers, HMOs, health-care-sponsored-organizations, or health care districts to offer consumers a choice of benefit plans at affordable prices. These plans will offer the option of catastrophic, non-catastrophic and supplemental coverage. According to the staff of the Governor's Office, the average plan will cost \$150 per month or less. Florida residences, ages 19 to 64 that have been uninsured for at least 6 months are eligible for the plans. These plans are issued on a guaranteed issue basis and are portable, such that an enrollee remains covered regardless of employment status or the cost sharing of premiums.

The state retiree Health Insurance Subsidy Program payment (\$30 to 150 per month) is designed to offset the cost of health insurance for retirees. It is unclear whether retirees enrolling in a Health Flex Plan or Cover Florida plans would be eligible for this subsidy.

Implications for Changes in Dependent Coverage

Extending coverage for dependent children from age 25 to 30 may result in a larger number of insureds since approximately 43 percent of the insured in Florida are comprised of persons aged 18 to 34.

Some concerns have been raised regarding possible adverse selection issues related to expanding dependent coverage. Although the estimated increase in premiums attributable to the continuance of dependent coverage to age 30 is expected to be minimal, some

employers, particularly small employers, may adopt cost-savings strategies to mitigate even modest increases, such as decreasing contributions for employee coverage or dependent coverage.

Federal Tax Liability Implications for Changes in Dependent Coverage

Concerns have been raised regarding potential federal tax issues for private and public employers and employers and employer administrative costs associated with the changes in the dependent coverage requirements. The possible issues include:

- increased income tax liability to an employee (i.e. imputing the fair market value of the non-tax dependent's health coverage to be included in the employee's gross income),
- increased payroll tax liability for employers, and
- additional administration for employers, related to including the fair market value of the non-tax dependent in the employee's taxable income; or if the employer allows contributions for dependent coverage to be paid with pre-tax salary reductions, arranging to take that portion of the salary reduction on a post-tax basis.

Section 125 of the Internal Revenue Code allows private and public employers to offer premium only plans, a cafeteria plan, or a Flexible Spending Account to their employees. These plans are designed to allow employers to deduct employee paid premiums for certain group and disability related benefits on a tax-exempt basis. As a result, the employer pays less payroll taxes and the employee pays less federal withholding taxes and income taxes. The eligibility changes in the dependent coverage health insurance coverage in the bill have raised concerns related to the impact on 125 plans. The Internal Revenue Code defines a certain class of dependents under federal law, which generally requires financial dependence on the parent. It is possible that the federal law would view payment of the premiums through a cafeteria plan with pre-tax dollars as a violation of s. 125 IRC.

C. Government Sector Impact:

The tax attorney for the Division of State Group Insurance provided the following comments on the fiscal impact related to the federal tax aspects of the dependent coverage changes for the State Group:

An employee can only pay on a pre-tax basis under a cafeteria plan for the health coverage of a spouse (as defined under the Defense of Marriage Act) or a Code Section 105(b) dependent. A cafeteria plan could be disqualified if it permits a participant to elect coverage on a pre-tax basis for a person who is neither. However, the cafeteria plan rules permit non-Code §105(b) dependent coverage health coverage to be offered under a cafeteria plan as a taxable benefit.

In summary, while the offering of coverage may be mandated by state law, the tax treatment (and ramifications for cafeteria plan administration) would be governed

by federal tax law. As a result, while coverage may be extended under the state law to any (recently expanded) eligible employee, only a subset of the eligible dependent children would be entitled to receive that coverage on a tax-free basis. Thus, for example, while pre-tax coverage could be extended to a child who receives over half of their support from the employee, other covered dependent children must have their coverage funded on an after-tax basis and/or have any employer subsidy imputed into income -- i.e., in much the same way that coverage is provided to non-tax dependent domestic partners and/or domestic partner children. Moreover, the otherwise eligible medical expenses of non-tax dependent children would not be eligible for pre-tax reimbursement under the health Flexible Spending Accounts or for tax-free distributions from the Health Savings Accounts. These nuances would need to be communicated (and administrative processes put in place) before coverage is extended to non-tax dependents.

There may be an increase in payment of the retiree health insurance subsidy as the bill specifies that coverage provided through the Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Cover Florida plans established in the bill is not considered "creditable coverage," for purposes of state (s. 627.6561(5)(a), F.S.) and federal laws (federal Health Insurance Portability and Accountability Act of 1996) that require health plans to give the policyholder credit for time covered under previous insurance coverage towards meeting any new preexisting condition exclusion. If the Legislature amended the Florida definition of creditable coverage, s. 627.6561, F.S., to include Cover Florida plans, this would appear to be effective under state law as applied to fully insured plans issued in Florida, but would appear not to apply, under federal law to self-insured plans or health plans in other states. This could potential confusion and administrative burdens for insurers and consumers in determining creditable coverage applicable in other states.

