HEALTH INSURANCE

CS/CS/SB 2534 — Health Insurance

by Health and Human Services Appropriations Committee; Banking and Insurance Committee; and Senators Peaden and Gaetz

The bill provides for two significant new programs designed to provide more affordable access to coverage for health care, primarily for individuals who are uninsured and small employers.

Cover Florida Health Access Program

Creates the "Cover Florida Health Access Program Act," which is designed to provide affordable health care options for uninsured residents. The program will allow insurers, HMOs, health-care-sponsored-organizations, or health care districts to offer consumers a choice of benefit plans at affordable prices. 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.

Enrollment Eligibility 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 lost coverage within the past 6 months under certain conditions.

Administration of the Cover Florida Health Access Program:
The Agency for Health Care Administration and the Office of Insurance Regulation are jointly responsible for 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 agency is required to ensure that the plans follow standardized grievance procedures. 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.

Health Flex Plan Program

The Health Flex Plan Program was established to offer basic affordable health care services to low income, uninsured residents. The amendment 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 subsidized Medicaid or KidCare coverage and who lost eligibility due to the income limits to apply for coverage without a lapse in coverage if all other requirements are met. Under current law, these persons would be required to be uninsured for the prior 6 months prior to enrolling in a health flex plan.
- Expands the population eligible for health flex plans by allowing individuals who 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.
- 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 percent of the FPL and not covered by private insurance during the last 6 months to be eligible for coverage. If the health flex plan is an insurer, only 50 percent of the employees must meet the income test.
- Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

Florida Health Choices Program

The bill creates the Florida Health Choices Program ("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. Products sold as part of the program would be exempt from regulation under the Insurance Code and laws governing health maintenance organizations.

Authorized Vendors
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 ch. 641, part II, 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. Vendors may not sell products that provide "risk-bearing coverage" unless those vendors are authorized

under a certification of authority issued by the Office of Insurance Regulation under the Florida Insurance Code. Vendors are required to make all risk-bearing products offered through the program guaranteed-issue policies, subject to preexisting condition exclusions established by the corporation.

Administration of the Program
The bill creates Florida Health Choice, Inc., as a not-for-profit corporation under ch. 617, F.S. The corporation will administer the program and function like a third-party administrator (TPA) for employers participating in the program. The corporation is responsible for certifying vendors and ensuring the validity of their offerings.

The corporation is governed by a fifteen member board, four members appointed by the Governor, four members appointed by the Senate President, four members appointed by the Speaker of the House of Representatives, and three ex-officio, non-voting members from the following agencies: Agency for Health Care Administration, Department of Management Services, and the Office of Insurance Regulation. The board members may not include insurers, health insurance agents, health care providers, HMOs, prepaid service providers, or any other entity or affiliate of eligible vendors.

The corporation is subject to the ethics (conflict of interest) requirements of part III of ch. 112, F.S., as well as the public records and public meetings requirements of chs. 119 and 287, F.S.

Board members are entitled to per diem and travel expenses but no other compensation is allowed. The board may secure staff and consultant services necessary to the operation of the program. A total of $1.5 million (the sum of 3 separate appropriation categories) in non-recurring funds is appropriated from the General Revenue Fund to fund the program.

Eligibility and Enrollment
The bill provides that small employers (1-50 employees), certain eligible individuals, cities (population less than 50,000), fiscally constrained counties, municipalities having a population of fewer than 50,000 residents, school districts in fiscally constrained counties, and statutory rural hospitals are eligible to enroll. 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.

Pricing; Risk Pooling
Prices for products sold through the program must be based on age, gender, and location of participants. The corporation must develop a methodology for evaluating the actuarial soundness of the product, which methodology must be reviewed by the OIR. The corporation must use the methodology to compare the expected costs and benefits of the products, which must be reported to individuals participating in the program. Prices must remain in force for at least one year. The corporation must add a surcharge not to exceed 2.5 percent to generate funding for

administrative services provided by the corporation and payments to buyer's representatives (including insurance agents).

The program must utilize methods for pooling the risk of individual participants and preventing selection bias, including a postenrollment risk adjustment of the premium payments to the vendors. Monthly distributions of payments to the vendors must be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

OIR Recommendation on Risk-Bearing Products
Prior to making a risk-bearing product available through the program, the corporation must provide information on the product to the OIR. The OIR has 30 days to review the product and make a recommendation that it should, or should not, be made available through the program. If the OIR recommends that a risk-bearing product should not be made available, the product may be offered only if a majority of the board vote to include the product.

Florida KidCare Program

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. The bill makes the following changes to the program:

- 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.

Dependent Coverage

The bill requires individual and group health insurers and HMOs 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.

The bill maintains the current law that requires dependents to be covered until age 25 if the child is dependent upon the parent for support and who either lives in the household of the parent or is a full-time or part-time student. However, this requirement currently applies only to group health

insurance policies, which the bill applies to individual health insurance policies and to all HMO contracts.

