HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 851 Nonprofit Agricultural Organization Health Coverage
SPONSOR(S): Anderson
TIED BILLS: **IDEN./SIM. BILLS:** SB 876

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	16 Y, 0 N	Herrera	Lloyd
2) Select Committee on Health Innovation			
3) Commerce Committee			

SUMMARY ANALYSIS

Health insurance is vital for protecting individuals from financial strain due to accidents, illnesses, or disabilities. Managed care, such as preferred provider organizations (PPOs) and health maintenance organizations (HMOs), integrates healthcare delivery and financing, ensuring cost-effective medical services within controlled networks.

An association health plan (AHP) is a group purchasing arrangement in which members of a trade group or professional association jointly obtain health insurance for employees. These arrangements differ from traditional group insurance by their unique structure, since they involve the purchase of insurance products across multiple employers.

The Office of Insurance Regulation (OIR), supervises and examines insurers ensuring compliance with applicable regulations, including performing market conduct examinations and monitoring insurer solvency. This includes the oversight of authorized insurers providing health insurance. A guaranty association is typically a nonprofit corporation established by law to safeguard policyholders against financial losses and delays in claim payment and settlement resulting from the insolvency of an insurance company. Every insurer licensed to sell direct life insurance policies, health insurance policies, annuity contracts, and supplemental contracts in the state must participate in the Florida Life and Health Insurance Guaranty Association (FLHIGA).

In a number of states, Farm Bureau Plans (FBPs) have been provide an exemption from regulation by the state's insurance regulatory authority to provide health coverage that is not regulated as an insurance product. The FBPs provide healthcare options to its members, typically catering to individuals and families within rural communities, including farmers and agricultural workers. To access FBPs, individuals must join their state's Farm Bureau organization. FBPs operate under a unique exemption from state insurance regulations, distinguishing them from traditional health insurance offerings.

The bill exempts the health coverage provided by a nonprofit agricultural organization from the regulation of insurance and insolvency guaranties provided by law to the consumers of such organizations under the Florida Insurance Code.

The bill may have a negative fiscal impact on state government revenues. It has no fiscal impact on state government expenses or local government revenues or expenses. It may have a positive economic impact on the private sector.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Health Insurance

Health insurance is the insurance of human beings against bodily injury or disablement by accident or sickness, including the expenses associated with such injury, disablement, or sickness.[1] Individuals purchase health insurance coverage with the purpose of managing anticipated expenses related to health or protecting themselves from unexpected medical bills or large health care costs. Managed care is the most common delivery system for medical care today by health insurers.[2] Managed care systems combine the delivery and financing of health care services by limiting the choice of doctors and hospitals.[3] In return for this limited choice, however, medical care is less costly due to the managed care network's ability to control health care services. Some common forms of managed care are preferred provider organizations[4] (PPO) and health maintenance organizations[5] (HMO).

Office of Insurance Regulation

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[6] The Financial Services Commission (FSC), composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as the OIR agency head for purposes of rulemaking. Further, the FSC appoints the OIR Commissioner.

As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.[7] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[8] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[9] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code (FIC).[10]

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) in Florida operate within a regulatory framework overseen by OIR. To offer health insurance plans in Florida, HMOs must obtain a license from the OIR.[11] Managed care plans are the primary offerings of HMOs in Florida. These plans provide comprehensive healthcare services to members for a fixed monthly premium.[12] Members typically select a primary care physician from within the HMO's network, who serves as the main point of contact for all healthcare needs and referrals to specialists.[13]

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[1] S. 624.603, F.S.
[2] Florida Department of Financial Services, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers,* available at: https://www.myfloridacfo.com/docs-sf/consumer-services-libraries/ (last visited Jan. 26, 2024).
[3] *Id*.
[4] S. 627.6471, F.S.
[5] Part I of ch. 641, F.S.
[6] S. 20.121(3)(a), F.S.
[7] S. 624.418, F.S
[8] S. 624, 316(1)(a), F.S.
[9] S. 624.318(2), F.S.
[10] *See* S. 624.3161, F.S. The Code is comprised of chs. 624-632, 634-636, 641, 642, 648, and 651, F.S. S. 624.01, F.S.
[11] S. 641.21(1), F.S.
[12] Medicare, What's an HMO? https://www.medicare.gov/health-drug-plans/health-plans/. (last visited Jan. 26, 2024).
[13] *Id*.