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 Committee on Health and Human Services Appropriations on April 2, 2008

- Removes the elimination of the 10 percent cap on enrollment in the KidCare program.
- Specifies that coverage provided through the Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy.

- Revises eligibility for the Cover Florida Health Care Access Program to specify that persons are eligible if not covered by private insurance or eligible for public insurance, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements;

CS by Committee on Banking and Insurance on March 18, 2008.

The CS provides the following changes:

- Creates the Cover Florida Health Care Access Program as a mechanism to provide guaranteed issue coverage through the private market to Florida residents ages 19-64 that do not have insurance coverage during the prior six months.
- Eliminates current 10 percent cap on enrollment in Kidcare for enrollees that pay full premium and have an income over 200 percent of the federal poverty level.
- Eliminates changes to the definition of premium assistance for purposes of the Florida Kidcare program.
- Eliminates provision allowing an employer group meeting certain criteria from participating in the Health Flex Plan.
- Deletes provision requiring eligible employees and their dependents to be covered under a health care plan offered by the employer unless the employee declines.
- Revises dependent coverage requirements.

B. Amendments:

None.

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

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 Banking and Insurance Committee

BILL: CS/SB 2534

INTRODUCER: Banking and Insurance Committee, Senator Peadar, and Senator Gaetz

SUBJECT: Health Insurance

DATE: March 19, 2008 REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Johnson</u>	<u>Deffenbaugh</u>	<u>BI</u>	<u>Fav/CS</u>
2.	_____	_____	<u>HA</u>	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

I. Summary:

According to the 2005 U.S. Census, Florida has the third highest uninsured rate in the nation at 20.2 percent. The bill provides mechanisms for increasing affordable coverage to the uninsured in Florida by revising eligibility for certain private and public health care coverage.

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- Resident of Florida;
- Ages 19 to 64;
- Not covered by private insurance or eligible for public insurance; 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 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:

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- Expands the population eligible to purchase health flex plans by raising the family income limit from 200 to 300 percent of the federal poverty level. Based on the 2008 Federal Poverty Guidelines, 200 percent of the federal poverty level is \$42,400 for a family of four, and 300 percent of the federal poverty level is \$63,600 for a family of four.
- Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

Florida KidCare Program

The Florida Kidcare program is a combination of Medicaid expansions and public/private partnerships that is primarily targeted to uninsured children under age 19 whose family income is at or below 200 percent of the federal poverty level. Medikids and Florida Healthy Kids, components of this program, provide coverage for coverage for children ages 1 to 5 and 5 to 19, respectively, who meet certain requirements. The bill expands eligibility for these programs by eliminating the 10 percent current cap on enrollment for enrollees who have a family income above 200 percent of the federal poverty level and pay full premiums.

Insurance Coverage for Dependent Children

Requires group health insurers to offer policyholders and certificateholders (parents) the option to continue coverage for their children on their family policy until age 30. Current law is maintained that requires coverage for dependent children until age 25. In addition, a group insurer would be required to offer the parent the option to continue coverage for a (non-dependent) child until age 30, if the child is unmarried with no dependents, a resident of Florida

or a full time-or part-time student, and does not have insurance coverage under any other private plan or is not entitled to benefits under Title XVII of the Social Security Act.

This bill substantially amends the following sections of the Florida Statutes: 408.814, 408.909, and 627.6562. The bill creates the following section of the Florida Statutes: 408.9091.

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Florida Health Flex Plan Program

In 2002 the Legislature established the Health Flex Plan Program as a mechanism to provide basic affordable health care services to low-income, uninsured residents. Health Flex was designed to encourage health insurers, health maintenance organizations, and health care providers to develop alternative approaches to traditional health insurance, which emphasize coverage for basic and preventative care services. The agency administers the Health Flex Plan Program.

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Health Flex Plans can be offered by licensed insurers, HMOs, health care providers, local governmental entities, health care districts, or other public or private organizations, and through small employers' business purchasing arrangements sponsored by local governmental entities. These entities must meet quality of care and financial guidelines jointly developed by the agency and the Office of Insurance Regulation.

Currently, eligibility to enroll in the Health Flex Plan is limited to individuals who meet the following requirements:

- residents of Florida;
- age 64 years of age or younger;
- family income equal to or less than 200 percent of the federal poverty level; uninsured status for at least 6 months prior to enrollment; and
- not covered by a private insurance policy and are not eligible for coverage by a public health program.

According to the agency, as of January 2008, there were five active Health Flex Plan providers that had enrolled a total of 2,232 beneficiaries. For the prior year, 2007, there were four health flex plans covering 1,776 members.⁴

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP), enacted as part of the Balanced Budget Act of 1997, created Title XXI of the federal Social Security Act, which provides health insurance to uninsured children in low-income families either through a Medicaid expansion, a separate children's health program, or a combination of both. The SCHIP was designed as a federal/state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance.

