Florida Small Employer Benefit Plan Committee

November 2002

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I. SUMMARY

SUMMARY

In 1992, as a result of a lack of access to health care coverage for small employers and their employees, the Florida Legislature enacted a series of laws entitled the Employers Health Care Access Act. The purpose and intent of the Act was to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status.

The key provisions of the Act were guarantee issue to small employers, and modified community rating which was expected to allow spreading of risk over a broader population. The Act also mandated the development of a Standard and a Basic benefit plan and required that each participating carrier actively market these mandated plans to prospective small employers. The standardized benefit plans were intended to provide a set of benefits that were identical, in order to allow comparison on the basis of price and service to facilitate competition.

Although the reforms seemed to improve access for a period of time, in recent years, Florida's small businesses have again been faced with double-digit increases in their health insurance premiums causing more and more small employers to discontinue coverage for their employees and themselves. These increases in premiums are driven by many complex factors that include:

- General Inflation (CPI)
- Drugs, Medical Devices / Advances
- Rising Provider Expenses
- Government Mandates and Regulation
- Increased Consumer Demand
- Litigation and Risk Management
- Fraud and Abuse

In addition, the sales of the standardized plans diminished as the plan designs have not kept up with the market changes. No changes have been made in these benefit plans for almost 10 years.

To address these concerns, Florida Treasurer and Insurance Commissioner Tom Gallagher assembled a new Small Employer Benefit Plan Committee in June 2002. The Committee was instructed to re-design the Standard and Basic plans to better meet Market needs and explore options and offer recommendations for making health plans available to small businesses more accessible and affordable.

During its work, the Committee addressed the following:

1) The importance the Basic or Standard plans as
    a) The only options available to One-Life Groups.
    b) The mandated option for individuals seeking conversion policy coverage.
    c) The basis for comparing the coverage offerings from different carriers.
2) The cost of small employer health insurance with an emphasis on cost reduction not merely cost shifting.
3) The overall condition of the market in any recommendations for legislative reform.

The Committee revised the Standard and Basic plans to include the features that the market has demanded of carriers in their "street" plans. Among the more significant features are increased lifetime maximum benefits and the addition of prescription drug and transplant coverage to the Basic plan. In addition, the plans have been modified to include the cost sharing features that have become common in the market, as employers have sought ways to limit or reduce premium increases.

For the Basic plan, the Committee had a second objective: to modify the plan to be affordable but to provide coverage against catastrophic expenses. Thus, for this plan, the Committee recommends multiple options, several of which include very significant increases in the cost sharing features.

Other highlights of the Committee's Recommended Standard and Basic benefit designs include:

- Basic plan includes a deductible and maximum option to use Medical Savings Accounts.
- Basic plan has been updated to include prescription drug benefits.
- Both the Standard and the Basic plans offer a broader range of transplant coverage benefits.
- The Standard plan, in recognition of its role as the mandated group conversion option, now clearly identifies that carriers must offer conversion plan applicants the standard plan option that is the closest to the applicants group coverage plan prior to conversion.
- The Basic plan offers a wider range of cost sharing options.
- Urgent Care provisions have been added to both plans to provide a cost-effective alternative to emergency room services.
- Out-of-Pocket maximum expenses have been defined to exclude deductibles and prescription copays in all plan options.

The new benefit plans are broken into four different categories:

1. HMO Copay plans
2. HMO Coinsurance plans
3. Indemnity Insurance plans
4. PPO Insurance plans

The Committee recommends that any carrier offering a "street" plan in one of these categories must also offer the mandatory Standard and Basic plans for that category.

The revised standard plan HMO copay, PPO and Indemnity options result in premium reductions of about 20%. The HMO coinsurance plan, which is a new configuration only recently authorized by statute, generates a premium about 40% lower than the current HMO plan.

For the Basic plan, the addition of the prescription drug and other benefits results in an increase in premium of approximately 13% from the current PPO plan and, for the indemnity plan, approximately 8%. However, applicants seeking a more affordable alternative can choose a higher deductible, coinsurance and/or out of pocket maximum that reduces premiums by approximately 18% to 20%. The HMO copay plan offers alternatives that may reduce premium by about 8%-10% from the current HMO plan. Depending on which deductible, coinsurance and/or out of pocket maximum options are chosen, this new coinsurance plan may bring about a premium reduction of approaching 50%.

In recognition of the urgency to get these plans into the marketplace, the Committee recommends that carriers offer the revised plans by April 1, 2003.

In addition to the redesign of the mandated benefit plans, the Committee deliberated possible market reforms and other market issues. The Committee agreed to focus on developing recommendations that meet the following criteria:

1. Bring more carriers into the market.
2. Make coverage within the market more affordable and therefore, provide coverage opportunities to more Floridians.
3. Provide more options for Florida's small employers.

To that end, the Committee makes recommendations on the following:

- Consider Additional Uses of a High-Risk PoolParity Issues: HMO – PPO Emergency Services Benefits
- Workers' Compensation Issues
- Mini-COBRA Issues
- Methods of defining "Employee," "Dependent," and "Employer"

The Committee felt strongly that the cost drivers discussed above require solutions that are beyond this current Committee's ability to address successfully without the direct involvement of all stakeholders in the health care industry (e.g. Patients, Funders, Physicians, Hospitals, Suppliers, Health Plans, Pharmacies,

Consumers and Trial Lawyers). The Committee strongly urges policymakers to explore the opportunity to create a broader communication and reform effort between all parties that may be affected.

Florida Small Employer Benefit Plan Committee

November 2002

II. FULL REPORT

INTRODUCTION

This report provides background information on the small group market, a history of the reform actions taken over the last several years, the work of the Small Employer Benefit Plan Committee and its recommendations. The Committee membership is as follows:

Co-Chairs

Ms. Randy Kammer
Blue Cross Blue Shield of Florida

Ms. Kenney Shipley
Florida Department of Insurance

Committee Members

Mr. Joe Berding
Vista Health Plan

Mr. John Black
Meridian Consulting, Inc

Mr. John Dwyer
United Healthcare

Mr. Scott Fenstermaker
Strategic Employee Benefit Services

Mr. Lane Green
Tall Timbers Research Station

Mr. John Hogan
Capital Health Plan

Ms. Tamara Meyerson
Preferred Medical Plan

Dr. Linda McClintock-Greco
Greco and Associates

Ms. Sharon Jacobs
Attorney-at-Law

Ms. Carolyn Pardue
Consumer

Mr. David Russell
Rogers Benefit Group

Mr. John Sinibaldi
John Sinibaldi Insurance Inc

Mr. Glen Volk
Arthur J. Gallagher & Co.

Mr. Robert Watkins
Robert Watkins & Company, PA

Mr. Steve Wohlwend
Aetna

A. Background

As reported in Florida Senate staff analysis at the time, approximately 2.2 million (17%) Floridians were without health insurance in 1992. Approximately 75% of these uninsured citizens were workers or their dependents. More than half of this group (54%) was employed in businesses with fewer than 50 employees. Again, according to the 1992 Senate staff analysis, there were few restrictions on an insurer's underwriting and rating practices. Some carriers' practices prevented many small employers from purchasing coverage even for those employees healthy enough to pass underwriting standards.

In response to the lack of available coverage for small employers, the Florida Legislature enacted a series of laws entitled the Employers Health Care Access Act. The purpose and intent of the Act was to promote the availability of health insurance coverage to small employers, regardless of their claims experience or their employees' health status. The Act was intended to improve the overall fairness and efficiency of the Small

Employer Group Market and ensure the availability of health insurance policies for small employer groups through rating practices that would encourage broader pooling of risks. Modified community rating and guarantee issue were the cornerstones of the reforms. In addition, mandated, standardized benefit plans allowed consumers to shop among competitors for the best price and service.

B. Standard and Basic Benefit Plans

The Act mandated the development of a Standard and a Basic benefit plan and required that each participating carrier actively market these mandated plans to prospective small employers. The intent of these mandated plans was to give employers and employees a basis for comparing prices and services between carriers. All carriers participating in this market offered identical benefit plans that met defined standards, with allowable differences in price, service, and out-of-pocket expenses.

The Act called for the Florida Insurance Commissioner to appoint a Health Benefit Plan Committee composed of representatives of carriers, agents, small employers, and employees of small employers. The assigned task of the Committee was to develop the new Standard and Basic plans within the limits imposed by statute and summarized below:

These health benefit plans are statutorily mandated by Section 627.6699, Florida Statutes, to contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services;
b. A procedure for preauthorization by the small employer carrier, or its designees.

Specifically, the Standard health benefit plans are to include:

- Coverage for inpatient hospitalization;
- Coverage for outpatient services;
- Coverage for newborn children;
- Coverage for child care supervision services;
- Coverage for adopted children upon placement in the residence;
- Coverage for mammograms;
- Coverage for handicapped children;
- Emergency or urgent care out of the geographic service area; and
- Coverage for services provided by a hospice.

The Basic health benefit plan must include all of the benefits specified above; but it can place additional restrictions on the benefits and impose additional cost containment measures. The plan can specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

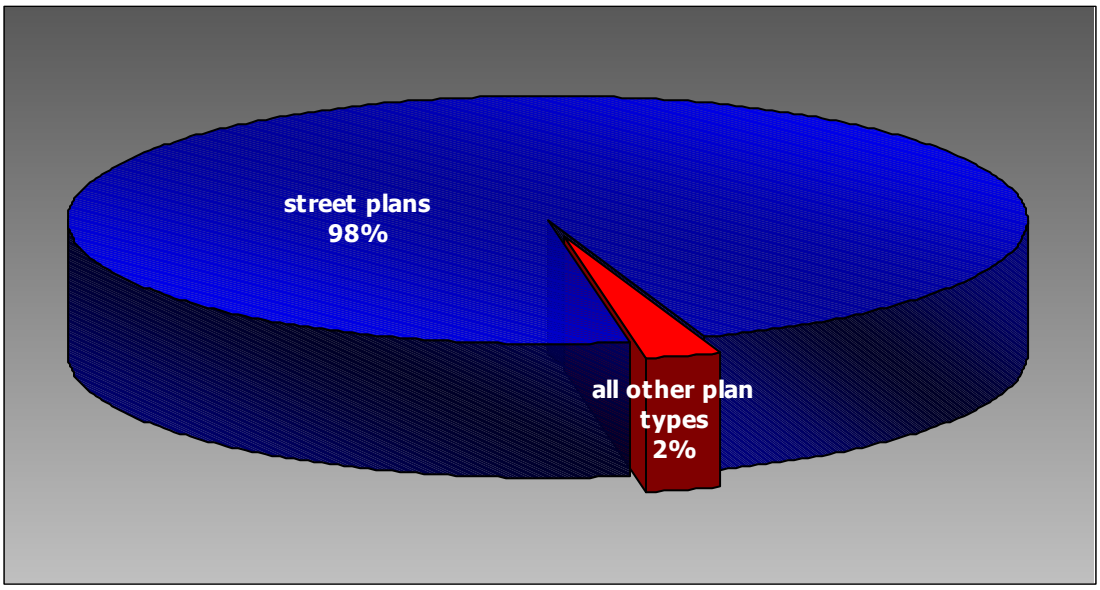
Initially there was great market interest in the mandatory benefit plans designed by the 1992 Committee. A series of high profile meetings were held to strongly encourage carrier and agent participation. Community health purchasing alliances (CHPAs) were formed to enable small employers to band together to purchase health insurance. Many carriers, agents, and employer associations grew increasingly skeptical of the mandated benefit designs the Standard and Basic plans represented.

As a result of adverse selection and increased administrative expenses, carrier support for the CHPAs completely dissolved by the 2000 Florida Legislature, leaving Florida's small employers to face mandated standardized benefit plan options that were out of step with current market conditions.

This inflexibility in benefit design gave rise to carrier-designed "street" plans. Both nationally and in Florida, carriers began to experiment with highly flexible and innovative health benefit designs and options. In addition to the Standard and Basic plans, employers and their employees were presented a variety of tailor-made plans, which met all the statutorily mandated benefits[1] but allowed the buyer to customize his copayment or coinsurance levels and/or maximum annual deductibles and out of pocket fees. As an indicator of the failure of the Standard and Basic benefit plans to remain competitive the chart below shows that at the close of 2001,

[1] *Please see summary of current mandated benefits in Attachment C.*

only 2% of the total covered lives in the Small Employer Group Market were covered under the Standard and Basic plans.



C. Affordability

Although the main focus of the Act was to ensure access to coverage for all small employers at equitable prices, it did not address affordability.

It was expected that prices would be leveled as a result of "modified community rating." Carriers are required to pool the experience of all of their small groups. Until 2000, premium rates could only differ between groups based on the composition of the group in terms of: gender, age, family composition, tobacco use, and geographic location. In 2000, the Act was modified to allow a further adjustment of rates by plus/minus 15% based on the health status, claims experience, or duration of the group.

In recent years, Florida's small businesses have been facing double-digit increases in their health insurance premiums. In 2000, health insurance premiums among Florida's small employers rose by an average of 16%. That number increased to 24% in 2001. For companies with fewer than 50 employees, health insurance costs are expected to rise an average of 30% this year. Self-employed individuals may encounter premium increases of more than 50%.

This alarming trend in small group rates has led to the concern that employers will be forced to stop offering health insurance to their employees, leaving workers and their families with little or no options for coverage.

D. Number of Carriers

The Small Employer Group Market has changed significantly since the inception of the Act. As recently as 1996, there was great interest expressed by carriers in the Small Employer Group Market. However, by the end of 2001, of the original 107 carriers that expressed intent to market small group products, only 27 remained in the Market. One third of the carriers that left the market did so as a result of merging with another carrier or liquidation. It is also interesting to note that the remaining 27 carriers have represented approximately 80% of the market consistently during the period from 1996 to present.

A summary of reasons for exiting the market:

7 carriers left the market as a result of liquidation, rather than choosing to leave
23 carriers merged into or were acquired by another small group carrier
50 carriers chose to withdraw from the market

Of the 107 carriers expressing interest in participating in the market in 1996:

19 carriers (18%) never actively marketed or enrolled lives in this market
47 carriers (45%) enrolled less than 1,000 lives while participating
82 carriers (77%) enrolled less than 10,000 lives while participating.