Insurance Code Exemption for Certain Religious Organizations

The bill creates an exemption from the Florida Insurance Code for nonprofit religious organizations that qualify under Title 26, sec. 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.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 40-0; House 118-1

CS/CS/CS/SB 2654 — Children with Disabilities

by Health and Human Services Appropriations Committee; Health Policy Committee; Banking and Insurance Committee; and Senators Geller, Ring, Bennett, Deutch, Villalobos, Rich, Fasano, Garcia, Wise, Atwater, Margolis, Crist, Joyner, Justice, Dockery, Dean, Dawson, Saunders, Pruitt, Webster, Alexander, Aronberg, Baker, Bullard, Carlton, Constantine, Diaz de la Portilla, Gaetz, Haridopolos, Hill, Jones, King, Lawson, Lynn, Oelrich, Peaden, Posey, Siplin, Storms, and Wilson

This bill authorizes the Agency for Health Care Administration (AHCA or Agency) to seek federal approval through a Medicaid waiver or state plan amendment for the provision of occupational therapy, speech therapy, physical therapy, behavior analysis, and behavior assistant services to individuals who are 5 years old and younger and have a diagnosed developmental disability, an autism spectrum disorder, or Down syndrome. Coverage for such services must be limited to $36,000 annually and $108,000 in total lifetime benefits. The agency must submit an annual report beginning on January 1, 2009 to the Legislature regarding progress on obtaining federal approval and recommendations for the implementation of services. The agency may not implement the provision of these services without prior legislative approval.

The bill creates the "Window of Opportunity Act" which requires the Office of Insurance Regulation (OIR or Office) to convene a workgroup by August 31, 2008, to negotiate a binding

compact agreement among participants relating to insurance and access to services for persons with developmental disabilities. The working group must include representatives from all licensed health insurers, all licensed health maintenance organizations, and employers with self-insured health benefit plans. No party must agree to the compact, but a party that does agree to the compact is bound to its terms and conditions. The compact agreement must include:

- A requirement to increase coverage for behavior analysis and behavior assistant services, speech therapy, physical therapy, and occupational therapy due to the presence of a developmental disability.
- Procedures for clear and specific notice to policyholders identifying the amount, scope, and conditions under which coverage is provided for such services.
- Penalties for documented cases of denial of claims for medically necessary services due to the presence of a developmental disability.
- Proposals for new product lines to be offered in conjunction with health insurance.

Once the compact agreement negations are completed, the OIR must report the results to the Governor, President of the Senate, and Speaker of the House of Representatives. Beginning February 15, 2009, the OIR must submit an annual report regarding the implementation of the compact agreement.

The bill also creates the "Steven A. Geller Autism Coverage Act" which requires insurer large group health insurance plans and HMO large group health maintenance contracts to provide coverage for diagnostic screening, intervention, and treatment of autism spectrum disorder in children through speech therapy, occupational therapy, physical therapy, and applied behavior analysis that is prescribed by the insured's treating physician in accordance with a treatment plan. All large group health insurance policies and HMO contracts issued or renewed on or after April 1, 2009, must provide the mandated autism spectrum coverage, except that the mandate is not enforceable against an insurer or HMO that is a signatory of the developmental disabilities compact for developmental disabilities, described above, as of April 1, 2009. However, the autism spectrum mandate is enforceable against a signatory of the developmental disabilities compact if the insurer or HMO has not complied with the terms of the compact by April 1, 2010.

The mandatory coverage for autism spectrum disorder is subject to a maximum benefit of $36,000 per year not to exceed $200,000 in total lifetime benefits. Beginning January 1, 2011, the maximum benefit is to be adjusted annually on that date to reflect annual changes in the medical inflation component of the Consumer Price Index. To be eligible for benefits and coverage, an individual must be diagnosed with an autism spectrum disorder at 8 years of age or younger. Benefits and coverage must be provided to eligible persons who are under 18 years of age or who are in high school. Coverage may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable than those applied to covered physical illnesses under the health plan or contract, except as allowed by the act. The coverage for autism may be

subject to other general exclusions and limitations of the insurer's or HMO's policy or plan. Benefits may not be denied on the basis that provided services are habilitative in nature.

Health insurance plans and HMOs may not deny, refuse to issue or reissue coverage, terminate, or restrict coverage because an individual is diagnosed with autism spectrum disorder.

If approved by the Governor, these provisions take effect July 1, 2008
Vote: Senate 40-0; House 117-0

CS/CS/SB 1012 — Health Insurance Claims Payments

by General Government Appropriations Committee; Banking and Insurance Committee; and Senators Gaetz, Baker, Fasano, Posey, Oelrich, Bennett, Ring, Lynn, and Storms

Senate Bill 1012 makes a number of changes to current law regarding assignment of benefits by policyholders or subscribers, third party access to provider networks, and recouping of certain overpayments to providers.

Assignment of Benefits

Committee Substitute for Senate Bill 1012 requires any insurer that contracts with a preferred provider to make payments directly to the preferred provider for such services to its insureds. The bill allows a health insurance policy insuring against loss or expense due to hospital confinement or medical and related services to provide direct payment to licensed ambulance providers, in addition to recognized hospitals and physicians to whom current law authorizes direct payment. Additionally, an insurance contract may not prohibit the direct payment of a licensed ambulance provider for emergency services provided pursuant to s. 395.1041, F.S., or medical transportation services provided pursuant to part III of chapter 401, F.S. Payment to the medical provider may not be greater than the payment the insurer would have paid without an assignment of benefits by the policyholder.

Health maintenance organizations (HMOs) are required to directly pay contracted hospitals, ambulance providers, physicians, and dentists for covered services if their subscribers make an assignment of benefits. An HMO contract may not prohibit the direct payment of benefits to a licensed hospital, ambulance provider, physician or dentist for covered services, for emergency services provided pursuant to s. 395.1041, F.S., or for ambulance transport and treatment provided pursuant to part III of chapter 401. Payment to the medical provider may not be more than the payment due in the absence of an assignment of benefits. These requirements do not affect the prohibition against balanced billing and other requirements in s. 641.3154, F.S., or the requirements for payment of emergency services in s. 641.31, F.S.