The Florida Kidcare Program

The Florida Kidcare program is combination of Medicaid expansions and public/private partnerships, with a wrap-around delivery system serving children with special health care needs. The Florida Kidcare program is primarily targeted to uninsured children under age 19 whose family income is at or below 200 percent of the federal poverty level.

As structured, Florida Kidcare is an "umbrella" program that currently includes the following four components: Medicaid for children; Medikids; the Florida Healthy Kids program; and the Children's Medical Services Network. Family income level, age of the child, and whether the child has a serious health condition are the eligibility criteria that determine which component serves a particular child.

As of January 2008, there were 1,401,038 children enrolled in the various components of the Florida Kidcare program. Of this total, 230,567 children were Title XXI eligible, 26,051 children

⁴ Health Flex Plan Program Annual Report, January 2007, by the Agency for Health Care Administration and the Office of Insurance Regulation.

were non-Title XXI eligible, and 1,144,420 children were eligible under the Medicaid Title XIX program.⁵

Administration of the Florida Kidcare Program

The Florida Healthy Kids program component of Kidcare is administered by the non-profit Florida Healthy Kids Corporation, established in s. 624.91, F.S. The Florida Healthy Kids program existed prior to the implementation of the federal Title XXI SCHIP. Florida was one of three states to have the benefit package of an existing child health insurance program grandfathered in as part of the Balanced Budget Act of 1997, which created SCHIP.

The Florida Healthy Kids Corporation contracts with managed care plans throughout the state for the provision of health care coverage. The Florida Healthy Kids Corporation contracts with a fiscal agent to perform initial eligibility screening for the program and final eligibility determination for children who are not Medicaid eligible.

The Florida Kidcare application is a simplified application that serves applicants for both the Title XXI Kidcare program as well as Title XIX Medicaid. Pursuant to federal law, each application is screened for the child's eligibility for Title XIX Medicaid. The fiscal agent refers children who appear to be eligible for Medicaid to the Department of Children and Families (DCF) for Medicaid eligibility determination, and children who appear to have a special health care need to CMSN within the DOH for evaluation.

If eligible for Medicaid, the child is enrolled immediately into that program. If the child is not eligible for Medicaid, the application is processed for Title XXI and if the child is eligible under Title XXI, the child is enrolled into the appropriate Florida Kidcare program component. Medicaid for children and Medikids are administered by the agency Medikids uses the Medicaid infrastructure, offering the same provider choices and package of benefits.

Coverage for Dependent Children

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. (s. 627.6562, F.S.)

III. Effect of Proposed Changes:

Florida Kidcare Program (Section 1)

Expands eligibility and enrollment for the KidCare program by eliminating the 10 percent cap on enrollment for MediKids (ages 1-5) and Healthy Kids (ages 6-19) enrollees who have a family income of greater than 200 percent of the federal poverty level and pay full premiums with no subsidized premiums.

⁵ 2008 Annual Report and Recommendations, Florida KidCare Coordinating Council.

Health Flex Plan Program (Section 2)

The bill revises eligibility criteria for enrollment in the Health Flex Plan and participation as an entity eligible to offer the plan. The bill expands the population eligible to purchase health flex plans by raising the income limit from 200 to 300 percent of the federal poverty level. Based on the 2008 Poverty Guidelines of the U.S. Department of Health and Human Services, 200 percent of the federal poverty level is \$42,400 for a family of four, and 300 percent of the federal poverty level is \$63,600 for a family of four.^b

The bill also extends the expiration date of the program from July 1, 2008 to July 1, 2013. In addition, the bill eliminates obsolete provisions related to a federally approved Medicaid demonstration waiver.

Cover Florida Health Access Program Act (Section 3)

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. To be eligible for the program, an enrollee must meet the following requirements:

- Resident of Florida;
- Ages 19 to 64;
- Not covered by private insurance or eligible for public insurance; and
- Uninsured for at least the prior 6 months, with exceptions for persons who lose coverage within the past 6 months under certain conditions.

Administration of the Cover Florida Health Access Program:

The Agency for Health Care Administration (agency) and the Office of Insurance Regulation (agency) 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, 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 Cover Florida plan entity having an existing statewide provider network, and may approve at least one regional network plan in each Medicaid area.

Changes in plan benefits, premiums, and forms are subject to regulatory oversight by the agency and the office. The office and the agency are required to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the status of the program.

The Cover Florida general plan must include the following components:

- Guaranteed issue to enrollees, subject to exclusions for pre-existing conditions approved by the agency and the office.
- Plans are portable, regardless of employment status.

^b <http://aspe.hhs.gov/poverty/>.

- Insurers 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.
- Insurers are required to develop two benefit plans having different cost and benefit levels.

