HEALTH FLEX PLAN PROGRAM

Annual Report
January 2016

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Background Information

Under the provisions of section 408.909, Florida Statutes (F.S.), 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), F.S.).

Program Description and Eligibility Requirements

Health Flex plans can be offered by licensed insurers, health maintenance organizations (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;
- Have family incomes equal to or less than 300 percent of the federal poverty level (FPL) ($72,750 for a family of four based on 2015 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 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 has applied for health care coverage through an approved Health Flex plan and has agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or

- A person who 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 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.

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 began enrollment in May 2003 in Miami-Dade County. 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 resulting in a slight membership growth. As of October 1, 2015, the total enrollment was 158 individuals, down from 185 the prior year. American Care offers its plan to employers and individuals.

Preferred Medical Plan, Inc.
Total membership as of October 1, 2015, was 343 individuals, down from 945 the prior year.

Enrollment by Plan Type as of October 1, 2015

Health Flex Plans	County	Membership
Plan A – Basic & Plus; Plus with Urgent Care	Miami-Dade	253
Plan B – Basic & Plus with Urgent Care	Miami-Dade	65
Plan B – Basic & Plus with Urgent Care	Broward	25
Total Membership		**343**

Enrollment has steadily declined since 2014 due to the implementation of the Federally Facilitated Marketplace Exchange plans. As such, Preferred Medical Plan made the decision to no longer renew existing member's policies, effective May 11, 2015. Preferred Medical Plan anticipates that its program will sunset May 2016.

Vita Health Plan
Total membership as of October 1, 2015, was 3,667 individuals, down from 9,801 the prior year.

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):	$40	(Effective January 1, 2015)
Adults (ages 21-54):	$100	(Effective January 1, 2015)
Adults (ages 55-64):	$185	(Effective January 1, 2015)

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 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 Plan discontinued new enrollment effective October 31, 2013, as a result of available coverage through the Affordable Care Act through the Marketplace Exchanges, and made the decision to sunset its program, effective December 31, 2015. All active members will be dis-enrolled on December 31, 2015. In 2014, Vita Health Plan staff became Certified Application Counselors and have encouraged and assisted members to enroll in a health insurance plan through the Marketplace Exchange during the open enrollment period.

Compliance Monitoring

The Agency conducted a survey of the plans October 2014. No violations of statutory requirements were identified. The survey evaluated 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 re-credentialing procedures, record retention requirements, and services coordination efforts.

Reported Financial Results

The following chart reflects the reported financial condition of each Health Flex Plan entity to the Office as of September 30, 2015. This information is compiled from the quarterly financial statements filed by each Health Flex Plan 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)
AMERICAN CARE, INC.	$2,386,546	$26,802	$2,359,744	$75,341	$8,917
PREFERRED MEDICAL PLAN, INC.	$135,581,438	$114,575,214	$21,006,224	$330,243	$53,916
VITA HEALTH PLAN (HEALTHY PALM BEACHES)	$12,357,950	$1,709,952	$10,647,998	$6,254,106	($5,479,101)
TOTAL	**$150,325,934**	**$116,311,968**	**$34,013,966**	**$6,659,690**	**($5,416,268)**

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 estimated or recorded the receivable from the county as of period ending September 30, 2015. The funds are expected before year end 2015, and will have a positive affect towards reported net income.