

FHIAB LEGISLATIVE PROPOSALS RECEIVED FROM BOARD MEMBERS

Louisa McQueeney, Florida Voices for Health Individual Policy Holder Representative

1. Employee Only Coverage in Small Group Plans

In the small group market, under most employer-sponsored group health plans, employers subsidize the employee's premium but spouse/dependent coverage are offered under the plan completely at the employee's expense, with no employer contribution.

In the ACA environment, it would be advantageous to have the option of not offering spouse/dependent coverage in small group, because the offer of coverage to a spouse and dependents, regardless of the affordability of that coverage, negates the ability of the spouse and dependents to qualify for subsidized coverage in the Marketplace (Exchange).

The ACA does not require small groups offer spouse or "dependent" coverage. However, in the small group market, carriers do not give small groups the option of not offering spouse/dependent coverage. The option of offering "employee only" coverage is required for carriers participating in the Small Business Health Options Program (SHOP) Marketplace (Exchange).

Recommendation: Provide a clear legislative directive whereby small group employers be specifically allowed the option to offer "employee only" coverage in the open market as is permitted in the Marketplace (Exchange).

2. Make more Marketplace Health Insurance Plans Health Savings Account eligible

Most Marketplace (Exchange) plans with high deductibles and maximum out of pocket limits appear not to be Health Savings Account eligible.

In order for a health plan to be considered HSA-compatible it has to satisfy three criteria to be considered a High Deductible Health Plan (HDHP), deductible, out-of-pocket maximum and first dollar average. For 2017 these requirements are as follows

- **Deductible:** A minimum annual deductible of \$1,300 for individual (self-only) coverage or \$2,600 for family (more than one individual) coverage.
- **Out-of-Pocket Maximum:** The annual out-of-pocket maximum for "In-Network" expenses cannot exceed \$6,550 for individual coverage or \$13,100 for family coverage. This refers to the amount of money an insured would have to pay before the insurance carrier would pay for 100% of any additional medical expenses incurred in that same year. It includes deductibles, co-payments and co-insurance expenses. It does not include premium payments.

- **First Dollar Coverage:** Can only be available for preventive care services, such as an annual physical. For all other care, the insured must satisfy their deductible before any co-payment or co-insurance benefits can go into effect.

Recommendation: Tailor more marketplace plans to be HSA eligible for consumers making more than 400% of the Federal Poverty Level, giving them the option to use pre-tax dollars for their medical expenses they are responsible for until they meet their deductible.

3. Make annual deductibles portable

When consumers change health insurance plans outside of the Open Enrollment period, such as a result of a change in geographic area where they are required to apply to a different insurance market, annual deductibles start all over again. So if a consumer has met part or all of the accumulators for one insurance plan and changes plans at any time during the 12-month contract period, the consumer is required to satisfy the entire annual deductible of the new insurance plan again.

Recommendation: Make annual deductibles portable if consumer is required to apply to a new carrier due to a geographic change.

4. Publish prescription drug prices in insurance plan's medication guide (formulary)

Insurance carriers negotiate prices with drug companies/pharmacy benefit managers on behalf of the consumer. Consumers have no clarity as to what the cost of a prescribed medication is until the prescription is filled and received by the consumer at which time payment is due. The cost of prescription drugs is a financial burden on many consumers and other drugs may be available at a lower cost. In order to assist the consumer in being a better informed and more prudent consumer of healthcare, it would be helpful if the negotiated prices for drugs are published in the medication guide (formulary) of each insurance plan.

Recommendation: Publish negotiated prices in the medication guide.

5. Protect Consumers from prescription drug formulary changes during a policy year

Reasons why consumers pick a particular health insurance plan is based on the prescription drugs available and the cost tiers they are classified in. In recent years, insurance carriers have been making changes to their drug formularies throughout the policy period. They are reclassifying drugs to a more restrictive drug tier or increase the amount a consumer must pay for a co-payment, co-insurance or deductible or reclassify a drug to higher cost sharing tier. Recently they are dropping certain drugs altogether and are mailing consumers letters that they will be financially responsible for the entire cost drug in the middle of the policy year.

