# HEALTH FLEX PLAN PROGRAM

## Annual Report
## January 2012

Agency for Health Care Administration
2727 Mahan Drive, MS 26
Tallahassee, FL 32308
1-888-419-3456
http://www.floridahealthfinder.gov/
http://ahca.myflorida.com/

Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399-0326
1-850- 413-3153
http://www.floir.com/

Office of Insurance Regulation

# Health Flex Plan Program
# Annual Report

## Background Information

Under the provisions of section 408.909, Florida Statutes, the Agency for Health Care Administration (Agency) and the Office of Insurance Regulation (Office) must submit a report to the Governor and the Legislature annually on the status of the Health Flex Plan Program. The law specifically mandates that "the agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as Health Flex plans, on the number of enrollees, and on the scope of health care coverage offered under a Health Flex plan; shall provide an assessment of the Health Flex plans and their potential applicability in other settings; shall use Health Flex plans to gather more information to evaluate low-income consumer driven benefit packages..." (subsection 408.909(9), Florida Statutes).

The 2002 Florida Legislature established the Health Flex Plan Program, recognizing that a significant number of Florida residents are unable to obtain affordable health insurance coverage. The Health Flex Plan Program was established as a pilot program to offer basic affordable health care services to low-income uninsured state residents "by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services" (subsection 408.909(1), Florida Statutes). The Legislature further mandated these options be coordinated with existing governmental or community-based health services programs.

Initially, the program was established as a pilot program in three areas of the state and Indian River County with an expiration date of July 2004; however, the 2003 Legislature extended the program to July 2008. The 2003 Legislature also authorized the purchase of Health Flex plan coverage through small business purchasing arrangements.

The 2004 Legislature passed House Bill 1629, expanding the authority to offer Health Flex plans to all 67 counties. This bill also required the Office to provide more stringent oversight of advertising and marketing procedures of each Health Flex plan, and required the Agency to ensure that Health Flex plans follow standardized grievance procedures similar to those required of health maintenance organizations (HMOs). To date, Health Flex plan enrollees have not reported any grievances to the Agency.

House Bill 1843, passed in 2004, amended the eligibility requirements specified in statute. The bill provides that residents of the state, who are eligible under a federally approved Medicaid demonstration waiver and reside in Palm Beach or Miami-Dade Counties, are eligible for enrollment in the Health Flex Plan (Chapter 2004-270, Section 2, Laws of Florida). The 2005 Legislature added provisions to strengthen the background requirements for management, officers, and directors of Health Flex plans.

In addition, the Legislature amended the statutes to allow Palm Beach County to develop a Health Flex plan using Medicaid funds, provided the County would receive approval under a Medicaid demonstration waiver. However, Palm Beach County opted to implement a Health Flex plan without relying on Medicaid funds.

Attempts in 2006 to increase the income eligibility threshold failed in the Legislature.

HB 0461, passed in 2008, amended the eligibility requirements specified in statute. The bill expanded family income equal to or less than 300 percent of the federal poverty level. The bill deleted the eligibility of residents in Palm Beach and Miami-Dade Counties if they are eligible under a federally approved Medicaid demonstration waiver. The bill extended the expiration date of the Health Flex Plan Program to July 1, 2013.

SB 2534, passed in 2008, further amended the eligibility requirements providing that persons who were covered under an already licensed individual health maintenance organization (HMO) contract, which was also an approved Health Flex plan on October 1, 2008, may apply for coverage in the same HMO's Health Flex plan without a lapse in coverage if all other eligibility requirements are met. Further, a person who was covered under Medicaid or KidCare and lost eligibility for those programs due to income restrictions within 90 days prior to applying for health care coverage through an approved Health Flex plan, may apply for coverage in a Health Flex plan without lapse in coverage if all other eligibility requirements are met.

The bill also amended language to cover an individual through an approved Health Flex plan if the individual agrees to make any payments required for participation, is part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level; and the employer group is not covered at any time during the past six months. If the Health Flex plan entity is a health insurer, health plan or licensed HMO, only 50 percent of the employees must meet the income requirements.