Plans without catastrophic coverage are required to provide coverage options for certain services, including but not limited to:

- Preventive health services and screenings, annual assessments, cervical cancer screenings, mammograms, prostate screening, and immunizations.
- Office visits and surgery
- Behavioral health services
- Durable medical equipment and prosthetics
- Diabetic supplies

Plans providing catastrophic coverage must provide coverage for all of the services required for non-catastrophic coverage, above, as well as the following coverage:

- Inpatient hospital stays
- Hospital emergency care
- Urgent care services
- Outpatient services and surgery

Evaluation and Approval of Cover Florida Plans:

A plan must be disapproved or withdrawn if the plan:

- Contains ambiguous, inconsistent, or misleading provisions;
- Provides benefits that are unreasonable in relation to the premiums charged or result in unfair discrimination in sales practices;
- Fails to demonstrate that the plan is financially sound;
- Cannot demonstrate that the applicant and management meet general eligibility requirements for insurers and HMOs, which includes competency and trustworthiness; or
- Does not guarantee that enrollees may participate in the plan entity's network of providers.

Applicability of the Insurance Code and HMO Laws:

Cover Florida plans are not subject to the Florida Insurance Code and ch. 641, relating to HMOs. However, these plans are considered to be insurance subject to the Unfair Insurance Trade Practices in Part IX of ch. 626, F.S. In the event of the insolvency of a Florida plan entity, these plans would not be covered by an insurance or HMO guaranty association.

Coverage for Dependent Children (Section 4)

Requires group health insurers to offer policyholders and certificateholders (parents) the option to continue coverage for their children on their family policy until age 30. Current law is

maintained that requires coverage for dependent children until age 25. In addition, a group insurer would be required to offer the parent the option to continue coverage for a (non-dependent) child until age 30, if the child is: (a) unmarried with no dependents, (b) a resident of Florida or a full time-or part-time student, and (c) does not have insurance coverage under any other private plan or is not entitled to benefits under Title XVII of the Social Security Act.

Under current law (retained by the bill), the policy must insure a dependent child until age 25, if the child is dependent upon the parent for support and is living in the household of the parent or is a full-time or part-time student.

If a child is provided coverage under the parent's policy after the child reaches age 25 and the coverage for the child is subsequently terminated, the child is ineligible to be covered again under the parent's policy unless the child was continuously covered by other insurance coverage without a coverage gap of more than 63 days. This would address adverse selection issues relating to children (age 25-30) dropping off and coming back on the parent's policy, due to needed medical treatment or services.

These provisions would not apply to self-insured employers since the federal Employee Retirement Income Security Act (ERISA) preempts state laws affecting self-insured employer plans. Approximately 50 percent of the employers in Florida are self insured.

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:

See Private and Public Sector Impact, below, regarding federal tax issues.

B. Private Sector Impact:

The bill increase access and eligibility to health care services and coverage through KidCare, the Health Flex Plan, Cover Florida Health Access, and the dependent coverage provided through group insurance policies.

Health Flex Plan Program

By broadening the income eligibility requirements for the Health Flex Plans for an individual from 200 to 300 percent of the federal poverty level, an indeterminate number of additional persons would be eligible to purchase this coverage. (See Effects of Proposed Changes for income levels.)

According to the agency, this change is also expected to provide an incentive to other health flex plan providers to implement a health flex program. The agency notes that existing health flex plan providers have contended that this change is needed to capture a larger number of individuals that are unable to afford health care premiums for commercial insurance products. Additionally, the expected increase in enrollment is needed to ensure the financial viability of the health flex programs.

KidCare

The statewide Florida Children's Health Insurance Study provides a detailed analysis about the health coverage status of children in Florida.⁷ The study includes estimates of the number of uninsured and the number of children eligible for the Florida KidCare Program. According to the study, approximately 52,768 children, may meet the Healthy Kids requirements and have family income greater than 200 percent of the federal poverty level. In addition, an estimated 11,754 children may meet the MediKids requirements and have family income greater than 200 percent of the federal poverty level. However, it is difficult to estimate how many potentially eligible families would actually apply for coverage and then become enrolled in the program. In addition, although the study obtained detailed information from the families that were surveyed in order to estimate eligibility, the actual number of eligible enrollees would not be known until a more detailed screening process was completed.

Two factors may limit the actual number of additional children who will take up the option of full pay. First, the current subsidized premium for the Healthy Kids program (\$20 per month) covers all the children in the family within the age limit. So whether a family has one child or three children between the ages of 6-19, the family would pay \$20 per month. However, for full pay purposes, it is per child. So, if the family income went over 200 percent of federal poverty level and the family has three children, the premium goes from \$20 per month to \$375 (approximately \$125 per child, for three children). Due to these additional costs per child, a family may only be able to afford coverage for the one child that is sick. Full pay could be too expensive for families with more than one child. Second, some of the children in this group may be eligible via citizenship, but their parents may not be legal residents. As such, it is unlikely they will enroll the child in the program.

In 2007, Florida Healthy Kids Corporation engaged an actuary to estimate the rate to the Healthy Kids program of various proposed changes, including removing the 10 percent cap on enrollment for persons with an income over 200 percent of the federal poverty level.⁸ According to the study, "the value of this change is about a 1 percent change in

⁷ Herndon, Bill Boylston and Shenkman, Elizabeth. The Florida Children's Health Insurance Study 2007. January 2008.
⁸ Ross Health Actuarial letter to Florida Health Kids Corporation, dated March 23, 2007.

rates for each 1 percent change in the mix of full pay enrollees." The study also noted that "the cost of full pay enrollees is about double that of the subsidized population." The report stated "the total impact of this change was estimated to be about 2 percent for each 1 percent increase in the full pay enrollment." According to the Office of Insurance Regulation, unless the actuary did an analysis of the procedure codes of the claims to determine which claims are chronic and which are pent-up demand, the estimate would be overstated.

According to the Florida KidCare Coordinating Council 2008 Annual Report, the full pay monthly premium rate per child is \$159 for MediKids and \$100 for Healthy Kids. As of January 2008, there were 22,412 full pay Healthy Kids enrollees and 2,150 full pay MediKids enrollees. In the Title XXI program there were 188,315 Healthy Kids and 26,141 Medikids enrolled.

Based on the actuarial rate estimates provided to Healthy Kids Corporation, the elimination of the 10 percent cap on full pay Healthy Kids and MediKids enrollees may result in an indeterminate increase in rates for participants, contingent upon the uptake in enrollment due to the removal of the 10 percent enrollment cap and whether the claims costs are driven by persons with chronic conditions and associated high claims or initial, pent-up demand.

Cover Florida Health Access Plans

The bill will allow insurers, HMOs, health-care-sponsored-organizations, or health care districts to offer consumers a choice of benefit plans at affordable prices. These plans will offer the option of catastrophic, non-catastrophic and supplemental coverage. According to the staff of the Governor's Office, the average plan will cost \$150 per month or less. Florida residences, ages 19 to 64 that have been uninsured for at least 6 months are eligible for the plans. These plans are issued on a guaranteed issue basis and are portable, such that an enrollee remains covered regardless of employment status or the cost sharing of premiums.

The state retiree Health Insurance Subsidy Program payment (\$30 to 150 per month) is designed to offset the cost of health insurance for retirees. It is unclear whether retirees enrolling in a Health Flex Plan or Cover Florida plans would be eligible for this subsidy.

Implications for Changes in Dependent Coverage

Extending converge for dependent children from age 25 to 30 may result in a larger number of insureds since approximately 43 percent of the insured in Florida are comprised of persons aged 18 to 34.

Some concerns have been raised regarding possible adverse selection issues related to expanding dependent coverage. Although the estimated increase in premiums attributable to the continuance of dependent coverage to age 30 is expected to be minimal, some employers, particularly small employers, may adopt cost-savings strategies to mitigate even modest increases, such as decreasing contributions for employee coverage or dependent coverage.

Federal Tax Liability Implications for Changes in Dependent Coverage

Concerns have been raised regarding potential federal tax issues for private and public employers and employers and employer administrative costs associated with the changes in the dependent coverage requirements. The possible issues include:

- increased income tax liability to an employee (i.e. imputing the fair market value of the non-tax dependent's health coverage to be included in the employee's gross income),
- increased payroll tax liability for employers, and
- additional administration for employers, related to including the fair market value of the non-tax dependent in the employee's taxable income; or if the employer allows contributions for dependent coverage to be paid with pre-tax salary reductions, arranging to take that portion of the salary reduction on a post-tax basis.

Section 125 of the Internal Revenue Code allows private and public employers to offer premium only plans, a cafeteria plan, or a Flexible Spending Account to their employees. These plans are designed to allow employers to deduct employee paid premiums for certain group and disability related benefits on a tax-exempt basis. As a result, the employer pays less payroll taxes and the employee pays less federal withholding taxes and income taxes. The eligibility changes in the dependent coverage health insurance coverage in the bill have raised concerns related to the impact on 125 plans. The Internal Revenue Code defines a certain class of dependents under federal law, which generally requires financial dependence on the parent. It is possible that the federal law would view payment of the premiums through a cafeteria plan with pre-tax dollars as a violation of s. 125 IRC.

C. Government Sector Impact:

The tax attorney for the Division of State Group Insurance provided the following comments on the fiscal impact related to the federal tax aspects of the dependent coverage changes for the State Group:

An employee can only pay on a pre-tax basis under a cafeteria plan for the health coverage of a spouse (as defined under the Defense of Marriage Act) or a Code Section 105(b) dependent. A cafeteria plan could be disqualified if it permits a participant to elect coverage on a pre-tax basis for a person who is neither. However, the cafeteria plan rules permit non-Code §105(b) dependent coverage health coverage to be offered under a cafeteria plan as a taxable benefit.