Recommendation: Other than at the time of renewal an insurance policy that is in force the insurance carrier may not amend or remove a covered prescription drug during the policy year.

6. Direct the Florida Office of Insurance Regulation to develop standards of network adequacy for all group and individual health plans

Standards are required for network adequacy to ensure plans provide access to the services for which subscribers pay. Narrow networks that plans create to control costs must be adequate to enable access to multiplicity of necessary health services including, but not limited to primary care, pediatric care, hospital care, mental health care, oncology care, obstetric and newborn care, and dental care where applicable. The “reasonable access” standard identified by CMS is insufficient at ensuring access to consumers, and more specifically consumers who are members of vulnerable populations with health disparities for instance in rural areas.

When provider networks are inadequate, consumers may have no choice but to seek care outside their health plan’s network. In those cases, insurers often require enrollees to pay a greater share of the cost for out- of-network care, and the insurer is not required to count those costs toward annual out-of-pocket maximums under the ACA.

Recommendation: In inadequate narrow networks treat out-of-network care as in-net-work care and/or at a minimum apply the cost of the care to the accumulators, such as the deductible.

7. Prohibit balance billing for emergency medical transportation

Consumers in a life-threatening accident or major medical emergency in need of emergency transportation by road, water or air to receive immediate health care attention at a nearby facility, are not able to make an informed decision or negotiate at arms-length about the cost of the transport. Health insurance companies provide coverage for this event, but some coverage gaps can leave consumers with surprise high medical bills for the service.

Recommendation: Apply the balance bill rules under HB221, signed into law by Governor Scott, to include emergency transportation.

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**Ken Stevenson, Earl Bacon Agency
Agent Representative**

1. 30-Hour Rule

The FL small group full-time definition for an employee continues to conflict with the federal standard of 30 hours. Florida defines eligible employee under small group as those working at least 25 hours. We recommend applying consistency to help small business owners manage eligibility. Those that hover around 50 employees find themselves constantly needing to perform multiple calculations based on federal definitions and state definitions, based on number of hours to determine who is eligible under both sets of rules. Florida should adopt the Federal eligibility criteria. This will ease the compliance burden on small businesses. It would still allow those employers that wish to offer coverage to those working less than 30 hours per week to do so.

2. Dependents to Age 30

Currently Florida allows dependents to stay on group plans until age 30, provided that they meet certain criteria as defined in the law. This statute was passed when coverage was difficult to obtain by dependents with medical problems coming off their parent's policies. With coverage now available on a guarantee issue basis, there is no longer a need to keep this rule in place. This increases costs of employer plans by allowing dependents to stay on the plan after age 26. It is also confusing to employers and employees, since dependents living outside of Florida are not eligible to remain on the parent's policy. It could be seen as discriminatory to those residing in other states.

3. 1332 Waiver

A waiver would give the State the ability to set its own parameters of a health care plan versus the ACA mandates. Since Congress cannot seem to agree on a solution, Florida should at least consider this as an option to bringing some control back to local ground. Several states including, Alaska, Iowa, Texas, and Michigan are looking at using the 1332 waiver to establish their own mandated health benefits and other rules relating to health plans. This would be a proactive move, instead of waiting for Congress to act. It would be prudent to convene a panel to determine if this is the right course for Florida.

4. Ambulance

The State has already convened an air ambulance task force, however out of pocket costs for non-network ambulance services are a problem that is growing quickly. These services and balance billings are more common and impacting consumers statewide. With Florida now only having one health carrier for individual plans in most counties, there may not be an in-network ambulance service in many counties, particularly those in rural areas such as Leon County. It's easy for a consumer to face a surprise ambulance bill, sometimes in the thousands of dollars.

5. Balance Billing

In 2016 the Legislature passed legislation preventing balance billing in an in-network facility for emergencies. We would like to see this extended to non-emergencies as well, or at least require disclosure to consumers in advance. Texas proposed legislation that would require such disclosure to the patient, those providers failing to do so would forfeit their ability to seek collection remedies from consumers. Too many consumers don't find out they have been seen by an out of network provider until they receive a bill in the mail. They should have the right to choose their provider in a non-emergency situation and be protected in the event they are not notified.