This 2012 annual report reiterates the basic provisions of the Health Flex plan legislation and activities that were included in the January 2010 and 2011 annual reports to ensure that this document can be read without referencing earlier reports.

There have been no new Health Flex plan applications approved since the January 2008 annual report. As of December 2011, three Health Flex plans are operational in Florida.

**Program Description and Eligibility Requirements**

A Health Flex plan differs from insurance products in several ways. Health Flex plan providers are not subject to licensure under the Florida Insurance Code. Instead, they must meet quality of care and financial guidelines jointly developed by the Agency and the Office. Health Flex plans are not subject to the mandated health care benefits specified in Chapter 627, Florida Statutes; instead providers can design a flexible benefit coverage product that may contain some or all of the mandates.

Health Flex plans can be offered by licensed insurers, HMOs, health care providers, local governments, health care districts, or other public or private organizations, and through small employers' business purchasing arrangements sponsored by local government. Eligibility to enroll in a Health Flex plan is limited to individuals who:

- Are residents of this state;
- Are 64 years of age or younger;
- Have family incomes equal to or less than 300 percent of the federal poverty level ($67,050 for a family of four based on 2011 federal guidelines);
- Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program such as Medicare or Medicaid, or another public health care program, such as KidCare, or have not been covered anytime during the past six months, except that:
- A person who was covered under an individual health maintenance organization (HMO) contract issued by an HMO licensed in the state of Florida which was also an approved Health Flex plan on October 1, 2008, may apply for coverage in the same HMO's Health Flex plan without a lapse in coverage if all other eligibility requirements are met; or
- A person who was covered under Medicaid or KidCare and lost eligibility for Medicaid or KidCare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved Health Flex plan may apply for coverage in a Health Flex plan without a lapse in coverage if all other eligibility requirements are met; and
- Have applied for health care coverage through an approved Health Flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or
- Are part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past six months. If the Health Flex plan entity is a health insurer, health plan or HMO, only 50 percent of the employees must meet the income requirements.

**Health Flex Plan Application Requirements**

Applicants must submit an application to both the Agency and the Office prior to beginning operations. Section 408.909 (3), Florida Statutes, requires the Agency to develop guidelines for review of Health Flex Plan applications and approve or deny applications that do not meet or no longer meet minimum standards for quality of care. The Office is required to develop financial guidelines to ensure that Health Flex plans are financially sound, and to deny or withdraw approval of plans that do not meet the financial guidelines. The Agency and the Office jointly developed a Health Flex Plan application that includes detailed quality and financial guidelines. The application can be found on the Agency's website http://ahca.myflorida.com/MCHQ/Managed_Health_Care/index.shtml, or the Office's website http://www.floir.com/sections/appcoord/is_ac_index.aspx .

The Health Flex Plan application guidelines and standards are summarized below:

- Quality of Care Standards: The provider, to the extent possible, should coordinate Health Flex plan services with existing community services; provide a marketing plan; provide a detailed description of the benefits coverage; establish utilization review procedures; demonstrate adequate network capacity; provide a listing of quality of care indicators; conduct patient satisfaction surveys; implement a quality assurance plan; contract with credentialed physicians; and provide a detailed description of the patient's responsibilities and rights. Enrollees must have access to an internal grievance process but do not have access to the Statewide Subscriber Assistance Program, the State's external grievance review panel.

  As of December 1, 2011, no grievances have been filed with the Agency.

- Financial Review Guidelines: The Office is responsible for determining that the Health Flex plans offered are financially sound and that the applicants are able to underwrite or finance the health care coverage provided. This determination is based upon a financial review, as well as an analysis of the proposed rates to be charged in comparison to the benefits being offered.

  To expedite financial determinations and immediately qualify a large base of eligible sources to offer the Health Flex Plan Program, health maintenance organizations, authorized health insurers, fraternal benefit societies, prepaid limited health plans, or prepaid health clinics that are considered in good standing by the Office are considered to meet the financial solvency standards required to offer a Health Flex plan. In addition, any local government or health care district that has the initial operating funds and taxing authority to fulfill its obligations under the proposed Health Flex Plan is considered to meet the financial solvency standards required to offer a Health Flex plan.