In summary, while the offering of coverage may be mandated by state law, the tax treatment (and ramifications for cafeteria plan administration) would be governed by federal tax law. As a result, while coverage may be extended under the state law to any (recently expanded) eligible employee, only a subset of the eligible dependent children would be entitled to receive that coverage on a tax-free basis. Thus, for example, while pre-tax coverage could be extended to a child who

receives over half of their support from the employee, other covered dependent children must have their coverage funded on an after-tax basis and/or have any employer subsidy imputed into income -- i.e., in much the same way that coverage is provided to non-tax dependent domestic partners and/or domestic partner children. Moreover, the otherwise eligible medical expenses of non-tax dependent children would not be eligible for pre-tax reimbursement under the health Flexible Spending Accounts or for tax-free distributions from the Health Savings Accounts. These nuances would need to be communicated (and administrative processes put in place) before coverage is extended to non-tax dependents.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Cover Florida plans established in the bill is not considered "creditable coverage," for purposes of state (s. 627.6561(5)(a), F.S.) and federal laws (federal Health Insurance Portability and Accountability Act of 1996) that require health plans to give the policyholder credit for time covered under previous insurance coverage towards meeting any new preexisting condition exclusion. If the Legislature amended the Florida definition of creditable coverage, s. 627.6561, F.S., to include Cover Florida plans, this would appear to be effective under state law as applied to fully insured plans issued in Florida, but would appear not to apply, under federal law to self-insured plans or health plans in other states. This could potential confusion and administrative burdens for insurers and consumers in determining creditable coverage applicable in other states.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

The CS provides the following changes:

- Creates the Cover Florida Health Care Access Program as a mechanism to provide guaranteed issue coverage through the private market to Florida residents ages 19-64 that do not have insurance coverage during the prior six months.
- Eliminates current 10 percent cap on enrollment in Kidcare for enrollees that pay full premium and have an income over 200 percent of the federal poverty level.
- Eliminates changes to the definition of premium assistance for purposes of the Florida Kidcare program.
- Eliminates provision allowing an employer group meeting certain criteria from participating in the Health Flex Plan.
- Deletes provision requiring eligible employees and their dependents to be covered under a health care plan offered by the employer unless the employee declines.

- Revises dependent coverage requirements.

B. Amendments:

None.

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

The Florida Senate
HOUSE MESSAGE SUMMARY

Prepared By: The Professional Staff of the Banking and Insurance Committee

[2008s2534.hms.doc]

BILL: CS/CS/SB 2534
INTRODUCER: Health and Human Services Appropriations, Banking and Insurance Committee, and Senator Peadar
SUBJECT: Affordable Health Coverage
DATE: April 24, 2008

I. Amendments Contained in Message:

House Amendment 1 ~ 364545 (title)

II. Summary of Amendments Contained in Message:

Similar or Identical Provisions Contained in House Amendment and CS/CS/SB 2534

The House delete-all amendment has the following provisions that are currently included in CS/CS/SB 2534, as passed by the Senate:

Cover Florida Health Care Access Program

Creates the Cover Florida Health Access Program, which is designed to provide affordable health care options for uninsured residents of Florida between the ages of 19-64 who meet certain other criteria. A Cover Florida plan entity must provide non-catastrophic coverage and may provide catastrophic coverage, supplemental insurance, prepaid health clinics, and discount medical plan product options to enrollees. The Agency for Health Care Administration (agency) and the Office of Insurance Regulation (office) are responsible for jointly establishing and administering the Cover Florida 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 (HMO), health care provider-sponsored organizations, and health care districts. The agency and the office are required to approve at least one Cover Florida plan entity having an existing statewide provider network and may approve at least one regional network plan in each Medicaid area.

Dependent Coverage

The Senate Bill and the House amendment continue the current law for dependent coverage until age 25. Eligibility for coverage until age 25 requires the child to be dependent upon the parent for support and living in the household of the parent, or is a full-time or part-time student.

The House amendment and the Senate Bill require group health insurers to offer policyholders and certificate holders (parents) the option to continue coverage of their children on their family

policy until age 30, if the child is: (1) unmarried with no dependents; (2) a resident of Florida or a full-time or part-time student; and (3) does not have insurance coverage under any private or public plan.