E. Market Share

The table below provides detail of the covered lives and market share for carriers serving Florida's small employers as of December 31, 2001. (This data was compiled from Florida Department of Insurance Employee Health Care Access Act Enrollment Report FLDOI Form#: DI4-1117 for 4th Quarter, 2001. "Covered Lives" is the sum of reported certificate holders/subscribers and their dependents.)

2001 Active Carrier	Covered Lives	Market Share
1. UNITED HEALTHCARE OF FLORIDA, INC	315,777	26.663%
2. AETNA US HEALTHCARE, INC.	221,704	18.720%
3. HEALTH OPTIONS, INC.	210,265	17.754%
4. BLUE CROSS BLUE SHIELD OF FL, INC.	138,287	11.677%
5. NEIGHBORHOOD HEALTH PARTNERSHIP	79,851	6.742%
6. HUMANA HEALTH INS. CO OF FL, INC.	40,326	3.405%
7. PACIFIC LIFE & ANNUITY COMPANY	29,030	2.451%
8. VISTA HEALTHPLAN, INC.	19,523	1.648%
9. HUMANA MEDICAL PLAN, INC.	18,548	1.566%
10. CAPITAL GROUP HEALTH SERVICES	17,580	1.484%
11. BEACON HEALTH PLANS	11,356	0.959%
12. AETNA LIFE INSURANCE COMPANY	10,874	0.918%
13. AV-MED, INC.	7,786	0.657%
14. HEALTH FIRST HEALTH PLANS, INC.	7,504	0.634%
15. HEALTHPLAN SOUTHEAST, INC.	6,155	0.520%
16. FLORIDA HEALTH CARE PLANS, INC.	4,812	0.406%
17. TRANSAMERICA LIFE INSURANCE COMPANY	2,441	0.206%
18. TRUSTMARK INSURANCE CO (MUTUAL)	2,216	0.187%
19. HUMANA INSURANCE COMPANY	1,645	0.139%
20. CIGNA HEALTHCARE OF FLORIDA, INC.	1,466	0.124%
21. WELL CARE HMO, INC.	1,446	0.122%
22. UNITED HEALTHCARE INSURANCE CO.	1,057	0.089%
23. TOTAL HEALTH CHOICE, INC.	1,044	0.088%
24. CONNECTICUT GENERAL INSURANCE CO.	339	0.029%
25. THE PUBLIC HEALTH TRUST OF DADE COUNTY	194	0.016%
26. PHYSICIANS HEALTHCARE PLANS, INC.	41	0.003%
27. UNICARE LIFE & HEALTH INS CO.	27	0.002%
28. OTHER CARRIERS *	33,735	2.788%
Total	**1,185,029**	**100%**

** Carriers no longer actively marketing to new groups and in the process of market withdrawal.*

F. Market Size

At the end of 2001, 25% of all Floridians receiving Major Medical health insurance or HMO coverage did so in the small group market. This equates to 155,022 employers and 1,185,029 lives. This represents a decrease of about 110,000 employers and 600,000 lives since 1996.

REPORTING YR	TOTAL EMPLOYER GROUPS	TOTAL COVERED LIVES
1996	265,825	1,793,671
1997	208,243	1,429,540
1998	219,238	1,435,361
1999	211,839	1,438,641
2000	184,104	1,332,259
2001	155,022	1,185,029

G. Summary of Florida's Uninsured Data

A final concern is best summarized by the following snapshot of Florida's uninsured population today, based on data collected by the Kaiser Commission on Medicaid and the Uninsured (http://www.kff.org):

- Approximately 2.9 million (18%) of Florida's citizens are uninsured.
- 30% of Florida's full-time employees do **NOT** receive health care coverage from their employers.
- 53% of Florida's small employers do **NOT** make health care coverage available to their employees.
- In comparison, only 3% of Florida's large employers do **NOT** provide health care coverage to their employees.

THE 2002 SMALL EMPLOYER BENEFIT PLAN COMMITTEE

Given these market conditions and citing concern for Florida's small employers struggling to pay for health insurance for their employees, in June 2002, Florida Treasurer and Insurance Commissioner Tom Gallagher assembled a new Small Employer Benefit Plan Committee. The Committee was again comprised of representatives of carriers, agents, employers, and employees. They were instructed to re-design the Standard and Basic plans to better meet Market needs and explore options and offer recommendations for making health plans available to small businesses more accessible and affordable.

The Committee met June 6, July 12, 19, August 9, 16, 23, September 5, 27, and November 1, 2002. Each meeting was duly noticed in the *Florida Administrative Weekly*, "Section VI Notices of Meetings, Workshops and Public Hearings," prior to the meeting. Public comment was received at each public meeting and was encouraged to be sent to assigned Florida Department of Insurance staff via email.

The Committee began its work by agreeing to address

1. The importance of the Basic or Standard plans as:
    a. The only options available to One-Life Groups.
    b. The mandated option for individuals seeking conversion policy coverage.
    c. The basis for comparing the coverage offerings from different carriers.
2. The cost of small employer health insurance with an emphasis on cost reduction not merely cost shifting.
3. The overall condition of the market in any recommendations for legislative reform.

A. Overview of Standard and Basic Plans

The Committee reviewed an outline of the Standard and Basic plans' current benefit structure. Areas requiring additional consideration were identified, including:

1) The Basic plan is benefit rich in the coverages that it provides, which makes it unaffordable: but the plan lacks some of the key benefits such as pharmaceuticals.
2) Deductible options need review; some of the lower ones should be eliminated and higher ones established.
3) The copay options for the HMO plans need to be increased.
4) Although there is reluctance from hospitals to participate and some carriers cannot presently do all the administration, hospital tiering should be considered.
5) Maternity benefits should remain a part of both plans.
6) Emergency room cost sharing should be modified to encourage the use of less costly facilities.
7) If transplant coverage is to be provided, it should be according to Medicare's transplant guidelines.
8) The HMO plans should consider offering coinsurance.
9) The outpatient benefits need revision.
    a) There is inconsistency between the HMO and insurance products (e.g., The HMO presently offers incentives to use outpatient surgery facilities while the insurance products do not.).
    b) The HMO copays are out of date.
10) Diagnostic services are also inconsistent between plans. HMOs are covered in full while insurance products have coinsurance.
11) The prescription drug benefits have not kept up with market conditions.
    a) The copays are low.
    b) There is no tiering.
    c) There is no distinction for mail order drugs.
12) Home health, skilled nursing, and durable medical equipment benefits may need some increased cost sharing.
13) Reconsider the cap on preventive medical benefits.

B. Additional Considerations

The Committee's general discussions at its initial meeting resulted in the following additional considerations:

1) Affordability is a major issue in the market.
2) There was no identified general demand for any new coverages, with the exception of potential inclusion of the prescription drug coverage in the Basic plan.
3) In response to the issues of affordability:
   a) Several new types of products were being developed including:
      (1) Medical Savings Accounts,
      (2) Mini-medical plans,
      (3) Discount cards, complemented by indemnity or supplemental plans.
   b) Small employers were joining illegal "ERISA" plans offered by unlicensed entities.
   c) Increasingly employers move to just having defined benefit plans such as hospital or medical indemnity.
4) Committee members were concerned that consumers may not fully realize the limitations (or illegality) of these plans at the time of purchase.
5) The Committee should consider offering carriers increased flexibility in regard to the Standard and Basic plans including the ability to use their own company contract language and terms.
6) The use of the Standard and Basic plans as a basis for comparison shopping may be distorted by the differences between carrier networks. Carriers with broader networks or lower contracted fees may actually offer less out-of-pocket expenses even though the policy form would be the same as another carrier's.
7) Among the cost drivers identified were:
   a) Hospital costs
   b) Pharmacy costs
   c) Adverse selection
      (1) The Small Employer Group Market is frequently selected against in favor of lower cost and limited benefit individual insurance products and other low-cost, low-coverage alternatives
      (2) The statutory requirement to offer coverage to any "employees" who work a minimum of 25 hours allows fraud because it is difficult monitor and enforce.

C. Formation of Subcommittees

Once the Committee reached consensus on the scope of work, it formed three separate Subcommittees to address specific tasks.

The first Subcommittee was charged with reviewing and making recommendations for revisions to the Basic plan. The Subcommittee was given the guidance that the Basic plan should be an affordable plan, but should also provide against catastrophic expenses.

The second Subcommittee was charged with addressing the Standard plan. Their direction was to modify the plan as necessary to make it more closely aligned with the more common "street" plans (small employer group plans that meet all minimum statutory requirements yet deviate from the mandated Standard and Basic benefit design). This would ensure that every carrier would offer a benefit plan designed to meet the current market standards. This is especially important for individuals seeking a conversion policy or One-Life Groups whose options are limited. (One-Life Groups are only offered the Basic and Standard plans. Conversion applicants are offered a choice between the Standard plan and an alternative benefit plan that meets some statutory minimum requirements.)

The third Subcommittee was established to review and make general recommendations on alternative funding mechanisms. The various alternative funding mechanisms being offered (or in some cases, not being offered) in the Small Employer Group Market include but are not limited to: medical savings accounts, health reimbursement arrangements, programs that provide access to a network of providers at a discount and mini-medical plans.

Each of the Subcommittees brought their recommendations back to the full Committee. A brief summary of each of the Subcommittee's work is provided below.

D. Basic Plan Subcommittee Report

This group's goal was to make the product more affordable by developing a more flexible Basic plan, possibly through the marriage of a deductible plan and a "health reimbursement arrangement" (HRA) or a catastrophic plan.

Keeping in mind the role of maximum out-of-pocket expenses in a consumer's health care utilization patterns, various pricing scenarios were forwarded for actuarial analysis after which the Subcommittee established its final recommended benefit plans. The Subcommittee also, after some discussion, determined that a Medical Savings Account type product would not be an appropriate option to be offered in conjunction with a traditional HMO product, due to this product's lack of defined Maximum Annual Deductions. Yet, the group did establish appropriate deductible and maximum out of pocket levels to allow the use of these types of savings accounts with other types of coverage, including the recently legislatively permitted HMO with deductible and coinsurance model.

An actuarial exhibit estimating the rate impact of changes to current copay and coinsurance levels, out-of-pocket maximum limits, and lifetime maximum limits was used in the Full Committee's final deliberations of the recommended Basic benefit plan contained in this report.

Additionally, to facilitate the identification of "cost driver" effects of mandated benefits, the Subcommittee agreed that a recommendation that a full study, including appropriate levels of actuarial and cost effectiveness analysis, be requested of the Florida Legislature when mandates are considered.

E. Standard Plan Subcommittee Report

The Standard Plan Subcommittee's charge was to:

(1) Analyze the role of the Standard plan in the Florida Small Employer Group Market.
(2) Make recommendations to revise the plan to make it a more viable option for the Florida Small Employer Group Market.
(3) Consider current innovations in health care, alternative financing and cost containment measures and their potential effects on the Standard plan specifically, and the Florida Small Employer Group Market in general.

The Subcommittee began its work discussing a wide range of topics concerning the Florida Small Employer Group Market in its entirety. It was determined that the Standard plan plays a dual role in this market:

- As a benchmark of comprehensive health care coverage, defining benefits mandated by statute.
- As a basis for an employer's decision to pursue a richer or lesser option.

After a thorough review of the mandated benefits, the Subcommittee recommended that the Committee should consider offering carriers increased flexibility in regard to the Standard and Basic plans including the ability to use their own company contract language and terms. Although the Subcommittee did not endorse any specific mandates, they recommended that, for administrative ease and marketability, the Standard plan should include all mandates that are required in the "street" plans.

The Subcommittee also discussed the effects of cost sharing. An actuarial exhibit estimating the rate impact of changes to current copay and coinsurance levels; out-of-pocket maximum limits and lifetime maximum limits was used in the Full Committee's final deliberations of the recommended Standard benefit plan contained in this report.

F. Alternative Financing Arrangements Subcommittee Report

This group investigated the many innovative product ideas presently being offered or considered in the market and provided recommendations to encourage the continued development of appropriate options while at the same time ensuring appropriate consumer protections and awareness.

The group discussed several items. These included discount card programs complemented by indemnity insurance, mini-medical plans, medical savings accounts, and health reimbursement arrangements. During the discussion of mini-medical plans and discount card programs, it became apparent that the group desired a more comprehensive type of coverage for the market. It was noted that the mini-medical plans may not be creditable coverage and may not be portable. The desire was to utilize programs that provided more risk sharing but retained the comprehensive nature of the coverage.

The group spent considerable time discussing the availability of Medical Savings Accounts (MSAs) compliant products in the small group market. They felt that it is important to the employers to have this option available to them.

The Committee reviewed a presentation on the recent IRS ruling concerning health reimbursement arrangements also known as Personal Health Accounts (PHAs). The primary purpose of these contribution accounts are for employers to set aside monies to be used to cover health expenses incurred by their employees.

Advantages include:

1. Roll over from year to year with few limitations on the contribution amount;
2. PHAs can be coupled with premium conversion plans to allow for pretax deductions of employees' contribution to their health insurance;
3. Encourages the user to incur health care costs more wisely;
4. Compliance may be less difficult than under a Flexible Spending Account (FSA) arrangement;
5. The PHAs can be set to be the last source of reimbursement by the terms of the plan document, otherwise an FSA, if available, is the last source of reimbursement;
6. May be set up to accommodate retirees and former employees.

Limitations include:

1. No employee contributions allowed;
2. No other sources of indirect funding permissible (e.g. employee salary reduction commensurate with size of employer PHAs contribution, etc.);
3. No cash options ("cash outs") available;
4. Pretax deduction only available for employer of PHAs contribution actually used for medical expenses by the employee;
5. Employer can terminate at anytime and for any reason as allowed in the plan document;
6. No vesting element;
7. Failure of the PHAs with one employee jeopardizes the PHAs tax preferred status for all employees for the plan year of the failure.

Differences between Personal Health Accounts (PHAs) and Medical Savings Accounts (MSAs):

1. MSAs has more complex rules on annual contributions;
2. MSAs are restricted to small employers only - e.g. 1 – 50 employees;
3. PHAs are not an option for One-Life Groups because of self-employment restrictions under 105 and 106 of the Federal Tax code;
4. MSAs represent money that belongs the employee. PHAs are more likely to be ledger accounts that are only available to the employee to the extent that the employee has reimbursable medical care expenses and could be terminated at any time by the employer.

The group recommended that the revisions to the Standard and Basic products include, as options, some plans that meet federal guidelines for MSAs and urges consumers and health care coverage carriers consider the use of PHAs.

G. Gathering of Public Opinion

From the first days of the Committee's deliberations, it was noted that an effort was needed to define what premium level Florida's Small Employers would consider "affordable" and what cost sharing levels would be acceptable to the market in order to attain "affordability." The Committee wishes to thank the Florida Chamber of Commerce and The Florida Association of Insurance and Financial Advisors (FAIFA) for assisting in the gathering of public opinion data used in its discussions. The results of the FAIFA and the Chamber's work can be seen at the end of this document as Attachment B.

SUMMARY OF BENEFIT PLAN RECOMMENDATIONS

A. Benefits

In keeping with its established objectives to: 1) modify the Standard benefit plan to more closely emulate the more popular "street" plans presently offered in the market, and 2) modify the Basic plan to provide an affordable alternative that provides at a minimum catastrophic protection, the Committee recommends the revised benefit designs outlined on the tables at the end of this section.

During the 2002 Legislative Special Session E, Senate Bill 46 E amended Section 627.6699(15)(a), F.S., to include "A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments does not apply to any health plan policy, including a Standard or Basic health benefit plan policy or contract, offered or delivered to a small employer unless such law is made expressly applicable to such policy or contract. However, every small employer carrier must offer to eligible small employers the Standard benefit plan and the Basic benefit plan, as required by subsection (5), as such plans have been approved by the department pursuant to subsection (12)."

Many of the carrier representatives indicated that their companies are planning to incorporate these features in future products. The Committee decided to incorporate the use of coinsurance and deductible in addition to some higher copayments, and annual or lifetime maximum payments in the HMO benefit design. HMOs may now offering, as one of their mandated offerings, Standard and Basic plans with a coinsurance and deductible option.

Other highlights of the Committee's Recommended Standard and Basic benefit designs include:

- Basic plan includes a deductible and maximum option to use Medical Savings Accounts.
- Basic plan has been updated to include prescription drug benefits.
- Both the Standard and the Basic plans offer a broader range of transplant coverage benefits.
- The Standard plan, in recognition of its role as the mandated group conversion option, now clearly identifies that carriers must offer conversion plan applicants the standard plan option that is the closest to the applicants group coverage plan prior to conversion.
- The Basic plan offers a wider range of cost sharing options.
- Urgent Care provisions have been added to both plans to provide a cost-effective alternative to emergency room services.
- Out-of-Pocket maximum expenses have been defined to exclude deductibles and prescription copays in all plan options.

B. Mandated Benefit Offerings

The new benefit plans are broken into four different categories:

1. HMO Copay plans
2. HMO Coinsurance plans
3. Indemnity Insurance plans
4. PPO Insurance plans

The Committee recommends that any carrier offering a "street" plan in one of these categories must also offer the mandatory Standard and Basic plans for that category. In addition, in order to meet the stated Committee goal of providing more options for Florida's small employers, the Committee recommends that each

participating Small Employer Group carrier be required to offer two Basic and two Standard plans to each prospective Small Employer Group purchaser from each category in which they offer those "street" plans, e.g., a carrier who offers a PPO small employer group product must also offer the mandatory Basic and Standard benefit plans. The benefit tables are broken into the two options that must be offered. Note that the Committee designed the Mandated Basic Benefit Plan Option TWO in a manner to allow the carrier to "build" a mandated option from a variety of deductibles, maximum out-of-pocket, and copayment combinations to best suit the customer.

C. Recommended Benefit Designs

Exhibit 1

For comparison purposes, please see current Standard and Basic benefit designs, which are located at the end of this report and identified as Attachment D.

STANDARD BENEFIT PLAN: M a n d a t e d O p t i o n O N E

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
I. Cost Sharing				
Deductible - Individual	None	$1,000	$1,000	$1,000
Deductible - Family	None	3x	3x	3x
Coinsurance percentage	Not Applicable	20%	20%	20% / 40% (in-out)
Copays	As Specified	As Specified	As Specified	As Specified
Maximum Out of Pocket - Individual*	$3,000	$3,000	$3,000	$3,000
Maximum Out of Pocket - Family*	2x	2x	2x	2x
Maximum Lifetime Benefit	$5M	$5M	$5M	$5M
II. Inpatient Hospital Services	$300 copay / day for first five (5) days	Coinsurance or $300 copay / day for first five (5) days	Coinsurance	Coinsurance or $300 copay / day for first five (5) days
III. Emergency Care Services				
Emergency Room	$150 copay	Coinsurance**	Coinsurance	Coinsurance
Ambulance	$100 copay	Coinsurance**	Coinsurance	Coinsurance
Urgent Care	$75 copay	Coinsurance**	Coinsurance	Coinsurance
IV. Outpatient Services				
Surgical Care in Outpatient Hospital Department	$200 copay	Coinsurance**	Coinsurance	Coinsurance
Surgical Care in Ambulatory Surgical Center	$100 copay	Coinsurance**	Coinsurance	Coinsurance
Primary Care Physician Office Visit	$25 copay	Coinsurance**	Coinsurance	Coinsurance or $25 copay in network
Specialist Office Visit	$50 copay	Coinsurance**	Coinsurance	Coinsurance or $50 copay in network
Non-Surgical Spine & Back Disorder Treatment	$25 copay/visit (Maximum 10 visits/CY)	Coinsurance** (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)	Coinsurance or $25 copay/visit (Maximum 10 visits/CY)
Outpatient Rehabilitative Services (Speech, PT, OT)	$25 copay (Maximum 20 visits/CY	Coinsurance** (Maximum 20 visits CY)	Coinsurance (Maximum 20 visits/CY)	Coinsurance or $25 copay in network (Maximum 20 visits/CY)

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance.*

STANDARD BENEFIT PLAN:
M a n d a t e d O p t i o n O N E

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
V. Prescription Drugs (Preferred Generic/Preferred Brand/ Non-Preferred)	$10 / $30 / $50	$10 / $30 / $50	$10 / $30 / $50	$10 / $30 / $50
VI. Home Health Care	$25 copay / visit (Maximum 60 visits/CY)	Coinsurance** (Maximum 60 visits/CY)	Coinsurance (Maximum 60 visits/CY)	Coinsurance or $25 copay / visit (Maximum 60 visits/CY)
VII. Mental Health Services				
Mental Health - Out Patient Services	$25 copay / visit (Maximum 20 visits/CY)	Coinsurance** (Maximum 20 visits/CY)	Coinsurance (Maximum 20 visits/CY)	Coinsurance or $25 copay / visit (Maximum 20 visits/CY)
Mental Health - In Patient Services	$100 copay / day (Maximum 20 visits/CY)	Coinsurance** (Maximum 20 visits/CY)	Coinsurance (Maximum 20 visits/CY)	Coinsurance (Maximum 20 visits/CY)
Alcohol - Substance Abuse	(Maximum $2000 Lifetime Benefit)	Coinsurance** (Maximum $2000 Lifetime Benefit)	Coinsurance (Maximum $2000 Lifetime Benefit)	Coinsurance (Maximum $2000 Lifetime Benefit)
VIII. Skilled Nursing Facility	100 days Lifetime Maximum	100 days Lifetime Maximum	100 days Lifetime Maximum	100 days Lifetime Maximum
IX. Hospice	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization
X. Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered
XI. Durable Medical Equipment, Orthotics & Prosthetics	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions
XII. X-Ray, Laboratory Diagnostic Services				
Diagnostic procedures including EKG, lab tests, traditional x-ray exams	Covered	[Coinsurance]	[Coinsurance]	[Coinsurance]
Imagery Services including MRI, PET, and CT scans	$100 copay	Coinsurance**	Coinsurance	Coinsurance

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance.*

STANDARD BENEFIT PLAN:
M a n d a t e d O p t i o n O N E

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
XIII. Preventative Services Including: Annual Physical Reproductive Exam Child Health Supervision Prenatal & Postnatal Care Screening and Health Assessment Exams Eye and Hearing Exams (adult & child)	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance.*

STANDARD BENEFIT PLAN:
M a n d a t e d O p t i o n T W O

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
I. Cost Sharing				
Deductible - Individual	None	$1,000	$1,000	$1,000
Deductible - Family	None	3x	3x	3x
Coinsurance	Not Applicable	20%	20%	20% / 40% (in-out)
Copays	As Specified	As Specified	As Specified	As Specified
Maximum Out of Pocket - Individual*	$5,000	$5,000	$5,000	$5,000
Maximum Out of Pocket - Family*	2x	2x	2x	2x
Maximum Lifetime Benefit	$5M	$5M	$5M	$5M
II. Inpatient Hospital Services	$300 copay / day for first five (5) days	Coinsurance or $300 copay / day for first five (5) days	Coinsurance	Coinsurance or $300 copay / day for first five (5) days
III. Emergency Care Services				
Emergency Room	$150 copay	Coinsurance**	Coinsurance	Coinsurance
Ambulance	$100 copay	Coinsurance**	Coinsurance	Coinsurance
Urgent Care	$75 copay	Coinsurance**	Coinsurance	Coinsurance
IV. Outpatient Services				
Surgical Care in Outpatient Hospital Department	$200 copay	Coinsurance**	Coinsurance	Coinsurance
Care in Ambulatory Surgical Center	$100 copay	Coinsurance**	Coinsurance	Coinsurance
Primary Care Physician Office Visit	$25 copay	Coinsurance**	Coinsurance	Coinsurance or $25 copay in network
Specialist Office Visit	$50 copay	Coinsurance**	Coinsurance	Coinsurance or $50 copay in network
Non-Surgical Spine & Back Disorder Treatment	$25 copay/visit (Maximum 10 visits/CY)	Coinsurance** (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)	Coinsurance or $25 copay/visit (Maximum 10 visits/CY)
Outpatient Rehabilitative Services (Speech, PT, OT)	$25 copay (Maximum 20 visits/CY)	Coinsurance** (Maximum 20 visits/CY)	Coinsurance (Maximum 20 visits/CY)	Coinsurance or $25 copay in network (Maximum 20 visits/CY)
V. Prescription Drugs (Preferred Generic/Preferred Brand/ Non-Preferred)	$10 / $30 / $50	$10 / $30 / $50	$10 / $30 / $50	$10 / $30 / $50
VI. Home Health Care	$25 copay / visit (Maximum 60 visits/CY)	Coinsurance** (Maximum 60 visits/CY)	Coinsurance (Maximum 60 visits/CY)	Coinsurance or $25 copay / visit (Maximum 60 visits/CY)

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance.*

STANDARD BENEFIT PLAN:
M a n d a t e d O p t i o n T W O

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
VII. Mental Health Services				
Mental Health - Out Patient Services	$25 copay / visit (Maximum 20 visits/CY)	Coinsurance** (Maximum 20 visits/CY)	Coinsurance (Maximum 20 visits/CY)	Coinsurance or $25 copay / visit (Maximum 20 visits/CY)
Mental Health - In Patient Services	$100 copay / day (Maximum 10 days/CY)	Coinsurance** (Maximum 10 days/CY)	Coinsurance (Maximum 10 days/CY)	Coinsurance (Maximum 10 days/CY)
Alcohol - Substance Abuse	(Maximum $2000 Lifetime Benefit)	Coinsurance** (Maximum $2000 Lifetime Benefit)	Coinsurance (Maximum $2000 Lifetime Benefit)	Coinsurance (Maximum $2000 Lifetime Benefit)
VIII. Skilled Nursing Facility	100 days Lifetime Maximum	100 days Lifetime Maximum	100 days Lifetime Maximum	100 days Lifetime Maximum
IX. Hospice	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization
X. Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered
XI. Durable Medical Equipment, Orthotics & Prosthetics	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions
XII. X-Ray, Laboratory Diagnostic Services				
Diagnostic procedures including EKG, lab tests, traditional x-ray exams	Covered	[Coinsurance]	[Coinsurance]	[Coinsurance]
Imagery Services including MRI, PET, and CT scans	$100 copay	Coinsurance**	Coinsurance	Coinsurance

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance.*

STANDARD BENEFIT PLAN:
M a n d a t e d O p t i o n T W O

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
XIII. Preventative Services Including: Annual Physical Reproductive Exam Child Health Supervision Prenatal & Postnatal Care Screening and Health Assessment Exams Eye and Hearing Exams (adult & child)	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance.*

BASIC BENEFIT PLAN:
M a n d a t e d O p t i o n O N E

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
I. Cost Sharing				
Deductible - Individual	None	$2,500	$2,500	$2,500
Deductible - Family	None	3x	3x	3x
Coinsurance	Not Applicable	40%	40%	40% / 60% (in/out)
Copays	As Specified	As Specified	As Specified	As Specified
Maximum Out of Pocket - Individual*	$7,500	$7,500	$7,500	$7,500
Maximum Out of Pocket - Family*	2x	2x	2x	2x
Maximum Lifetime Benefit	$2M	$2M	$2M	$2M
II. Inpatient Hospital Services	$750 copay / day	Coinsurance**	Coinsurance	Coinsurance
III. Emergency Care Services				
Emergency Room	$250 copay	Coinsurance**	Coinsurance	Coinsurance
Ambulance	$100 copay	Coinsurance**	Coinsurance	Coinsurance
Urgent Care	$75 copay	Coinsurance**	Coinsurance	Coinsurance
IV. Outpatient Services				
Surgical Care in Outpatient Hospital Department	$500 copay	Coinsurance**	Coinsurance	Coinsurance
Surgical Care in Ambulatory Surgical Center	$250 copay	Coinsurance**	Coinsurance	Coinsurance
Primary Care Physician Office Visit	$25 copay	Coinsurance**	Coinsurance	Coinsurance or $25 copay in network
Specialist Office Visit	$75 copay	Coinsurance**	Coinsurance	Coinsurance or $75 copay in network
Surgical Care in Ambulatory Surgical Center	$75 copay	Coinsurance**	Coinsurance	Coinsurance or $75 copay in network
Non-Surgical Spine & Back Disorder Treatment	$25 copay/visit (Maximum 10 visits/CY)	Coinsurance** (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)	Coinsurance or $25 copay/visit (Maximum 10 visits/CY)
Outpatient Rehabilitative Services (Speech, PT, OT)	$25 copay (Maximum 10 visits/CY)	Coinsurance** (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)	Coinsurance or $25 copay in network in network (Maximum 10 visits/CY)
V. Prescription Drugs (Preferred Generic/Preferred Brand/ Non-Preferred)	$10 / $50 / $100	$10 / $50 / $100	$10 / $50 / $100	$10 / $50 / $100
VI. Home Health Care	$25 copay / visit (Maximum 60 visits/CY)	Coinsurance** (Maximum 60 visits/CY)	Coinsurance (Maximum 60 visits/CY)	Coinsurance or $25 copay / visit (Maximum 60 visits/CY)

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance.*

BASIC BENEFIT PLAN:
M a n d a t e d O p t i o n O N E

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
VII. Mental Health Services				
Mental Health - Out Patient Services	$25 copay / session (Maximum 10 visits/CY)	Coinsurance** (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)
Mental Health - In Patient Services	$750 copay / day (limit of 5 days/CY)	Coinsurance** (limit of 5 days/CY)	Coinsurance (limit of 5 days/CY)	Coinsurance (limit of 5 days/CY)
Alcohol - Substance Abuse	(Maximum $2000 Lifetime Benefit)	Coinsurance** (Maximum $2000 Lifetime Benefit)	Coinsurance (Maximum $2000 Lifetime Benefit)	Coinsurance (Maximum $2000 Lifetime Benefit)
VIII. Skilled Nursing Facility	100 days Lifetime Maximum	100 days Lifetime Maximum	100 days Lifetime Maximum	100 days Lifetime Maximum
IX. Hospice	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization
X. Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered
XI. Durable Medical Equipment, Orthotics & Prosthetics	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions
XII. X-Ray, Laboratory Diagnostic Services				
Diagnostic procedures including EKG, lab tests, traditional x-ray exams	Covered	[Coinsurance]	[Coinsurance]	[Coinsurance]
Imagery Services including MRI, PET, and CT scans	$200 copay	Coinsurance**	Coinsurance	Coinsurance

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance.*

BASIC BENEFIT PLAN:
M a n d a t e d O p t i o n O N E

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
XIII. Preventative Services Including:	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit
Annual Physical Reproductive Exam				
Child Health Supervision				
Prenatal & Postnatal Care				
Screening and Health Assessment Exams				
Eye and Hearing Exams (adult & child)				

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance.*

BASIC BENEFIT PLAN:
M a n d a t e d O p t i o n T W O

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
I. Cost Sharing				
Deductible - Individual	None	[$500] [$750] [$1,000] [$1,500] [$2,500] [IRS-defined MSA Maximum Annual Deduction]	[$500] [$750] [$1,000] [$1,500] [$2,500] [IRS-defined MSA Maximum Annual Deduction]	[$500] [$750] [$1,000] [$1,500] [$2,500] [IRS-defined MSA Maximum Annual Deduction]
Deductible - Family	None	3x [IRS-defined MSA Maximum Annual Deduction]	3x [IRS-defined MSA Maximum Annual Deduction]	3x [IRS-defined MSA Maximum Annual Deduction]
Coinsurance	Not Applicable	20%	20%	[30% / 50% (in-out)] [40% / 60% (in/out)]
Copays	As Specified	As Specified	As Specified	As Specified
Maximum Out of Pocket – Individual*	$5,000	[$5,000] [$7,500] [IRS-defined MSA Maximum Annual Out-of-Pocket Expenses]	[$5,000] [$7,500] [IRS-defined MSA Maximum Annual Out-of-Pocket Expenses]	[$5,000] [$7,500] [IRS-defined MSA Maximum Annual Out-of-Pocket Expenses]
Maximum Out of Pocket - Family*	2x	2x [IRS-defined MSA Maximum Annual Out-of-Pocket Expenses]	2x [IRS-defined Maximum MSA Annual Out-of-Pocket Expenses]	2x [IRS-defined Maximum MSA Annual Out-of-Pocket Expenses]
Maximum Lifetime Benefit	$2M	$2M	$2M	$2M
II. Inpatient Hospital Services	$750 copay / day	Coinsurance**	Coinsurance	Coinsurance
III. Emergency Care Services				
Emergency Room	$250 copay	Coinsurance**	Coinsurance	Coinsurance
Ambulance	$100 copay	Coinsurance**	Coinsurance	Coinsurance
Urgent Care	$75 copay	Coinsurance**	Coinsurance	Coinsurance

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance*

BASIC BENEFIT PLAN:
Mandated Option TWO

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
IV. Outpatient Services				
Surgical Care in Outpatient Hospital Department	$500 copay	Coinsurance**	Coinsurance	Coinsurance
Care in Ambulatory Surgical Center	$250 copay	Coinsurance**	Coinsurance	Coinsurance
Primary Care Physician Office Visit	$25 copay	Coinsurance**	Coinsurance	Coinsurance or $25 copay in network
Specialist Office Visit	$75 copay	Coinsurance**	Coinsurance	Coinsurance or $75 copay in network
Non-Surgical Spine & Back Disorder Treatment	$25 copay/visit (Maximum 10 visits/CY)	Coinsurance** (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)	Coinsurance or $25 copay/visit (Maximum 10 visits/CY)
Outpatient Rehabilitative Services (Speech, PT, OT)	$25 copay (Maximum 10 visits/CY)	Coinsurance** (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)	Coinsurance or $25 copay in network in network (Maximum 10 visits/CY)
V. Prescription Drugs (Preferred Generic/Preferred Brand/ Non-Preferred)	$10 / $50 / $100	$10 / $50 / $100	$10 / $50 / $100	$10 / $50 / $100
VI. Home Health Care	$25 copay / visit (Maximum 60 visits/CY)	Coinsurance** (Maximum 60 visits/CY)	Coinsurance (Maximum 60 visits/CY)	Coinsurance or $25 copay / visit (Maximum 60 visits/CY)
VII. Mental Health Services				
Mental Health - Out Patient Services	$25 copay / session (Maximum 10 visits/CY)	Coinsurance** (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)	Coinsurance (Maximum 10 visits/CY)
Mental Health - In Patient Services	$750 copay / day (limit of 5 days/CY)	Coinsurance** (limit of 5 days/CY)	Coinsurance (limit of 5 days/CY)	Coinsurance (limit of 5 days/CY)
Alcohol - Substance Abuse	(Maximum $2000 Lifetime Benefit)	Coinsurance** (Maximum $2000 Lifetime Benefit)	Coinsurance (Maximum $2000 Lifetime Benefit)	Coinsurance (Maximum $2000 Lifetime Benefit)
VIII. Skilled Nursing Facility	100 days Lifetime Maximum	100 days Lifetime Maximum	100 days Lifetime Maximum	100 days Lifetime Maximum
IX. Hospice	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization	Covered in lieu of Hospitalization
X. Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered
XI. Durable Medical Equipment, Orthotics & Prosthetics	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance*

BASIC BENEFIT PLAN: Mandated Option TWO

	HMO COPAY	HMO COINSURANCE	INDEMNITY	PPO
XII. X-Ray, Laboratory Diagnostic Services				
Diagnostic procedures including EKG, lab tests, traditional x-ray exams	Covered	[Coinsurance]	[Coinsurance]	[Coinsurance]
Imagery Services including MRI, PET, and CT scans	$200 copay	Coinsurance**	Coinsurance	Coinsurance
XIII. Preventative Services Including: Annual Physical Reproductive Exam Child Health Supervision Prenatal & Postnatal Care Screening and Health Assessment Exams Eye and Hearing Exams (adult & child)	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit	1-Preventive Medical & Reproductive Care is subject to $250 CY maximum benefit 2-The carrier may waive cost sharing for these services or use an alternative cost sharing mechanism that does not exceed the level of a Primary Care Physician's Office Visit

**Out-of-Pocket maximum expenses are defined to exclude deductibles and prescription copays in all plan options.*
***In certain cases, HMO may use the amount from the HMO copay plan model in lieu of coinsurance*

D. New Benefit Plan Premium Relationships
Exhibit 2

As indicated earlier, one of the objectives of the Committee was to revise the Standard and Basic plans to include the features that the market has demanded of carriers in their "street" plans. Among the more significant features are increased lifetime maximum benefits and the addition of prescription drug and transplant coverage to the Basic plan. In addition, the plans have been modified to include the cost sharing features that have become common in the market, as employers have sought ways to limit or reduce premium increases.

For the Basic plan, the Committee had a second objective to modify the plan to be affordable, but to provide coverage against catastrophic expenses. Thus for this plan, the Committee recommends multiple options, several of which include very significant increases in the cost sharing features.

One way to look at the results of the Committee's revisions is to compare the relative price of the new plans to that of the current plans. The table below provide such a comparison for the Standard plan models. ***These premium comparisons are based on illustrative pricing models: Actual premiums differences offered by carriers may vary and will be impacted by other factors such as increases of utilization and medical trend.***

As can be seen, the revised Standard plan HMO copay, PPO and Indemnity options result in premium reductions of about 20%. The HMO coinsurance plan, which is a new configuration only recently authorized by statute, generates a premium about 40% lower than the current HMO plan.

For the Basic plan (which is illustrated in a series of tables as an Attachment E), the addition of the prescription drug and other benefits results in an increase in premium of approximately 13% from the current PPO plan and, for the indemnity plan, approximately 8%. However, applicants seeking a more affordable alternative can choose a higher deductible, coinsurance and/or out of pocket maximum that reduces premiums by approximately 18% to 20%. The HMO copay plan offers alternatives that may reduce premium by about 8%-10% from the current HMO plan. Depending on which deductible, coinsurance and/or out of pocket maximum options are chosen, this new coinsurance plan may bring about a premium reduction of approaching 50%.

Recommended STANDARD Plans in comparison to Current STANDARD Plans
These premium comparisons are based on illustrative pricing models: Actual premiums differences offered by carriers may vary and will be impacted by other factors such as increases of utilization and medical trend.

HMO Copay Plans

All Relative Values Use the Current Plan as the Base

Mandated Option ONE	18% less than current
Mandated Option TWO	19% less than current

HMO Coinsurance Plans

All Relative Values Use the Current HMO Copay Plan as the Base

Mandated Option ONE	39% less than current
Mandated Option TWO	41% less than current

Indemnity Plans

Relative Values Use Current $250 Deductible as Base

Mandated Option ONE	20% less than current
Mandated Option TWO	23% less than current

PPO Plans

Relative Values Use Current $250 Deductible as Base

Mandated Option ONE	24% less than current
Mandated Option TWO	27% less than current

E. Policy Language

The Committee acknowledged carrier concerns regarding the additional costs associated with administering the required contract language of the Basic and Standard plans because those plans are different from the carriers' "street" plans. However, the Committee also felt that maintaining the consumer's ability to effectively compare the Basic and Standard options offered by various carriers is as important as reducing the administrative burden to carriers.

The Committee recommends that a complete standardized policy form be developed for each product. Carriers desiring to do so can use these standardized forms after filing and obtaining Department approval. Carriers that prefer to use policy forms that mirror the carrier's forms for similar products in the Market, will be allowed to do so. However, those forms will be reviewed by the Department and only approved if they provide coverage, terms and conditions to the standardized forms are substantially equivalent. Regardless of the Department's approval of a particular form, in the event of any subsequent dispute, the standardized forms will take precedence and be used to resolve any disputed issues.

F. Effective Date of New Plans

The consumer survey, other market research and consumer testimonials have stressed the immediate need for these more affordable benefit plans. In recognition of this urgency to get these plans into the marketplace, the Committee recommends that carriers offer the revised plans by April 1, 2003.

MARKET REFORM AND OTHER RECOMMENDATIONS

In addition to the redesign of the mandated benefit plans, the Committee considered possible market reforms and other market issues. The Committee agreed to focus on developing recommendations that meet the following criteria:

1. Bring more carriers into the market.

2. Make coverage within the market more affordable and therefore, provide coverage opportunities to more Floridians.

3. Provide more options for Florida's small employers.

The Committee discussed a variety of items, some of which resulted in specific recommendations and some of which led to observations and/or a recommendation for additional review of the issue. The major items discussed and a summary of the Committee discussions, recommendations, and observations are provided follow:

A. Cost Drivers

The Committee spent a portion of its time investigating and defining Small Employer Group Market premium cost drivers and discussing possible solutions. Data from the US Department of Labor Bureau of Labor Statistics illustrate how American health care dollars have shifted over time, nationally and by region. According to this data, in all areas of the US, health insurance premiums have become the main health care expenditure. And, according to recent studies by Kaiser Family Foundation, heath insurance premiums rose further by an average of 12.7% in 2001. The Committee recognized the following as the more significant factors driving these cost increases.

The Committee identified the ever-increasing cost of medical care, particularly **Escalating Hospital Services and Prescription Drug Costs**, as the primary cost driver in today's health care premiums. This observation is echoed in the recently released the Kaiser Family Foundation and Health Research and Educational Trust's *Employer Health Benefits: 2002 Summary of Findings*:

> *This high rate of growth [of insurance premiums] appears to have been driven primarily by rapid inflation in spending for health care services. Premium equivalents for self-insured plans (the estimated cost of health care claims for an employee whose employer self-insures) – which are a reflection of growth in underlying health care costs – grew by 12.3% over the last year, or roughly the same rate as premiums for insured plans. This suggests that insurers' decisions about premiums are being influenced more by cost trends than by catch-up pricing associated with the underwriting cycle.*

The cost of **Medical Malpractice Insurance Premiums** is also a significant problem affecting the availability of care and the cost of health coverage. Many providers are leaving certain specialties due to an inability to afford premiums creating access problems to those specialties. Others are increasing their fees to cover the costs which result in premium increases in the market.

Anti-Selection (also known as **Adverse Selection**[2]) is the tendency of persons who possess a greater likelihood of medical expenses to apply for or continue insurance to a greater extent than others. Obtaining health insurance coverage when one is already sick, or has a great chance of becoming ill in the short-term undermines the concept of insurance, which is a means of protection from uncertain, future financial loss. Individuals and small groups are more likely to adversely select coverage than larger groups This is further exacerbated by healthy individuals leaving the market as result of escalating premiums.

2 Morton, G.A., Principles of Life and Health Insurance, Life Office Management Association (LOMA), 1984.

Additional Factors Driving Health Insurance Cost

Key Trends[3]

- Overall, health expenditures are increasing relative to GDP (2002 projected for health care: 14%). National health expenditures are projected to reach $2.8 trillion in 2011, growing at a mean annual rate of 7.3 percent during the forecast period 2001-2011. During this period, health spending is projected to grow 2.5 percent per year faster than gross domestic product (GDP), so that by 2011 it will equal 17.0 percent of GDP compared to its 2000 level of 13.2 percent.[4] Per capita health care expenditure growth rate is accelerating.

- National health expenditures are projected to nearly double by 2011 (Projected: 2002: $1.5 trillion; 2011: $2.8 trillion).

- Health expenditures represent the largest sector in the U.S. economy (GDP) (Projected 2002: $10.2 trillion).

The Committee felt strongly that the **Cost Drivers** discussed above are well beyond this Committee's ability to address successfully without the direct involvement of all stakeholders in the health care industry (e.g. Patients, Funders, Physicians, Hospitals, Suppliers, Health Plans, Pharmacies, Consumers and Trial Lawyers). These cost drivers include a complex set of incentives and inter-dependencies that require thoughtful, deliberative solutions. This Committee was specifically charged with designing benefit plans that would be affordable, flexible, and attractive in the general marketplace. Without the full involvement and honest commitment of all stakeholders, more comprehensive solution cannot occur. The Committee strongly urges policymakers to explore the opportunity to create broader communications between all parties and initiate further strategies to affect true market reforms.

B. Small Employer Group Market and the High-Risk Pool

Background

In 1982, Section 627.6488 of the Florida Statutes created Florida's high-risk pool for Florida's most ill citizens who could not obtain traditional, medically underwritten insurance or were not eligible for any government program. This pool is known as the Florida Comprehensive Health Association (FCHA). The FCHA is a nonprofit legal entity of which all health insurers and health maintenance organizations, as a condition of doing business in Florida, are members. Insurers are assessed for any pool losses based on their market share. Enrollment in the FCHA plan peaked in 1990, providing health care coverage to approximately 7,500 Floridians.

Initially, insurers received a premium tax credit for their assessment. However, after this tax was eliminated by the legislature and in the face of increasing deficits, the pool closed to new members and has remained so since June 30, 1991.

C. Additional Uses of the High-Risk Pool

Florida is one of the two states that include sole proprietors and other groups comprised of only one person in its small group market. While this extends a valuable benefit to all small businesses, it also has led to a number of market problems. These One-Life Groups tend to act more like individuals than groups. The healthy sole proprietor will tend to seek coverage in the underwritten individual market. This market generally offers much more affordable coverage because it excludes sick individuals. Sole proprietors with health problems tend to take advantage of the guaranteed issue feature of the Small Employer Group Market because they cannot pass underwriting standards in the individual market. This anti-selection is one factor that leads to increased overall premiums in the Small Employer Group Market. In addition, in the absence of a high-risk pool in Florida, the availability of guaranteed issue coverage in the Small Employer Group Market can encourage uninsurable individuals to establish a small business in order to obtain health insurance or to submit fraudulent applications.

3 BCBSA Medical Cost Reference Guide, BCBSA Website, 2002.
4 National Conference of State Legislatures, 2002.

The Committee discussed possible options to modify the to avoid the anti-selection/fraud that results from the One-Life Group. An alternative that was considered was to use the state's high-risk pool, which has been closed to new members, as the vehicle to provide the guaranteed issue coverage to the sole proprietor.

This discussion expanded to one of also using the high-risk pool as Florida's mechanism to meet its Federal HIPAA requirements. This would mean that individuals who lose their coverage in a self-insured group or whose individual carrier withdraws from the market would get guaranteed issue coverage from the high-risk pool rather than in the individual market. And, individuals who lose the group insurance coverage would no longer be eligible for a group conversion policy. Rather they, too, would be eligible for a guaranteed issue policy from the high-risk pool.

The Committee generally agreed to a number of benefits to these uses of the high-risk pool. It would avoid having any one carrier absorbing an inordinate share of the HIPAA responsibilities or the potential anti-selection of the sole proprietor group.

However, the Committee also expressed concern that the high-risk pool might not be as vigilant as carriers in avoiding fraudulently established sole proprietor groups. They also questioned the high-risk pool's ability to effectively manage the cost of care for high-risk HIPAA eligibles. There were additional concerns expressed about the current funding mechanism and possible alternative funding mechanisms that would be more stable and broader.

Because these concerns could not be adequately addressed at this time, the Committee determined that it could not make any specific recommendation on this issue except that, should such a proposal develop from another source:

(1) The benefit plan offered should be the Standard and Basic.
(2) There must be assurance that the FCHA is capable and is committed to effective underwriting and case management.
(3) The funding should be as broad based as possible, but, also, realistic, sustainable and equitable.

D. Parity Issues: HMO – PPO Emergency Services Benefits

Except in the case of emergency care, Health Maintenance Organizations (HMO) generally limit access to care to providers under contract with the organization. Florida statutes require that HMOs must reimburse provider of emergency medical services for the diagnosis and treatment of emergency medical conditions. In addition, HMOs are required to protect their subscribers from any billing from providers for amounts other than cost sharing defined in the subscriber agreement. Other than through contracting with providers, there is no mechanism for HMOs to establish reasonable reimbursement levels for non-participating providers.

This puts HMOs at a cost disadvantage when compared to Preferred Provider Organizations (PPO) that can limit their reimbursement to the industry accepted standard of "usual, customary, and reasonable" charges for such services, and have no obligation to protect policyholders or subscribers from balance billing.

The Committee recommends a statutory change to allow HMOs to limit their emergency service reimbursement but still provide consumer protection against excessive balance billing. This can be accomplished by amending *SECTION 641.513 (5), FLORIDA STATUTES* as follows:

(5) Reimbursement for services under this section provided to subscribers who are not Medicaid recipients by a provider for whom no contract exists between the provider and the health maintenance organization shall be the lesser of:

a. The provider's charges;
b. The usual, customary, <u>and reasonable</u> provider charges for similar services in the community where the services were provided;
*c. The charge mutually agreed to by the health maintenance organization and the provider within 60 days after the submittal of the claim**; or***

d. *125% of the Medicare payment rate for the services in accordance with the prevailing Medicare Allowable Fee Schedule.*
e. *Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).*

E. Workers' Compensation Issues

Among other things, Workers' Compensation insurance provides protection for on-the-job injuries. Presently, certain classes of small groups, including those with fewer than 4 employees, are not required to carry Workers' Compensation insurance. As a result, unless their carrier excludes coverage for on-the-job injuries, many small employer groups resort to their health insurance policy instead of carrying a Workers' Compensation policy. This tends to drive the cost up for those carriers.

Carriers that exclude coverage for on-the-job injury protection can create a gap in coverage for employees whose employer is exempted from the requirement to provide Workers' Compensation coverage. In some cases, carriers do not exclude on-the-job injury protection but add a premium surcharge to employers without Workers' Compensation coverage. The Committee discussed the valuable consumer protection that would be provided by requiring that on-the-job injury protection be included in all health policies. On the other hand, the Committee also expressed concern with mandating these additional benefits with an increased cost at a time when health care costs are already approaching an unaffordable level. Therefore, the Committee recommends that this issue be further examined at the Workers' Compensation Taskforce or similar advisory body.

After weighing all considerations, the Committee agreed to recommend:
Modify statute to clearly:

(1) Require that 24 hour coverage be provided in Small Employer Group Market health policies.
(2) Allow an extra premium charge for those Small Employer Groups without proof of Workers' Compensation coverage.

F. Mini-COBRA Issues

Federal and Florida law require that all groups with 20 or more employees must allow individuals who lose coverage as a result of a qualifying event to continue as an insured member of the group for 18 to 36 months. Employers are responsible for notifying their employees or their dependents of this right. This coverage is referred to as COBRA. Florida law extends similar protection to groups with less than 20 employees. However, there is no requirement that the employer provide notification in the event of eligibility for this "mini-COBRA." This lack of responsibility for notification becomes a problem when a group with individuals using their mini-COBRA rights changes carriers. Statute provides that if the employer terminates coverage under the group health plan for all employees and if such group health plan is replaced by similar coverage under another group health plan, the qualified beneficiary shall have the right to become covered under the new group health plan for the balance of the period that she or he would have remained covered under the prior group health plan. A qualified beneficiary is to be treated in the same manner as an active beneficiary for whom a qualifying event has not taken place.

To ensure that qualified individuals rights are protected, the Committee recommends that statute be amended to provide that the *group health plan shall give the qualified beneficiary 30-days advance written notice that their continuation coverage is ending because their former employer terminated their group coverage. The effective date of the qualified beneficiary's termination shall not be retroactive to the termination date of the group coverage, but shall be the last day of the month following the 30-day termination notice. This termination notice shall be mailed as soon as possible after the termination of the group health plan, but no later than 90 days after the group's termination date, and shall notify the qualified beneficiary that they should contact their former employer to determine if they replaced their group coverage. If replacement occurred, the beneficiary shall notify the replacement carrier within 30 days, as evidenced by postmark, of the termination of coverage. If the group did not replace the group health plan with similar coverage, or the carrier failed to notify the qualified beneficiary within 90 days, the beneficiary shall be entitled to apply for conversion coverage. All privileges outlined above are conditioned on payment of required premiums.*

G. Methods of defining "Employee," "Dependent," and "Employer"

Small group statute defines an **Eligible Employee** as "an employee who works full time, having a normal workweek of 25 or more hours…" It is difficult to monitor compliance with this definition. Frequently, individuals are reported as working 25 hours per week, yet the payroll records show only minimal, if any, salary paid to such employee.

The Committee recommends that the statutory definition of a small group employee be modified to include the phrase "an employee, other than owner, who works full time, having a normal workweek of 25 or more hours and is paid wages or a salary at least equal to federal minimum hourly wage applicable to such employee…"

Presently, Florida large group insurance policies are required to incorporate language that is specified in statute defining **Dependents** (627.6562 F.S.) and to provide coverage for natural born, adopted and foster children (627.6578 F.S.). Small group policies are subject to a different dependent definition. Individual health insurance and all non-small group HMO coverage are without any specific required definitions. The large group definition is the most liberal and includes children to age 25 who are financially dependent and living with the insured **or** are full time students. Carriers have generally limited the use of this definition to only the required polices. As a result, an individual who qualifies as an eligible dependent on one policy does not qualify for another.

To ensure consistency, the Committee recommends the revision of statutes to incorporate the large group definitions into all health insurance policies

A recognized problem in the Small Employer Group Market is that there is some abuse of the availability of guaranteed issue policies, especially by One-Life Groups. Individuals who are unable to obtain coverage elsewhere are alleged to claim illegitimately to be a sole proprietor. As a means of ensuring the legitimacy of these groups as **Employers**, Florida statute indicates that the business must result in taxable income "as indicated on IRS From 1040 schedule C [non-farm income] or F [farm income], and which has generated taxable income in one of the 2 previous years." However, Schedule C and F do not use the words "taxable income." Schedule C uses "Gross receipts or sales" to describe total operating revenues. It uses "Gross income" to mean gross receipts plus other income minus cost of goods sold. Schedule F uses "Gross income" to mean all revenue.

This issue is further complicated by the fact that, unlike a partnership or regular corporation, a sole proprietor or One-Life Group is not a separate entity. The Sole Proprietorship or Group of One[5] business is one and the same with the individual. Net Profit or Loss is reported on Form 1040, Schedule C (or CZ) and Schedule F. This becomes part of the individual's adjusted gross income. (A net loss from this type of business arrangement can generally be deducted during the computation of one's adjusted gross income.) Sole proprietors and those claiming One-Life Group status are, therefore, liable for self-employment tax (reported on Form 1040, Schedule SE) and will also be required to make estimated tax payments.

SE tax must be paid and the Schedule SE must be filed if either of the following minimums applies.
1) Net earnings from self-employment (excluding church employee income) of $400 or more.
2) Church employee income of $108.28 or more.

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[5] *These groups traditionally include:*

Independent Contractors*: persons whose work hours and procedures are not controlled by another but receives compensation for their efforts directly from those with whom they have contracted to perform the work.*

Statutory Employees*: Defined by the IRS as*

1. *Certain agent and commission drivers*
2. *Full-time life insurance sales representatives*
3. *Certain home workers performing work according to the specifications furnished by the person for whom the service is being performed*
4. *Certain traveling or city salespersons that work full-time (except as sideline sales activities) for one firm or person, soliciting orders from customers.*

Statutory Nonemployees: *defined by the IRS as:*

1. *Direct Sellers*
2. *Licensed Real Estate Agents*

Hobby vs. Activity for Profit

The Committee studied federal Internal Revenue Service (IRS) guidance on the legitimacy of sole proprietors to shed light on a potential way to revise Florida law to establish a mechanism for determining small employer status. Like Florida Health Insurance law, the Internal Revenue Service faces a significant challenge in determining whether a person is actively engaged in a business. As a result, the IRS has issued a publication entitled (*Tax Guide for Small Business (For Individuals Who Use (Schedule C or C–EZ) for Preparing 2001 Returns*). The IRS publication indicates that the IRS will take the following into account in determining whether a person is operating a business for profit:

- Is the activity conducted in a business-like manner?
- Is the time and effort placed into the activity an indicator the end results are to make a profit?
- Is there a dependence on income from the activity for your livelihood?
- Are the losses due to circumstances beyond the operator's control (or are normal in the start-up Phase of this type of business)?
- Was there a change in methods of operation in an attempt to improve profitability?
- Do key players in the operation have the knowledge needed to carry on the activity as a successful business?
- Were profits made in similar activities in the past?
- Has the activity made a profit in some years (and the amount of profit it made)?
- Is there an expectation to make a future profit from the appreciation of the assets used in the activity?