Entities such as health care provider sponsored organizations or public/private community-based organizations or public/private partnerships have their financial solvency requirements set according to the type of benefits offered by the Health Flex Plan. The minimum surplus requirement is set at $150,000 for plans desiring to provide basic clinic services such as emergency care, physician care other than hospital inpatient physician services, ambulatory diagnostic treatment, and preventive health care services. Plans that offer limited health services such as ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services must maintain a minimum surplus of $150,000. Plans proposing to include a combination of basic clinic services and limited health services are subject to a minimum surplus requirement which is the greater of $300,000 or ten percent (10%) of total liabilities. If any plan includes inpatient hospital services, the minimum surplus required is the greater of $1,500,000 or ten percent (10%) of total liabilities, or two percent (2%) of annualized premium for this potential high-risk exposure.

In addition, applicants are subject to fingerprinting and background checks; provision of management and company information; submission of a feasibility study by a certified actuary in conjunction with a certified public accountant; provision of a recent independent financial audit; and compliance with form and rate review guidelines. Such form and rate review guidelines have been developed to ensure the evidence of coverage document provided to enrollees is not ambiguous or misleading and the premiums charged are reasonable in relation to the benefits provided.

An underlying concern is that entities with no health care or risk-bearing experience will over expand or underestimate the liabilities they are incurring. The Office has established reporting requirements aimed at reducing this exposure. All financial requirements are based upon Statutory Accounting Principles (SAP) as outlined in the National Association of Insurance Commissioners (NAIC) Accounting Practices and Procedures Manual. Financial reports must be submitted on the NAIC Annual and Quarterly Health Insurance Blanks. Local government entities or health care districts fully supported by local taxes must file only selected pages from the Health Insurance Blanks. All Health Flex plans must file both quarterly and annual reports with the Office. Audited financial statements prepared in accordance with SAP and an actuarial certification that the organization is actuarially sound must be filed annually.

## Approved Health Flex Plans

| American Care, Inc. – Healthcare Provider Sponsored Organization | | | |
|---|---|---|---|
| **Application Date** | **Approved Date** | **Current Status** | **Approved Counties** |
| December-02 | March-03 | Operating | Broward, Hillsborough, Miami-Dade, Palm Beach, Polk and St. Lucie |
| **Preferred Medical Plan, Inc. - Health Maintenance Organization** | | | |
| **Application Date** | **Approved Date** | **Current Status** | **Approved Counties** |
| January-03 | March-03 | Operating | Miami-Dade & Broward |
| **JaxCare, Inc. - Public/Private Partnership Program** | | | |
| **Application Date** | **Approved Date** | **Current Status** | **Approved Counties** |
| September-03 | December-03 | Closed - 2007 | Duval |
| **The Public Health Trust of Miami-Dade County/JMH Health Plan - Health Maintenance Organization** | | | |
| **Application Date** | **Approved Date** | **Current Status** | **Approved Counties** |
| January-04 | May-04 | Closed - 2009 | Miami-Dade |
| **Vita Health Plan, operated by Healthy Palm Beaches, Inc. - Health Maintenance Organization** | | | |
| **Application Date** | **Approved Date** | **Current Status** | **Approved Counties** |
| November-05 | February-06 | Operating | Palm Beach |

## Active Health Flex Plans

**(Information contained on the following pages of this report was provided by the specific Health Flex plans.)**

### American Care, Inc.

This plan offers preventive and diagnostic services and is entirely premium funded. Services are rendered through wholly owned American Care centers in the various counties of Florida to ensure a more consistent quality delivery system.

A brief summary of the current premium costs and benefits package is provided below:

- Monthly premium: $50 regardless of age and sex
- Prescription medication (generic): $4, dispensed through American Care medical centers
- Transportation: Free transportation from and to the medical center
- Center portability: A member traveling and needing urgent medical services can be treated at any of American Care's medical centers with $0 co-pay provision
- Specialty care: Specialty care coverage is available as a separate coverage

American Care, Inc. began enrollment in May 2003 in Miami-Dade County. Initial enrollment levels were well below expectations; however, the statutory expansion of the

program statewide, and the increase in the Medicaid eligibility income threshold to 300 percent of the federal poverty level, have increased overall enrollment.

In 2008, American Care was approved to extend the Health Flex Program to four additional counties, including Broward, Palm Beach, Hillsborough, and Polk. In 2011, American Care was approved for expansion of the program into St. Lucie County. As of November 2011, the total enrollment was 242 individuals. American Care offers its plan to employers and individuals.

**Preferred Medical Plan, Inc.**

PMP launched new and improved products effective October 1, 2011 that offer the following:

- A new Health Flex Basic Plan and Plus with Urgent Care Plan with an expanded provider network (Plan B) in Broward and Miami-Dade Counties with the flexibility for members to access providers in either county.
- Improved benefits for new (Plan B) and existing (Plan A) Health Flex products such as:
    - An expanded prescription formulary including an expanded generic formulary; lower copays of up to $10 for formulary generics; and discounts for non-formulary generic and brand drugs;
    - No maximum annual or lifetime limits;
    - Additional diagnostic and radiology services such as CT Scans and MRIs, and access to independent network laboratories;
    - No change in premiums for members enrolled in the existing plans: Plan A – Basic, Plus, and Plus with Urgent Care; and
    - An expanded list of covered specialties and specialist providers for the Plus and Plus with Urgent Care Plans.

Overall, Preferred Medical Plan, Inc. (PMP) has maintained a steady membership throughout 2011 in comparison to 2010.

| Plan Type | Current Enrollment as of 12/1/11 | Comparison Enrollment as of 10/1/10 |
|---|---|---|
| Plan A - Basic | 59 | 53 |
| Plan A - Plus | 405 | 487 |
| Plan A – Plus with Urgent Care | 733 | 560 |
| Plan B - Basic | 6 | n/a |
| Plan B – Plus with Urgent Care | 156 | n/a |
| Total Enrollment | 1359 | 1100 |

| Product Offerings | Premiums | Description |
|---|---|---|
| Plan A - Basic | $40 per month | Basic preventive/ diagnostic care/ generic drugs |
| Plan A - Plus | $51 per month | Basic plan plus specialty physician care visits |
| Plan A – Plus with Urgent Care | $63 per month | Plus plan with access to urgent care facilities |
| Plan B - Basic | $45 per month | Basic preventive/ diagnostic care/ generic drugs |
| Plan B – Plus with Urgent Care | $69 per month | Basic and specialist services with access to urgent care facilities |
| Dental Optional Rider | $6 per month | Basic dental coverage |
| Optical Optional Rider | $5 per month | Basic vision coverage |

PMP has enhanced its marketing efforts for its Health Flex products which are branded and marketed as "Medi-Flex Plans" in the community. Flyers specific for Medi-Flex Plans were developed. Medi-Flex Plans are now included in some of PMP's main marketing brochures. PMP has also expanded its sales network for its Medi-Flex Plans.

**Vita Health Plan**

Vita Health is a shared cost health coverage plan operated by Healthy Palm Beaches, Inc., a fully accredited HMO by the Accreditation Association for Ambulatory Health Care. Healthy Palm Beaches began operating the Vita Health Health Flex plan in February 2006. Vita Health targets individuals and families in Palm Beach County in an effort to offer an affordable health coverage option. Vita Health offers a variety of medical coverage including: emergency, inpatient services, outpatient surgery, preventive care, specialty coverage, diagnostics, prescriptions, lab and radiology.

Members are responsible for a share of the monthly premium. The Health Care District of Palm Beach County subsidizes the additional share of the premiums. The member's share of the monthly premium is as follows:

| | |
|---|---|
| Children (ages 1-20): | $30 |
| Adults (ages 21-54): | $65 |
| Adults (ages 55-64): | $125 |

To further assist Palm Beach County residents, a two-tiered co-payment schedule exists. Vita Blue is offered to beneficiaries with an income level up to 150 percent of the Federal Poverty Level (FPL); and Vita Green is offered to those with incomes between 150 and 300 percent of the FPL.

| Services | Vita Blue | Vita Green |
|---|---|---|
| Hospital Services | $20 per admission | $30 per admission |
| Outpatient Surgery | $20 per visit | $25 per visit |
| Emergency Room | $15 (waived if admitted) | $25 (waived if admitted) |
| Outpatient Diagnostic | $15 per visit | $15 per visit |
| Lab and X-Ray | $15 per visit | $15 per visit |
| MRI/CT Scan | $25 per scan | $25 per scan |
| Primary Care Physician | $5 per visit | $10 per visit |
| Specialist | $15 per visit | $20 per visit |
| Hospital Based Services | No co-payment | No co-payment |
| Generic Prescription | $10 per prescription | $10 per prescription |

Vita Health has experienced a 38 percent growth over the past year. Membership grew from 5,692 members in September 2010 to 7,879 members in September 2011. In addition to excellent customer service, Vita Health attributes its rapid growth to word-of-mouth referrals, eligibility income criteria up to 300 percent of the FPLG, and the subsidized premium by the Health Care District of Palm Beach County whereby members pay 1/3 of the premium cost and the Health Care District pays 2/3 of the premium cost.

## Compliance Monitoring

The Agency intends to survey the health plans in 2012. The survey will evaluate the plan's compliance with the eligibility requirements, plan member grievance procedures, quality assurance plan, utilization review plan, patient and provider satisfaction data, outreach education efforts, provider networks, credentialing and recredentialing procedures, record retention requirements, and services coordination efforts.

## Reported Financial Results

The following chart reflects the enrollment and reported financial results of each Health Flex Plan entity to the Office as of September 30, 2011. The information is compiled from the quarterly financial statements filed by each Health Flex Plan entity with the Office. The information reflected below has not been audited or independently verified.

| COMPANY | TOTAL ADMITTED ASSETS | TOTAL LIABILITIES | TOTAL CAPITAL AND SURPLUS | CALENDAR YTD PREMIUM | CALENDAR YTD NET INCOME OR (LOSS) | ENROLLEES |
|---|---|---|---|---|---|---|
| AMERICAN CARE, INC. | $1,749,436 | $7,282 | $1,742,154 | $126,666 | $58,947 | 319 |
| PREFERRED MEDICAL PLAN, INC. | $38,180,235 | $24,421,718 | $13,758,517 | $620,787 | $223,616 | 1,203 |
| VITA HEALTH PLAN (HEALTHY PALM BEACHES) | $17,481,618 | $6,515,989 | $10,965,629 | $7,496,144* | ($6,731,567) | 7,879 |
| **TOTAL** | **$57,411,289** | **$30,944,989** | **$26,466,300** | **$8,243,597** | **($6,449,004)** | **9,401** |

Balance sheet accounts include all operations of each entity, including Health Flex business.
Income statement operations include Health Flex transactions only.
Vita Health Plan has not yet received the Health Care District subsidy for 2011, which could have a positive material effect on Calendar YTD Net Income.
*Includes $1.25 million of recorded low income pool subsidy.

## Summary

Subsection 408.909(9), Florida Statutes, charges the Agency and the Office with evaluating the pilot program and its effect on the entities that seek approval as Health Flex plans, on the number of enrollees, and on the scope of health care coverage offered. In addition, the Agency and the Office are required to determine the potential applicability of this program to other settings.

This report provides data on the number of plans approved, the number of enrollees by plan as of September 2011, and financial data submitted to the Office of Insurance Regulation.

The extension of the program's expiration date from July 2008 to July 2013 was expected to increase interest in the program. In looking at the enrollment data, it appears that only those plans that receive significant local government or other subsidies, and provide expanded benefits, are reasonably successful. Plans relying entirely on member premiums show considerably lower than expected enrollment rates. The future of the Health Flex Program appears to depend largely on the availability of government or private funding sources to subsidize part of the costs.

Health Flex plans were created by the Florida legislature as an alternative to licensed insurance plans. While some of the Health Flex plans are operated by licensed health maintenance organizations, Florida's law also allows health care provider-sponsored organizations to offer Health Flex plans.

The Florida Health Flex Plan Program expires July 13, 2013 unless reenacted by the Legislature. While the Health Flex Program is not believed to be subject to the provisions of the new federal Patient Protection and Affordable Care Act, the future of the program depends largely on the implementation of the act.