Health Flex Plan Program

The Health Flex Plan Program was established to offer basic affordable health care services to low-income, uninsured residents. The bill provides the following changes to the program:

- Expands the population eligible to purchase health flex plans by raising the family income limit from 200 to 300 percent of the federal poverty level (FPL).
- Allows a person who is covered under a subsidized Medicaid or KidCare coverage and lost eligibility due to the income limits to apply for coverage without a lapse in coverage if all other requirements are met.
- Expands the population eligible for health flex plans by allowing individuals that are covered under an individual contract issued by an HMO that has an approved health flex plan, as of October 1, 2008, to enroll in the HMO's health flex plan. These individuals would not be subject to the current requirement of being uninsured for the prior 6-months. Currently, three of the health flex plan providers are authorized as Medicaid HMOs. Persons no longer eligible for the HMO coverage would be able to obtain coverage in a health flex plan and avoid a gap in coverage.
- Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

Provisions Not Included from CS/CS/SB 2534

CS/CS/SB 2534 Bill has the following provisions that are not contained in the House amendment:

1. KidCare

- Expands eligibility and enrollment for the KidCare program by eliminating the 10 percent cap on enrollment for MediKids (ages 1-5) and Healthy Kids (ages 6-19) enrollees who have a family income of greater than 200 percent of the federal poverty level and pay full premiums. These enrollees must pay the full cost of the premium (unsubsidized).
- Requires Healthy Kids Corp. to submit a report to the Legislature and Governor, by February 1, 2009, on the premium impact to the subsidized portion of KidCare from the inclusion of the full-pay program, and recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.

2. Small Employer Group Coverage

The Senate Bill revises the definition of small employer for group coverage to provide that, for purposes of calculating the numbers of employees, companies that are affiliated groups, as defined in s. 1504(a) of the Internal Revenue Code, are considered one employer. This change conforms the statutory definition of "small employer," to the definition contained in the NAIC Model Act and ensures that the majority of the employees of an employer work in Florida and that a company is not formed primarily for buying health insurance. The result will be that certain companies that are currently considered small employers will no longer be entitled to guarantee issue and modified community rating since they will no longer be deemed small employers.

Provisions Not Included in CS/CS/SB 2534

The House amendment includes the following provisions, which are not in CS/CS/SB 2534:

1. Cover Florida Health Care Access Program

The House amendment contains the Cover Florida provisions found in the Senate Bill and also requires a disclosure to be signed by all consumers purchasing program options or insurance coverage through the program, which provides that the program is or isn't an insurance program and the benefits are limited to benefits provided under s. 408.9091, F.S., and that such coverage is an alternative to coverage without such limitations.

2. Florida Health Choices Program

The House amendment creates the Florida Health Choices Program. The program is designed to be a single, centralized market for the sale and purchase of health care products including, but not limited to, health insurance plans, HMO plans, prepaid services, service contracts, and flexible spending accounts. Policies sold as part of the program would be exempt from regulation under the Insurance Code and laws governing health maintenance organizations. The following entities are authorized to be eligible vendors of these products and plans: (1) insurers authorized under ch. 624, F.S., (2) HMOs authorized under ch. 641, F.S., (3) prepaid health clinics licensed under part II, ch. 641, F.S., (4) health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers, (5) provider organizations, including services networks, group practices, and professional associations, and (6) corporate entities providing specific health services.

The House amendment creates Florida Health Choice, Inc., as a not-for-profit corporation under ch. 617, F.S. The corporation would administer the program and function like a third-party administrator (TPA) for employers participating in the program. The corporation can collect premiums and other payments from employers. The corporation is not required to maintain any level of bonding. The corporation is responsible for certifying vendors and ensuring the validity of their offerings. The House amendment does not require or specify any type of independent actuarial or financial reporting by the vendors to the corporation or the submission of such reports or any marketing materials or forms to a regulator, such as the Office of Insurance Regulation or the Agency for Health Care Administration, for review, approval or denial.

The corporation is governed by a 15 member board, 5 members appointed by the Governor (agency representative, Department of Management Services representative, the Commissioner of the Office of Insurance Regulation, and two representatives of public employees), 5 members appointed by the Senate, and 5 members appointed by the House. The employees, officers, and directors of the Florida Health Choice, Inc., are not subject to the ethics (conflict of interest) requirements of s. 112.3145, F.S.. However, even though it is silent on the subject, it appears that the corporation is subject to the public records and meeting requirements under chs. 119 and 286, F.S., respectively.¹ However, medical information or other sensitive, personal information received by the corporation regarding employers and employees are not exempt from public records laws since ch. 119, F.S., does not provide such a general exemption. There is no public records exemption bill addressing the records of the corporation. The House amendment provides that the corporation will develop policies and procedures regarding

¹Florida Office of the Attorney General, Government-in-the-Sunshine Manual, 2007 Edition, Pages 61-62.

conflicts of interest. The House amendment requires the corporation to submit an annual report on its activities to the Legislature and the Governor; however, it does not require an annual independent financial audit and actuarial report of the corporation or authorize the Auditor General to examine the books and records to determine compliance with the statutory requirements. The office and the agency are not authorized to review the books or records of the corporation or vendors.