Additionally, an activity is presumed to have been for profit if it results in a profit in at least 3 out of 5 consecutive tax years whether the activity is held individually, in trust, as a partnership or as a S Corporation. If one has engaged in an activity for less than this period, this determination may be postponed by completing filing IRS form 5213. However, the IRS has the burden of proving that the activity is only a hobby. Yet, if one does not meet the 3-year test and the IRS determines that the activity is, indeed, a hobby, then the filer bears the burden of proving the profit motive.

As a result of the above, the Committee recommends the revision of statute (F.S. 627.6699(3)(u)) to read: *"Self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which necessitates the filing of (1) Federal Income Tax Forms, with supporting schedules and accompanying income reporting forms or (2) Federal Income Tax Extensions of Time To File Forms with the Internal Revenue Service (IRS) for the most recent tax year.*

Further, the Committee recommends amendment to regulation to include:

1. A carrier may request information and documentation to determine whether an individual qualifies as an active business that is eligible for coverage. At the carrier's request, each applying sole proprietor or partner of a partnership seeking guarantee issue coverage under the Employers Health Care Access Act shall provide the carrier a signed and filed copy of either the sole proprietor's or partner's (1) Federal Income Tax Forms, with appropriate supporting schedules and accompanying income reporting forms or (2) any forms and / or correspondence documenting requests for Extensions of Time To File as filed by the sole proprietor or partner with the Internal Revenue Service (IRS) for the most recent tax year.

2. If the applying sole proprietor or partner has not been in business long enough to provide the federal tax documentation prescribed above, the sole proprietor or partner may establish he/her engagement in a legitimate enterprise by submitting all of the following which apply:

(a) A copy of any occupational license required by the jurisdiction in which the business is located or performing regular work;

(b) A copy of any trade or professional license required by the political subdivision of the State in which the work is being performed;

(c) Proof that the business has obtained a fictitious name if a fictitious name is used;

(d) A Federal Employer Identification Number issued to the business;
Or
(e) A copy of a certificate of commercial liability insurance for the business.

3. The following information may be stricken by any applicant from a Federal Income Tax Form before providing to the carrier:

(a) Identification of the spouse and dependents of the applicant, including filing status;
(b) Any W-2 income, interest and dividend income, refunds, credits, alimony received, capital gains or losses other than those associated with the applicant's business enterprise;
(c) IRA distributions, pensions, annuities, farm income, unemployment compensation, or social security benefits;
(d) Any deductions from income in order to derive adjusted gross income;
(e) Tax computation, credits, other taxes, payments, refunds, or amounts owed

4. Any other conforming rule amendments to accomplish these recommendations.

H. Study of Mandated Benefits

The Committee recognized that mandated benefits were difficult to quantify in regard to cost effectiveness and recommends that the actuarial and cost effects of all existing and proposed mandates be evaluated both individually and in combination.

III. ATTACHMENTS

ATTACHMENT A

November 1, 2002

Ms. Randy Kammer, Co-Chair
Ms. Kenney Shipley, Co-Chair
Small Employer Benefit Plan Committee
Florida Department of Insurance
Tallahassee, Florida 32399

Dear Madam Co-Chairs:

The Small Employer Benefit Plan Committee is to be commended for assuming the awesome task of reviewing the Standard and Basic plans in an effort to address the changing market demands in the industry and to increase the availability and affordability of coverage to small employers. Access to quality, affordable medical care is a critical issue for consumers and their families.

As Consumer Advocate, I share the belief that the rising cost of health insurance premiums is the primary reason why small employers are no longer offering health insurance. In reviewing the committee report, the following issues are noted:

- Cost sharing and cost shifting are certainly approaches to reducing the soaring cost for employers. The question to be asked is, how many employees can afford to absorb the deductible and coinsurance dollars outlined in the benefit plans? Numerous state and national surveys have identified "high cost" or "too expensive" as the main reason why employees have declined health insurance coverage even when employers offer it. The employees working for small businesses represent the largest number of uninsured Floridians; consequently, higher cost sharing options may simply increase the growing number of uninsured consumers. Furthermore, the basic and standard plans with high out-of-pocket costs are rarely attractive to low and middle income wage earners.

- Small Employer Health Insurance Survey – the report was prepared based on 200 responses from 5,000 employers. Even with this small return rate, the response to the cost sharing questions reflect a reduction in the number of employees willing to pay more as the cost sharing increases. Consequently, this approach may provide some relief for employers but limit employee participation rates.

- Health Maintenance Organizations (HMO's) - recognizing that the original purpose of HMO's has evolved over the years partly due to consumer demand and rising health care costs, the plans and options outlined in the committee's report reflect such drastic changes in HMO plans, it is unclear what advantages, if any can be achieved through enrolling in these plans. The indemnity or PPO's may become more attractive without the burden of restricted access associated with HMO's. It has been challenging to educate consumers on the contrasting aspects of insurance coverage through HMO's. These recommendations will require a new educational campaign to assist the public with this transitional change.

- Catastrophic Coverage – as efforts are made to offer coverage to consumers through increases in large out-of-pocket expenses, catastrophic coverage may be the only choice. Healthy individuals who can afford health insurance may decline to participate in the market, resulting in adverse selection. They may view a catastrophic plan as a "stop gap" measure not for health care but protection from financial bankruptcy.

I recognize that the scope of the Committee was limited to addressing the plans and to offer recommendations for easing the burden on small employers. Even if premium costs are decreased, the increase in out-of-pocket costs, though less expensive initially, may ultimately become "too costly" for consumers. A recent study published in *Health Affairs* found that health insurance coverage among workers declined largely because per capita health care costs increased more rapidly than personal income.

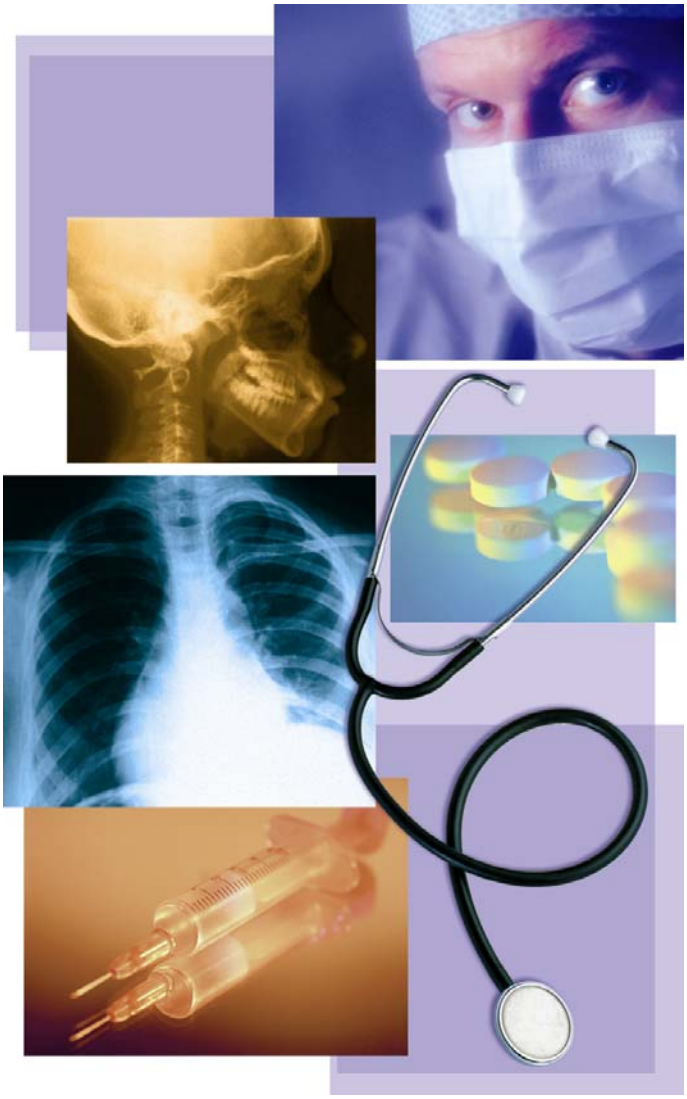
While the benefit plans are a major part of the insurance program, the economics of health care must be addressed comprehensively to include all components and stakeholders of the health care system. This committee has completed its task and created a starting point for dialogue by recommending plans that reflect the changing health care industry.

Sincerely,

Elsie B. Crowell
Consumer Advocate

ATTACHMENT B

Small Employer Health Insurance Survey Results



Conducted By:

FLORIDA CHAMBER of Commerce

The Treasurer of the State of Florida
Department of Insurance

SEPTEMBER 2002

PARTICIPANT PROFILE

The Department of Insurance, in cooperation with the Florida Chamber of Commerce, is working to ensure affordable health insurance coverage is available to small businesses in Florida. In an effort to find solutions to this critical problem, we conducted a statewide health insurance survey of five thousand employers from September 11-18, 2002. We received nearly 200 responses from employers with 50 or fewer employees*, representing cities across the state, such as:

Apopka	Gainesville	Melbourne	Plant City
Arcadia	Grand Island	Miami	Pompano Beach
Boca Raton	Hilliard	Micanopy	Saint Augustine
Bradenton	Homosassa Springs	Naples	Saint Petersburg
Bronson	Hudson	New Port Richey	Sanford
Cape Canaveral	Jacksonville	New Smyrna Beach	Santa Rosa Beach
Cape Coral	Jensen Beach	Niceville	Sarasota
Clearwater	Jupiter	North Palm Beach	Stuart
Coral Gables	Key Largo	Ocala	Tallahassee
Daytona Beach	Key West	Orange Park	Tamarac
Deerfield Beach	Lake Worth	Orlando	Tampa
Delray Beach	Lakeland	Ormond Beach	Tavares
Destin	Largo	Palm Bay	Venice
Fernandina Beach	Longboat Key	Palm Beach	Vero Beach
Fort Lauderdale	Longwood	Panama City	West Palm Beach
Fort Myers	Loxahatchee	Pensacola	Winter Park
Fort Pierce	Maitland	Pierson	

Forty-six percent of responses were sent in by the company's president and 19 percent from the owner. The remaining 65 percent of responses came from of the following titles:

Administrator	CEO	Executive Director	Office Manager
Attorney	Contract Manager	Financial Advisor	Partner
Bookkeeper	Controller	General Manager	Vice President
Business Manager	Corporate Officer	Human Resources	
Chairman	Exclusive Agent	Marketing Manager	

KEY FINDINGS

- **Eighty-five percent currently offer health insurance to their employees.**
- **Of those who do not offer health insurance to their employees, 63 percent never offered benefits and 33 percent dropped coverage prior to this year.**
- **Twenty-nine percent pay all of their employees' health insurance premiums.**
- **Thirty-four percent pay more than $3,000 per employee, per year for health insurance.**

** We also received responses from large groups, please note, their results are NOT included in this report.*

1. Do you offer health benefits to your employees? **(n = 181)** **153 (85%)** Yes **28 (15%)** No

2. If you answered no to question 1, when did you drop benefits? **(n = 27)**

17 (63%)	Never offered benefits
1 (4%)	Dropped benefits this year
9 (33%)	Dropped benefits prior to this year

3. Which group best describes you in terms of the number of employees? (Select one only) **(n = 164)**

3 (2%)	1 employee	**20 (12%)**	6-10 employees	**80 (49%)**	21-49 employees
19 (11%)	2-5 employees	**42 (26%)**	11-20 employees		

4. How many of those employees do you ***insure***? **(n = 150)**

9 (6%)	1 employee	**28 (19%)**	6-10 employees	**38 (25%)**	21-49 employees
26 (17%)	2-5 employees	**49 (33%)**	11-20 employees		

5. If you offer health insurance to your employees, what percentage of the premium does your company pay?**(n=161)**

12 (7%)	None	**63 (39%)**	25-74%	**47 (29%)**	100%
2 (1%)	1-24%	**34 (21%)**	75-99%	**3 (2%)**	Unknown

6. What is the average amount you currently spend ***per employee, per year*** for health insurance? **(n = 159)**

18 (11%)	Less than $500	**18 (11%)**	$1,501 - $2,000	**54 (34%)**	Over $3000
15 (9%)	$501 - $1,000	**20 (13%)**	$2,001 - $2,500	**7 (4%)**	Unknown
9 (6%)	$1,001 - $1,500	**18 (11%)**	$2,501 - $3,000		

7. ***To prevent an increase*** in your current rates, what's the ***highest cost sharing*** amount you'd be willing to pay for:

Primary Care Physician (co-pay per visit) (n = 139)
99 (71%) $25 **16 (12%)** $50 **2 (1%)** $75 **22 (16%)** Other

Prescription drug cost (for generic drugs) (n = 144)
61 (42%) $10 **56 (39%)** $20 **14 (10%)** $30 **13 (9%)** Other

Maximum out of pocket expense (per yr) (n=139)
89 (64%) $2,500 **17 (12%)** $3,000 **7 (5%)** $7,500 **26 (19%)** Other

Inpatient hospital (per day) (n=140)
78 (56%) $300 **26 (19%)** $500 **2 (1%)** $750 **34 (24%)** Other

8. ***To reduce your current rates***, what's the ***highest cost sharing*** amount you would be willing to pay for:

Primary Care Physician (co-pay per visit) (n = 141)
92 (65%) $25 **25 (18%)** $50 **3 (2%)** $75 **21 (15%)** Other

Prescription drug cost (for generic drugs) (n = 143)
57 (40%) $10 **52 (36%)** $20 **20 (14%)** $30 **14 (10%)** Other

Maximum out of pocket expense (per year) (n = 141)
87 (62%) $2,500 **21 (15%)** $5,000 **7 (5%)** $7,500 **26 (18%)** Other

Inpatient hospital (per day) (n = 139)
74 (53%) $300 **28 (20%)** $500 **3 (2%)** $750 **34 (24%)** Other

9. Would you buy a plan that allows employers to put money in a pre-tax savings account to help cover employees' deductibles and out-of-pocket expenses? **(n = 150)**

92 (61%) Yes **58 (39%)** No

SAMPLE RESPONDENT COMMENTS

In addition to completing the survey, respondents were invited to share additional comments with us. The following are a sample of some of the comments we received.