HMOs maintain networks of healthcare providers, including primary care physicians, specialists, hospitals, and other healthcare facilities.[14] Members are generally required to receive care from within the HMO's network, with exceptions for emergencies or authorized out-of-network care.[15]

Florida law provides various consumer protections for individuals enrolled in HMO plans, including guaranteed access to emergency services, coverage for essential health benefits mandated by the Affordable Care Act, and the right to appeal coverage decisions made by the HMO.[16]

Association Health Plans (AHPs)

An association health plan (AHP) is a group purchasing arrangement in which members of a trade group or professional association jointly obtain health insurance for employees. These arrangements differ from traditional group insurance by their unique structure, since they involve the purchase of insurance products across multiple employers.

On June 21, 2018, the Employee Benefits Security Administration within the federal Department of Labor (DOL) issued a final rule amending the parameters for association health plans (AHPs),[17] consistent with the directives of a 2017 Presidential Executive Order.[18] The revised regulations were intended to give an employer greater flexibility to participate in an AHP. The new federal rule, among other things, permitted establishing an AHP for the explicit purpose of providing health coverage, so long as the association has another legitimate purpose for members and allowed the self-employed and sole proprietors to participate in an AHP.[19] Overall, the federal rule was designed to offer an expanded pathway for the establishment of an AHP.

In July 2018, eleven states[20] and the District of Columbia sued the DOL, alleging the final rule, and particularly the rule's provisions on bona fide association and working owner provisions, conflicted with the text and purpose of Employee Retirement Income Security Act (ERISA) and Patient Portability and Affordable Care Act (PPACA), and exceeded DOL's statutory authority.[21] On March 28, 2019, the U.S. District Court for the District of Columbia agreed with the states, finding that the DOL unreasonably expanded ERISA's definition of "employers" as an end run around the requirements of PPACA.[22] The court struck down the portions of the DOL's AHP rule that expanded the ability of small businesses and owners to buy health insurance on the large group market that was not subject to PPACA requirements that apply to the small group market.[23]

State Regulation of AHPs

The regulatory oversight of health insurance is generally reserved to the states, except when explicitly preempted by federal law. In Florida, OIR is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuing certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the FIC.[24]

[14] S. 641.19(12), F.S.
[15] Medicare, *What's an HMO?*, https://www.medicare.gov/health-drug-plans/health-plans/. (last visited Jan. 26, 2024).
[16] Consumer Services, *Health Insurance & HMO Overview*, https://www.myfloridacfo.com/division/consumers/understanding-insurance/health-insurance-and-hmo-overview (last visited Jan. 26, 2024).
[17] Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans, 83 FR 28912. June 21, 2018.
[18] Promoting Healthcare Choice and Competition Across the United States, 82 FR 48385. October 21, 2017.
[19] Milliman, Inc., *"Association health plans after the final rule"*, August 22, 2018, available at http://www.milliman.com/insight/2018/Association-health-plans-after-the-final-rule/ (last viewed on Jan. 30, 2024).
[20] California, Delaware, Kentucky, Maryland, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, Virginia, and Washington.
[21] State of New York, et al. v. U.S. Department of Labor, et al., No. 1:18-cv-01747 (D.D.C. Mar. 28, 2019).
[22] *Id*.
[23] *Id*.
[24] S. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).