The House amendment provides that there is no liability on the part of, and no cause of action can arise against, any member of the board or its employees or agents for any action taken by them in the performance of the powers and duties under this act. This provision may waive any liability and cause of action for misfeasance and malfeasance by the board or its employee or agents.

Eligibility and Enrollment-Employers (1-50 employees), certain eligible individuals, cities (population less than 50,000), fiscally constrained counties, vendors (insurers, HMOs, prepaid health clinic providers, out-of-state insurers, health care providers, provider organizations, and corporate entities providing specific services via service contracts), health insurance agents, statutory rural hospitals. Eligible individuals include individual employees of enrolled employers, state employees ineligible for the state group insurance plan, state retirees, and Medicaid reform participants who opt-out.

Health insurance agents serve as buyers' representatives, contingent upon completing specified training and participation agreements. Since an agent is not required to be appointed by an insurer or vendor, it is unclear whether a captive insurer could prohibit an agent from representing such entities.

A consumer purchasing program coverage is required to sign a disclosure regarding the nature of the product, whether it is insurance or not, and that the coverage is subject to certain limitations under the act. If the consumer signs the form, it is presumed that there was an informed, knowing acceptance of such limitations.

The initial enrollment period by an individual participant is a minimum of 12 months. The selection of products and services must be made by an individual participant within 60 days after the date the individual's employer qualified for participation. If an individual fails to enroll within 60 days, the individual is limited to participation in flexible spending account services until the next enrollment period. This provision could be a mandate on some small employer to establish a flexible spending account, resulting in additional administrative costs to the employer.

Pricing--Allows vendors to establish prices based on age, gender, and location of the participants. The corporation must analyze the prices and compare the costs in relationship to the price and provide such information to individuals participating. The Office of Insurance Regulation is authorized to "review" the methodology. However, the office cannot approve or deny such methodology that is used by the corporation. The corporation is authorized to make a post-enrollment risk adjustment of the premium payments to vendors. The corporation may charge a surcharge of 2.5 percent for administrative costs.

Liquidation or Dissolution—The Department of Financial Services would supervise any such action pursuant to the department's authority under the insurance code relating to liquidation and dissolution under ch. 631, F.S. However, some of these vendors are not insurance entities regulated under ch. 631, F.S., and would be subject to the federal bankruptcy laws. The bill does not expressly exempt these products or services from coverage under Florida Life and Health Insurance Guaranty Association or the Health Maintenance Organization Consumer Assistance Plan in the event of insolvency. The House amendment does not specify the distribution of assets in the event of dissolution of the corporation.

Oversight of Participating Vendors—The corporation may exclude vendors from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement. The amendment does not define financial solvency or require financial or actuarial reports from vendors to determine financial solvency or compliance with the participation agreements. The bill does not define deceptive practices or subject these insurer vendors to the unfair insurance trade practices under part IX of ch. 626, F.S., or non-insurer vendors to part II of ch. 501, F.S. (Florida Deceptive and Unfair Trade Practices Act). Disputes regarding the payment or denial of claims are not governed by the insurance code. Instead, the corporation is responsible for establishing grievance procedures and establishing terms for participation by vendors. It is unclear what recourse an enrollee would have in the event a claim was denied.

Applicability of the Insurance Code—Policies sold under program not subject to the insurance code, ch. 641, or the mandated offerings or coverage established in part VI of ch. 627 and ch. 641. The corporation, acting as TPA is not subject to the licensure requirements of part VII of ch. 626. The program is not subject to the Unfair Insurance Trade Practices Act under part IX of ch. 626, F.S.

Tax Credit—Requires the corporation to work with the Department of Revenue to establish tax credits or refunds for participating employers. A plan must be submitted to the Governor and the Legislature by 1/1/09.

The House proposed General Appropriations Act provides \$1,029,561 in non-recurring General Revenue to initially implement the Florida Health Choices Program.

3. Health Flex Plans

The House amendment allows a person who is part of an employer group with at least 75 percent of the employees having income equal to or less than 300 FPL and not covered by private insurance during the last 6 months to be eligible for coverage. If the health flex is an insurer, only 50 percent of the employees must meet the income test.

4. KidCare Program

The House amendment authorizes the direct payment of premium for a qualifying child to be covered as a dependent under an employer family plan when such payment does not exceed the KidCare payment.

5. Dependent Coverage

The House Amendment also provides that until April 1, 2009, a dependent child who qualifies for dependent coverage under this act but whose coverage is terminated may make a written election to reinstate coverage, without proof of insurability. The House Amendment also provides that the changes to dependent coverage do not:

- Require coverage for services provided prior to October 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 (to age 25) 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 the office, 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. This provision applies to individual and group insurance policies and HMO contracts.

6. Insurance Code Exemption for Certain Religious Organizations

The House amendment 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.

7. Prepaid Health Clinics

The House Amendment revises the term, "basic services," for purposes of a prepaid clinic 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.