"Cost containment – higher co-pays for office visits and prescriptions to reduce dependency on doctors and drugs, eliminate coverage for domestic partners."

– Lakeland

"Insurance has gone sky-high for premiums. My employees cannot afford to pay a percentage for health insurance, as a matter of fact, neither can my company, but I have NO CHOICE."

– Niceville

"For the last 3 years, we've seen between 25%-40% increases. If we're hit with another increase like that, there is a very good possibility that we will drop our insurance."

– Orlando

"We are sick with the current insurance situation any more, and I will drop it all. My profits are mostly gone. What a rip off."

– Sarasota

"We are tired of being forced into HMO coverage due to costs. Prescription benefits keep rising for the employee. HMO docs don't want to refer to specialists and it takes forever to get referral when they do. Local docs and hospitals keep dropping out."

– Ormond Beach

"Our health insurance costs $7,500 a month right now and it increases every year. We just started capping it at $450 this year. We would love some help with this."

– Jacksonville

"Health insurance became a real burden for us as a company. Our company dropped out of the group insurance business. We need help. Thanks."

– Vero Beach

"Maximum employer share in costs 50% for employee in and HMO plan have limited funds. Since we are non-profit gone to ADP total source in order to get better benefits than was possible on our own"

– Miami

"There are very few options, or rather insurance companies, available to Florida employers, according to agents. State laws prevent a lot of insurance carriers to insure Florida residents."

– West Palm Beach

"Costs are increasing to a point that we may have to ask our employees to pay part of the premium or reduce benefits again. We have a 125 plan in place."

– Boca Raton

"Employees now pay 100% of dependent coverage. Working poor have dropped coverage and rely on free clinics."

– Clearwater

"Costs skyrocket and benefits bottom out. Number of carriers are limited. Like having no pre--existing conditon in Florida."

– Clearwater

"We are considering contracting with AmStaff Employee Leasing for cheaper insurance rates and better insurance services."

– Santa Rosa Beach

"Small business can't carry the burden of insurance – workers' comp is very high and protects employee while working. Should be low cost insurance with high deductable that each person orders, pays and looks after themselves."

– Delray Beach

"We had a 35% increase in our health plan costs this year. Further increases will cause us to reduce the plan coverage or ask the employees to compensate the difference."

– Miami

"Company vs employee's share of premium are at levels that make payments difficult to maintain. Fewer employees are taking advantage of group health offering. This will eventually eliminate group health plans--cannot meet the 75% participation requirement."

– Homosassa Springs

"Employer already pays approximately $3,600 per year per employee for health insurance only. Not including dental, vision and life premiums.

– Deerfield Beach

"As a small business owner that pays 100%, the hardest issue I have to deal with is "when" and how much I will have to pass along to the employees."

– Tampa

"No competition exists, conflict of interests between HMO's/Proper health care. Collusion between medical care and insurance providers. Lawyers who drive up costs, insurance companies that have hidden profits & money making schemes."

– Vero Beach

"Our employees cannot pay for the high cost premiums that the health insurance company is charging us. They are considering dropping coverage and going to Shands Hospital for free healthcare."

– Jacksonville

"With only two carriers curently writing policies in Indian River County for group health for small businesses the lack of competition causes higher premiums"

– Vero Beach

"We don't pay any dependent coverage for employees because we can't afford to. Neither can they – it causes them tough decisions. We are at employee. cost of $60/week to employee for kids and employee pays $125/week for family coverage – after company contribution."

– Fort Myers

"I feel it's inconceivable for the Dept. of Insurance to allow a rate increase to HMOs up to 54% in one year."

– Orlando

"Three companies left in the area. Get rid of the mandated coverages and let employers decide on what to offer (i.e. maternity, well baby care, etc.)."

– Bradenton

"I tried to get group MSA insurance, but thanks to the Florida insurance rules, it is not available here, even though it is in most states."

– Longboat Key

FAIFA 2002 Health Insurance Survey Results

The Florida Association of Insurance and Financial Advisors (FAIFA) in cooperation with the Florida Department of Insurance is working to ensure affordable health insurance coverage is available to small businesses in Florida. On September 27, 2002, we emailed an online health insurance survey to approximately 2000 FAIFA members selected from our total membership. We asked only those agents who sell health insurance to respond to the survey and received 187 responses or had approximately a 9% response rate.

While the survey results are from 187 agents, the questions were asked on behalf of their employer groups, so the responses encompass a very large number of employers (well over 2500) being serviced by our member agents. Overall indications show a willingness to move to higher cost sharing options at time of service to reduce premium. Many comments indicated a growing interest in high deductible health plans. The questions on 24/7 medical coverage show this as an area of concern and confusion, but a majority (66%) realize that the coverage comes at a cost.

The results of the survey are listed below: (Questions 1 & 2 and their respective answers are not shown here as they were for FAIFA data collection purposes only.)

3. What percentage of the premium do the majority of your employers pay?

	Number of responses	Percentage
0%	02	01%
1-24%	06	03%
25-74%	100	55%
75-99%	54	30%
100%	21	11%

4. What is the average premium your employers spend per employee, per year for health insurance? $3000 average

In your opinion, to prevent an increase in current rates, what's the highest cost sharing amount the majority of your employer's employees would be willing to pay in questions 5-8?

5. Primary Care Physician (co-pay per visit)

	Number of responses	Percentage
$25	123	66%
$50	48	27%
$75	2	1%
Other	26	14%*

**Of the 26 that responded in the "other" category, 2 suggested $15, 3 suggested $20, 4 suggested $30, 2 suggested $35, 1 suggested $40 and 2 suggested $50.*

6. Prescription drug cost (for generic drugs)

	Number of responses	Percentage
$10	46	25%
$20	99	53%
$30	31	18%
Other	13	7%*

**Of the 13 that responded in the "other" category, 4 suggested $15 and the rest were varied amounts with no significant agreement.*

7. Maximum out of pocket expense (per year)

	Number of responses	Percentage
$2,500	82	45%
$5,000	83	44%
$7,500	13	7%
Other	4	2%*

**Of the 4 that responded in the "other" category, 2 suggested $1,500 and the other two were different amounts.*

8. Inpatient hospital (per day)

	Number of responses	Percentage
$300	60	33%
$500	73	40%
$750	19	10%
Other	9	5%*

**Of the 9 that responded in the "other" category, 5 suggested $100-$150 and 4 suggested $1,000.*

In your opinion, to reduce current rates, what's the highest cost sharing amount the majority of your employer's employees would be willing to pay in questions 9-12?

9. Primary Care Physician (co-pay per visit)

	Number of responses	Percentage
$25	106	57%
$50	59	32%
$75	7	4%
Other	10	5%*

**Of the 10 that responded in the "other" category, 5 suggested $20, 3 suggested $30 and the remaining 2 had individual responses.*

10. Prescription drug cost (for generic drugs)

	Number of responses	Percentage
$10	38	21%
$20	99	53%
$30	39	22%
Other	4	2%*

**Of the 4 that responded in the "other" category, all were different suggestions with no agreement*

11. Maximum out of pocket expense (per year)

	Number of responses	Percentage
$2,500	66	35%
$5,000	87	47%
$7,500	21	11%
Other	7	4%*

**Of the 7 that responded in the "other" category, 3 suggested $1,500, 2 suggested $10,000 and the other two had two different suggestions with no agreement.*

12. Inpatient hospital (per day)

	Number of responses	Percentage
$300	63	34%
$500	69	37%
$750	28	15%
Other	13	7%*

**Of the 13 that responded in the "other" category, 3 suggested $150, 7 suggested $1,000 and the remaining 3 were different suggestions with no agreement.*

13. What percentage of your employers presently offers a premium only Section 125 plan?
22% Average

14. What percentage of your employers would buy a plan that would allow them to make additional contributions in a deductible account for the employee to use to pay higher co-pays, deductibles and qualified out of pocket expenses? 33% Average

15. What percentage of your employer's employees would be willing to have a high cost sharing plan combined with a savings fund to pay those higher cost sharing items (like MSA or HRA)?
27% Average

16. Should group medical policies provide any coverage for work related losses?

	Number of Responses	Percentage
Yes	62	33%
No	124	67%

17. If the answer to question # 16 was yes, please explain why.
The comments on this question numbered over 65. Only those who answered yes to question #16 were requested to explain why 24/7 medical coverage should be included. There were 5 general categories of responses:

1. Eligible exemptions, legal opting out for officers/owners (18)
2. Not required by law to carry comp (17)
3. Cost (18)
4. Secondary/combination coverage (4)
5. Other (8)

18. If the answer to question # 16 was yes, please explain how to surcharge the group plan rates to cover the exposure.
The suggestions pertaining to this question varied widely with no clear consensus on a solution.

**When reviewing the survey data, it must be kept in mind that this survey was sent to only select FAIFA members and the results may have varied if all members were given the opportunity to respond.

The mission of the Florida Association of Insurance and Financial Advisors (FAIFA) is to enhance the ability of members to provide financial security for their clients, through appropriate legislative action, continuing education, professional skills development and promotion of ethical conduct of agents and others engages in insurance and related financial services.

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ATTACHMENT C

CURRENT MANDATED BENEFITS

Section 1. Required Policy Benefits

Required Benefits	Summary	Standard & Basic
Bone Marrow Transplants	The policy may not exclude coverage for bone marrow transplant procedures recommended by referring and treating physicians under a policy exclusion for experimental or investigative procedures if the particular use of the procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to rules adopted by the Agency for Health Care Administration, based on the recommendations of an advisory panel. Procedures must include costs associated with the donor-patient.	627.4236 (But limited coverage provided in Standard)
Child Health Supervision Services	Policy benefits for children must include coverage for child health supervision services from birth to age 16 and be exempt from any deductible. Services include a physical examination, developmental assessment and anticipatory guidance, and immunizations and laboratory tests, consistent with the *Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics*.	627.6699(12)(b)4
Cleft Lip/Palate for Children	Policy benefits for a child under age 18 must include treatment of cleft lip and cleft palate, including medical, dental, speech therapy, audiology, and nutrition services if prescribed by the treating physician or surgeon and certified as medically necessary.	627.6699(12)(b)7
Diabetes Treatment	Policy must cover all medically appropriate and necessary equipment, supplies, and diabetes outpatient self-management training and educational services used to treat diabetes, if the treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary.	627.65745
Emergency Care (HMO)	HMOs must provide coverage, without prior authorization, for emergency care (screening and stabilization) based on determination by hospital physician or appropriate licensed professional hospital personnel under supervision of physician, provided by either a participating or nonparticipating provider.	641.513(3) & 641.31(12)
HIV Coverage	A policy may not exclude coverage for HIV-infection or acquired immune deficiency syndrome, except as provided in a preexisting condition exclusion.	627.429 & 641.3007
Mammograms	Policy must include coverage for a baseline mammogram for a woman age 35-39, a mammogram every two years for a woman age 40-49, every year for a woman age 50 or older, and one or more a year based on a physician's recommendation for a woman who is at risk for breast cancer based on specified criteria.	627.6418 &641.31095
Mastectomy: Length of stay and out-patient coverage	A policy that provides coverage for breast cancer may not limit in-patient hospital coverage for mastectomies to any period that is less than that determined by the treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient. Must also provide coverage for outpatient post-surgical follow-up care in keeping with prevailing medical standards by a licensed health care professional qualified to provide such care.	627.6699(12)(b)7
Mastectomy: Surgical Procedures and Devices	If the policy provides coverage for a mastectomy, coverage must include prosthetic devices and breast reconstructive surgery incident to a mastectomy.	627.6699(12)(b)7
Maternity Care: Length of Stay and Post-Delivery Care	A policy that provides coverage for maternity benefits or newborn coverage may not limit coverage for length of stay in a hospital or for follow-up care outside of a hospital to any time period less than that determined to be medically necessary by the treating obstetrical care provider or the pediatric care provider, in accordance with prevailing medical standards. The policy must provide coverage for post-delivery care for the mother and infant, including medically necessary clinical tests and immunizations.	627.6699(12)(b)7
Newborn Hearing Screening	Policies covering a family member of the insured must provide coverage for the initial hearing screening and any medically necessary follow-up reevaluations leading to diagnosis shall be a covered benefit. Medicaid recipients' services (including those in Medicaid HMOs or PSNs) will be reimbursed as fee-for-service (Medicaid rate) and other insurers will be reimbursed at the contracted rate.	627.6699(12)(b)4d

Section 2: Required Offer of Benefits

Required Offer	Summary	Standard & Basic
Mental and Nervous Disorders	Insurers and HMOs must make available to a group policyholder (e.g., the employer) as part of the application, for an appropriate additional premium, coverage for mental and nervous disorders. If mental health benefits are elected, coverage must include at least 30 days of in-patient coverage and at least $1,000 per year for outpatient benefits for consultations with a licensed physician, psychologist, mental health counselor, marriage and family therapist, and clinical social worker.	627.668 (But with different limits)

Section 3: Required Payment to a Class of Providers

Provider	Summary	Standard & Basic
Ambulatory Surgical Centers	A policy must provide coverage for any service performed in an ambulatory surgical center, as defined in s. 395.002, if such service would have been covered as an eligible inpatient service.	627.6616
Birthing Centers and Nurse Midwives	A policy or HMO contract that provides coverage for maternity care must cover the services of certified nurse midwives and midwives licensed under chapter 467, and birth centers licensed under ss. 383.30-383.335.	627.6699(12)(b)7
Chiropractors	A health insurance policy must be construed to include payment to a chiropractic physician who provides covered benefits or procedures within the scope of his or her license. (Not applicable to HMOs.)	627.6699(12)(b)7
Dentists	The word "physician" when used in a health insurance policy providing for the payment of surgical procedures performed in an accredited hospital in consultation with a licensed physician must be construed to include payment to a dentist who provides benefits or procedures within the scope of his or her license.	627.419(2)
OB/GYNs	HMO must allow each female subscriber to select as her primary physician an obstetrician/gynecologist. (Also see Table 1, OB/GYN Annual Visit)	HMO only: 641.19(13)(e)
Ophthalmologist	Insurance policy and HMO contracts which provide coverage or services that are performed by physicians who are ophthalmologists, licensed under chapter 458 or 459, must offer the subscriber the services of an ophthalmologist.	627.6699(12)(b)7
Optometrists	A health insurance policy that provides coverage for services within the scope of an optometrist's licenses shall be construed to include payment to an optometrist who performs such procedures.	627.6699(12)(b)7
Optometrists (HMO)	HMO contracts that provide coverage or services as described in s. 463.002(5), must offer to the subscriber the services of an optometrist licensed under chapter 463.	627.6699(12)(b)7
Podiatrists	A health insurance policy that provides coverage for services within the scope of a podiatrist's license shall be construed to include payment to a podiatrist who performs such procedures.	627.6699(12)(b)7
Podiatrists (HMO)	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	627.6699(12)(b)7

Section 4: Required Coverage of Insureds; Underwriting Restrictions

Insured	Summary	Standard & Basic
Children: Adopted and Foster Children	Benefits applicable to children apply to an adopted child and foster child from the moment of placement in the residence. Coverage begins at the moment of birth if a prior written agreement to adopt the child has been executed. The policy may not exclude coverage for any preexisting condition except in the case of a foster child. For HMOs and small group policies, only the benefits applicable to adopted children apply.	627.6578(12)(e)
Children: Handicapped	Policies covering children must continue to provide coverage beyond the age limit for dependent children as long as the child continues to be incapable of self-sustaining employment due to mental retardation or physical handicap; and is chiefly dependent on the policyholder or subscriber for support.	627.6699(12)(b)4
Children: Newborn Coverage	Policies covering a family member of the insured must provide coverage for a newborn child from the moment of birth. The policy must also cover the newborn child of a covered family member (son or daughter), which coverage terminates 18 months after birth.	627.6699(12)(b)4
Continuation of Group Coverage	Group policies covering fewer than 20 employees must allow an employee to continue coverage for 18 months (or 29 months for handicapped individuals; 36 months for divorced and widowed spouses) after their group coverage would otherwise terminate, subject to payment of up to 115% of the group premium. (Comparable to the federal COBRA law for employers with 20 or more employees.)	Small group: 627.6692
Guaranteed Availability of Individual Coverage (HIPAA-Eligible)	Persons who lose coverage after being covered for at least 18 months, the most recent of which is group coverage, are entitled to individual coverage. If the prior coverage is under an insured group plan, the group insurer must offer an individual conversion policy. If the prior coverage is with a self-insured plan, coverage may be obtained on a guaranteed-issue from any insurer or HMO issuing individual coverage. Persons who lose eligibility for individual coverage issued in Florida due to the insurer becoming insolvent, the insurer discontinuing all coverage in the state, or the individual moving out of the service area of the insurer or HMO, are entitled to guaranteed-issuance of coverage from any individual carrier.	627.6487
Guaranteed Renewability	All individual and group policies and group HMO contracts must be guaranteed renewable, subject to certain exceptions.	627.6699(7)
Preexisting Conditions	Group policies and group HMO contracts may not exclude preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee, and may relate only to conditions that manifested themselves during the 6-month period prior to coverage. The period of the exclusion is reduced by the time the insured was covered under prior creditable coverage.	627.6699(5)(f)
Special Enrollment Periods	Insurers and HMOs issuing group health policies and contracts must: 1) allow an employee to enroll who previously did not enroll due to having other coverage, and the other coverage terminates due to certain conditions; 2) allow a person to enroll who becomes a dependent of a covered person by reason of marriage, birth, or adoption.	627.6699(5)(h)7

ATTACHMENT D

CURRENT STANDARD AND BASIC BENEFIT DESIGNS

	HMO - COPAY		INDEMNITY / PPO	
	CURRENT STANDARD (A)	CURRENT BASIC (B)	CURRENT STANDARD (C)	CURRENT BASIC (D)
I. Cost Sharing Deductible - Individual	None	None	$250 / $500 / $750 / $1,000	$500
Deductible - Family	None	None	3x	$1,500
Coinsurance	Not Applicable	Not Applicable	As Specified	As Specified
Copays	As Specified	As Specified	As Specified	As Specified
*Maximum Out of Pocket - Individual	$1,500	$1,500	$2,000	$4,800
*Maximum Out of Pocket - Family	2x	2x	2x	2x
Maximum Lifetime Benefit	None	None	$1M EPO - No Maximum	$500,000 EPO-No Max
II. Inpatient Hospital Services	$100 copay / day for first five (5) days	$250 copay / day, days 1-5, balance covered	80 / 20 coinsurance	60/40 coinsurance
III. Emergency Care Services Emergency Room	$100 copay	$100 copay/visit	80 / 20 coinsurance, $50 copay	60/40 coinsurance, $50 copay
Ambulance	$25 copay	$50 copay	80 / 20 coinsurance	60/40 coinsurance
Urgent Care	Not Applicable	Not applicable	Not Applicable	Not applicable
IV. Outpatient Services Surgical Care in Outpatient Hospital Department	$50 copay	$100 copay/procedure	80 / 20 coinsurance	60/40 coinsurance
Surgical Care in Outpatient Health Care Provider	$25 copay	$50 copay/procedure	80 / 20 coinsurance	60/40 coinsurance
Non-Surgical Care in Ambulatory Surgical Center	No copay	No copayment	80 / 20 coinsurance	60/40 coinsurance
Primary Care Physician Office Visit	$10 copay	$10 copay/visit	80 / 20 coinsurance $10 copay / office visit (surgery)	60/40 coinsurance
Specialist Office Visit	$10 copay	$20 copay/visit	80 / 20 coinsurance $10 copay / office visit (surgery)	60/40 coinsurance
Surgical Care in Ambulatory Surgical Center	$50 copay	$100 copay/procedure	80 / 20 coinsurance	60/40 coinsurance

	HMO - COPAY		INDEMNITY / PPO	
	CURRENT STANDARD (A)	CURRENT BASIC (B)	CURRENT STANDARD (C)	CURRENT BASIC (D)
Non-Surgical Spine & Back Disorder Treatment	$10 copay Maximum 10 visits for CY	$20 copay/visit Maximum 10 visits for CY	80 / 20 coinsurance Maximum 10 visits for CY	60/40 coinsurance Maximum 10 visits for CY
Outpatient Rehabilitative Services (Speech, PT, OT)	$20 copay Maximum 10 visits for CY	$20 copay Maximum 10 visits for CY	80 / 20 coinsurance Maximum 10 visits for CY	60/40 coinsurance Maximum 10 visits for CY
V. Prescription Drugs	$7 / generic or brand name only $14 / brand name + 100% of the difference	Not covered	$7 / generic or brand name only $14 / brand name + 100% of the difference	Not Covered
VI. Home Health Care	Maximum 60 visits for CY	Maximum 60 visits for CY	80 / 20 coinsurance; 60 visits/CY; $3600/CY (in lieu of hospital)	60/40 coinsurance; 60 visits/CY
VII. Mental Health Services Mental Health - Out Patient Services	$10 copay / sessionMaximum 20 visits for CY	$20 copay per visit (limit of 10 visits per CY)	80 / 20 coinsurance; (limit 20 days/CY and $50 per session), maximum reimbursement of $50 per session	60/40 coinsurance(limit of 10 visits per CY)
Mental Health - In Patient Services	$100 copay / day Maximum 20 visits for CY Maximum reimbursement of $50 per session	$250 copay/day (limit of 5 days/CY)	80 / 20 coinsurance; (limit 10 days/CY)	60/40 coinsurance (limit of 5 days/CY)
VIII. Skilled Nursing Facility	100 days Lifetime Maximum	Covered; lifetime maximum of 100 days (in lieu of hospital)	60 / 40 coinsurance 100 days Lifetime Maximum	80/20 coinsurance; lifetime maximum of 100 days (in lieu of hospital)
IX. Hospice	Covered in lieu of Hospitalizaton	Covered (in lieu of hospital)	80 / 20 coinsurance in lieu of Hospitalizaton	60/40 coinsurance; (in lieu of hospital)
X. Private Duty Nursing	Not Covered	Not covered Exemption: See Home Health Services	Not Covered	Not covered Exemption: See Home Health Services
XI. Durable Medical Equipment, Orthotics & Prosthetics	Covered as Described in Coverage Provisions	Covered	80 / 20 coinsurance	60/40 coinsurance
XII. X-Ray, Laboratory Diagnostic Services	Covered as Described in Coverage Provisions	Covered	80 / 20 coinsurance	60/40 coinsurance
XIII. Preventative Services	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions	Covered as Described in Coverage Provisions

ATTACHMENT E

Recommended BASIC Plans in comparison to Current BASIC Plans

These premium comparisons are based on illustrative pricing models: Actual premiums differences offered by carriers may vary and will be impacted by other factors such as increases of utilization and medical trend.

Relative Values Use the Current Plan as the Base
Deductible Factors are Relative to $500 Deductible
Coinsurance % Factor are Relative to 60% Coinsurance Plan
OPM Factors are Relative to $5000 Out-of-Pocket Maximum Plan

HMO Copay Plans

Copay 1	8.73% less than current
Copay 2	7.93% less than current

HMO Coinsurance Plans

out-of-pocket option	deductible	coinsurance %	out-of-pocket	**change from current**
current	$ 500	60%	$ 4,800	**n/a**
A	$ 2,500	60%	$ 7,500	**-47%**
B	$ 500	60%	$ 5,000	**-28%**
C	$ 750	60%	$ 5,000	**-31%**
D	$ 1,000	60%	$ 5,000	**-34%**
E	$ 1,500	60%	$ 5,000	**-38%**
F	$ 2,500	60%	$ 5,000	**-45%**
G	$ 500	60%	$ 7,500	**-30%**
H	$ 750	60%	$ 7,500	**-34%**
I	$ 1,000	60%	$ 7,500	**-36%**
J	$ 1,500	60%	$ 7,500	**-41%**
L	$ 2,500	60%	$ 7,500	**-47%**
M	$ 500	80%	$ 5,000	**-18%**
N	$ 750	80%	$ 5,000	**-23%**
O	$ 1,000	80%	$ 5,000	**-26%**
P	$ 1,500	80%	$ 5,000	**-32%**
Q	$ 2,500	80%	$ 5,000	**-41%**
R	$ 500	80%	$ 7,500	**-20%**
S	$ 750	80%	$ 7,500	**-24%**
T	$ 1,000	80%	$ 7,500	**-27%**
U	$ 1,500	80%	$ 7,500	**-33%**
V	$ 2,500	80%	$ 7,500	**-42%**

These premium comparisons are based on illustrative pricing models: Actual premiums differences offered by carriers may vary and will be impacted by other factors such as increases of utilization and medical trend.

Indemnity Plans

Relative Values Use the Current Plan as the Base
Deductible Factors are Relative to $500 Deductible
Coinsurance % Factor are Relative to 60% Coinsurance Plan
OPM Factors are Relative to $5000 Out-of-Pocket Maximum Plan

out-of-pocket option	deductible	coinsurance %	out-of-pocket	**change from current**
Current	$ 500	60%	$ 4,800	**n/a**
A	$ 2,500	60%	$ 7,500	**-20%**
B	$ 500	60%	$ 5,000	**+08%**
C	$ 750	60%	$ 5,000	**+03%**
D	$ 1,000	60%	$ 5,000	**no change**
E	$ 1,500	60%	$ 5,000	**-06%**
F	$ 2,500	60%	$ 5,000	**-16%**
G	$ 500	60%	$ 7,500	**+03%**
H	$ 750	60%	$ 7,500	**-02%**
I	$ 1,000	60%	$ 7,500	**-05%**
J	$ 1,500	60%	$ 7,500	**-11%**
L	$ 2,500	60%	$ 7,500	**-20%**
M	$ 500	80%	$ 5,000	**+21%**
N	$ 750	80%	$ 5,000	**+17%**
O	$ 1,000	80%	$ 5,000	**+13%**
P	$ 1,500	80%	$ 5,000	**+05%**
Q	$ 2,500	80%	$ 5,000	**-06%**
R	$ 500	80%	$ 7,500	**+20%**
S	$ 750	80%	$ 7,500	**+14%**
T	$ 1,000	80%	$ 7,500	**+10%**
U	$ 1,500	80%	$ 7,500	**+03%**
V	$ 2,500	80%	$ 7,500	**-08%**

These premium comparisons are based on illustrative pricing models: Actual premiums differences offered by carriers may vary and will be impacted by other factors such as increases of utilization and medical trend.

PPO Plans

Relative Values Use the Current Plan as the Base
Deductible Factors are Relative to $500 Deductible
Coinsurance % Factor are Relative to 60% Coinsurance Plan
OPM Factors are Relative to $5000 Out-of-Pocket Maximum Plan

out-of-pocket option	deductible	coinsurance %	out-of-pocket	**change from current**
Current	$ 500	60%	$ 4,800	**n/a**
A	$ 2,500	60%	$ 7,500	**-17%**
B	$ 500	60%	$ 5,000	**+13%**
C	$ 750	60%	$ 5,000	**+09%**
D	$ 1,000	60%	$ 5,000	**+05%**
E	$ 1,500	60%	$ 5,000	**-02%**
F	$ 2,500	60%	$ 5,000	**-12%**
G	$ 500	60%	$ 7,500	**+07%**
H	$ 750	60%	$ 7,500	**+02%**
I	$ 1,000	60%	$ 7,500	**-02%**
J	$ 1,500	60%	$ 7,500	**-08%**
L	$ 2,500	60%	$ 7,500	**-17%**
M	$ 500	80%	$ 5,000	**+19%**
N	$ 750	80%	$ 5,000	**+14%**
O	$ 1,000	80%	$ 5,000	**+10%**
P	$ 1,500	80%	$ 5,000	**+02%**
Q	$ 2,500	80%	$ 5,000	**-09%**
R	$ 500	80%	$ 7,500	**+13%**
S	$ 750	80%	$ 7,500	**+08%**
T	$ 1,000	80%	$ 7,500	**+04%**
U	$ 1,500	80%	$ 7,500	**-03%**
V	$ 2,500	80%	$ 7,500	**-13%**