

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 Grutzer 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 Business¹⁰

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 Instate 2-5 Member Groups	\$168,488,242	\$144,585,527	18,830	18,830	32,330
Instate 6-50 Member Groups	\$720,398,361	\$537,063,636	43,065	122,891	200,253
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 2004¹² 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 Grutzer, “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, at 13 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 times 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 plan³⁰

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 "[I]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.