All health insurance policies issued in Florida, with the exception of certain self-insured policies,[25] must meet certain requirements that are detailed throughout the FIC. Ch. 627, F.S., sets parameters and requirements for health insurance policies and ch. 641, F.S., provides requirements for health plans issued by HMOs. At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[26]

Florida Life and Health Insurance Guaranty Association

A guaranty association is typically a nonprofit corporation established by law to safeguard policyholders against financial losses and delays in claim payment and settlement resulting from the insolvency of an insurance company. In the event of an insolvency of a member, the guaranty association takes over the servicing of claims on eligible policies. Authorized insurers in Florida are typically required to participate in the applicable guaranty association for the relevant line of insurance as a condition of eligibility to transact insurance in the state.

Section 631.715, F.S., establishes the Florida Life and Health Insurance Guaranty Association (FLHIGA). Every insurer licensed to sell direct life insurance policies, health insurance policies, annuity contracts, and supplemental contracts in the state must participate in FLHIGA as a requirement for conducting business in Florida.[27] FLHIGA functions as a nonprofit corporation, governed by a Board of Directors consisting of nine to eleven members appointed by member insurers.[28]

Farm Bureau Health Plan

In a number of states, Farm Bureau Plans (FBPs) have been provide an exemption from regulation by the state's insurance regulatory authority to provide health coverage that is not regulated as an insurance product. The FBPs operate as healthcare options provided by a state's Farm Bureau to its members, typically catering to individuals and families within rural communities, including farmers and agricultural workers. To access FBPs, individuals must join their state's Farm Bureau organization. Membership often entails paying dues to support the Farm Bureau's advocacy and community initiatives. FBPs operate under a unique exemption from state insurance regulations, distinguishing them from traditional health insurance offerings. This exemption allows FBPs to be considered separately from standard health insurance products. Unlike typical health insurance, FBPs, which predate the Affordable Care Act (ACA), utilize medical underwriting and are not subject to state or federal insurance mandates. Consequently, they can decline applicants based on medical history or impose waiting periods for pre-existing conditions without having to comply with essential health benefit requirements or maximum out-of-pocket limits mandated for ACA-compliant plans. While FBPs aren't classified as insurance, they still provide comprehensive benefits. In every state with FBPs, they typically offer options for comprehensive coverage at reasonable monthly costs, including free or low-cost preventative care, prescription drug coverage, telehealth services, dental and vision care options, and health savings accounts for qualified High Deductible Health Plans, with most plans having no annual or lifetime limits. Unlike individual market plans, participants can enroll in FBPs at any time.[29]

Effect of the Bill

The bill exempts the health coverage provided by a nonprofit agricultural organization from the regulation of insurance and insolvency guaranties provided by law to the consumers of such organizations under the Florida Insurance Code.

[25] 29 U.S.C. 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida. These plans cannot be regulated by state law.
[26] S. 627.413(1)(d), F.S.
[27] S. 631.716(1), F.S.
[28] *Id*.
[29] The states are Tennessee, Iowa, Kansas, Indiana, and Texas. The Foundation for Government Accountability, *Farm Bureau Health Coverage Plans*, https://thefga.org/wp-content/uploads/2021/01/Farm-Bureau-Plans-FAQ.pdf (last visited Jan. 30, 2024).

B. SECTION DIRECTORY:

Section 1: Creates the "Nonprofit Agricultural Organization Health Coverage Act of 2024."

Section 2: Retitles the "Fraternal Benefit Societies" to the "Fraternal Benefit Societies and Nonprofit Agricultural Organizations."

Section 3: Redesignates ss. 632.601 through 632.638, F.S. as part I of Ch. 632.

Section 4: Creates s. 624.4032, F.S., relating to nonprofit agricultural organization health coverage.

Section 5: Providing an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Insurance premium tax revenues may be reduced to the extent that purchasers of health coverage shift their business from health insurance to the exempt health coverage proposed by the bill.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Members of eligible nonprofit agricultural organizations may realize savings on health coverage to the extent that health coverage products offered by such organizations are priced lower that insurance products that they may already purchase.

D. FISCAL COMMENTS:

The bill makes no provision for solvency guaranties similar to that currently provided under the FIC. In the event of an insolvency, it is unclear if there will be any guaranty of payment of the health coverage purchased under the operable health coverage agreements at the time of any insolvency.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES