FLORIDA OFFICE OF
INSURANCE REGULATION

Evaluation of Florida's Essential Health Benefits Benchmark Plan

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DAVID ALTMAIER
INSURANCE COMMISSIONER

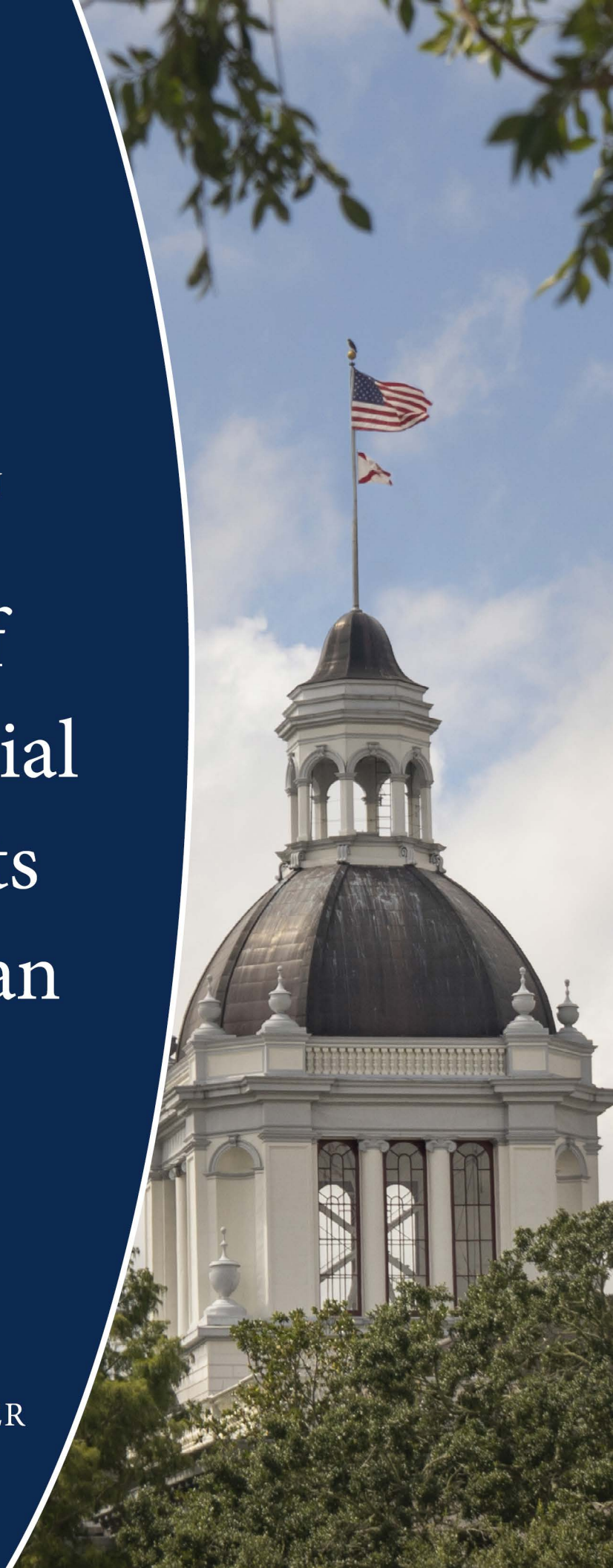

TABLE OF CONTENTS

Executive Summary

Directive

Senate Bill 322 was signed into law by the Governor on June 25, 2019, and included the provisions below:

> The office shall conduct a study to evaluate this state's current EHB-benchmark plan for nongrandfathered individual and group health plans and options for changing the EHB-benchmark plan pursuant to 45 C.F.R. s. 156.111 for future plan years. In conducting the study, the office shall:
>
> (a) Consider EHB-benchmark plans and benefits under the 10 essential health benefits categories established under 45 C.F.R. 357 s. 156.110(a) which are used by the other 49 states;
>
> (b) Compare the costs of benefits within such categories and overall costs of EHB-benchmark plans used by other states with the costs of benefits within the categories and overall costs of the current EHB-benchmark plan of this state; and
>
> (c) Solicit and consider proposed individual and group health plans from health insurers and health maintenance organizations in developing recommendations for changes to the current EHB-benchmark plan.
>
> By October 30, 2019, the office shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include recommendations for changing the current EHB-benchmark plan to provide comprehensive care at a lower cost than this state's current EHB-benchmark plan. In its report, the office shall provide an analysis as to whether proposed health plans it receives under paragraph (2)(c) meet the requirements for an EHB-benchmark plan under 45 C.F.R. s. 156.111(b).

Ch. 2019-129, § 10, at 7-8, Laws of Fla.

Methodology

OIR compared the benefits contained in Florida's benchmark plan to those in other states (other states as used in this report include the District of Columbia). OIR then

determined which benefits are in Florida's benchmark plan but not in the benchmark plan of at least one other state. OIR also reviewed the visit limits[1] for certain benefits.

OIR then entered into a contract with the Wakely Consulting Group for that company to calculate the per member per month (PMPM) claim cost of each benefit not in all other states' benchmark plans as described on page 8. This calculation allowed OIR to derive an approximate premium reduction if carriers offered plans without these benefits. OIR then conducted an analysis of the federal subsidies and after-subsidy premiums for which many Florida consumers qualify.

As required by Senate Bill 322, OIR solicited comments and substitute benchmark plans from stakeholders (see Informational Memorandum issued September 6, 2019, a copy of which is attached as Exhibit 2). OIR received one comment letter from a carrier, two comment letters from consumer groups, and no proposed plans.

Summary of Findings

OIR identified 12 benefits which were included in Florida's benchmark plan, not present in at least one other state's benchmark plan, and not required by Florida Statutes. If carriers removed these 12 benefits from their plans, there would be an approximate decrease in unsubsidized premiums of $10.22 PMPM (2.1%) in the individual market and $9.25 PMPM (2.3%) in the small group market.

Most of these savings arise from excluding the non-preferred brand name drug benefit from the state benchmark plan. Only one state does not include non-preferred brand name drugs in its benchmark plan. If non-preferred brand name drugs were kept in Florida's benchmark plan and the other 11 benefits were eliminated, the decrease in unsubsidized premiums would be approximately $4.07 PMPM (0.84%) in the individual market and $2.98 PMPM (0.75%) in the small group market.

OIR did not attempt to approximate the effects of any behavioral changes that may result in consumers substituting benefits. For example, if carriers stopped providing coverage for urgent care centers, there may be an increase in the use of emergency rooms. Similarly, removing coverage for non-preferred brand name drugs may result in increased utilization of other drugs.

Recommendation Summary

Reducing benefits in Florida's benchmark plan will have the effect of reducing premiums for those individuals who do not receive a subsidy. However, that reduction will only benefit 13% of consumers in the individual market as 87% of consumers in the

[1] Visit limits are the number of visits that will be covered for a specific service. For example, a policy may provide coverage for 30 sessions of physical therapy after which the consumer is responsible for all payments.

individual market receive a subsidy. For consumers receiving a subsidy, reducing the benefits in the benchmark plan will have adverse impacts. Consumers in a silver plan who receive a subsidy will end up paying the same post-subsidy premium for less benefits. Consumers in a bronze plan who receive a subsidy will end up paying more post-subsidy for less benefits. Therefore, while the analysis below shows options for changing the benchmark plan, OIR recommends that these options not be enacted.

Report

ACA Background

On March 23, 2010, the Patient Protection and Affordable Care Act was signed into law. Together with the Health Care and Education Reconciliation Act of 2010 signed March 30, 2010, these bills are referred to as the ACA.

Two of the goals of the ACA were to standardize individual and small group health plans (development of the bronze, silver, gold and platinum plans) and standardize the benefits in the individual and small group markets (10 essential health benefits or EHBs). While the ACA does impact the large group and self-insured markets to a small extent, the impact is comparatively minor.

Prior to the ACA, coverage in the individual market varied considerably among plans. Many plans did not offer coverage for prescription drugs, mental health or substance use disorders, maternity services, or rehabilitative services. However, most group, particularly large group plans, provided coverage for these benefits.

A goal of the ACA was to address this disparity by increasing the consistency of benefit levels between group and individual plans so that a person would have more stability in their insurance coverage when switching jobs or becoming self-employed. This increased consistency was done through the introduction of EHBs and benchmark plans.

Each ACA-compliant plan is required to provide benefits in the following 10 categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity, and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren’t essential health benefits)

The minimum benefits in each of the 10 EHBs is set using the benchmark plan. This allowed benefits that could vary from state to state but offered consumers a plan that was a typical employer plan, not too rich and not too lean, for their state.

State of the Market

As of March 31, 2019, the Florida individual health insurance market consisted of 1.64 million covered lives in the ACA on-exchange market and an additional 130,000 covered lives in the ACA off-exchange market. Consumers must purchase on the exchange to be eligible for a premium subsidy. Consumers can purchase off the exchange, for example directly from the company, but would not be eligible for a premium subsidy. Approximately 150,000 people had coverage in the pre-ACA plans known as grandfathered and transitional plans.

Approximately 1.53 million of the 1.64 million consumers with coverage obtained from the exchange receive a premium subsidy from the federal government.

Under the ACA, there are four main metal levels of coverage which include bronze, silver, gold, and platinum and three additional silver level variants that are available to low income individuals. Under bronze plans, the insurer pays on average 60% of expected costs while the individual is responsible for 40%. Under the main silver plan the insurer's portion is on average 70%; under a gold plan it is 80%; and under a platinum plan it is 90%.

Due to the fact that bronze plans offer the leanest amount of coverage, they are the least expensive plans in the individual market, enrolling 530,000 consumers or 30% of the market. Nearly 1.2 million consumers are enrolled in silver plans, and this accounts for 66% of the individual market, with most enrolled in the enriched variant plans designated for consumers with incomes less than 250% of the federal poverty level. Gold and platinum plans combine for less than 80,000 consumers and make up 4% of the individual market.

The small group market consisted of 334,000 covered lives in the ACA-compliant market and 154,000 covered lives in the pre-ACA market.

Benchmark Plan Analysis

The Centers for Medicaid and Medicare Services (CMS) provides a summary of each state's benchmark plan. These summaries are available on CMS's web site here. OIR conducted an analysis of the 67 benefits listed in the Benchmark Plan Summaries to determine how many states covered each benefit. Below is a summary of that analysis.

Column one contains the list of benefits. Column two indicates whether the benefit is in Florida's benchmark plan. Column three represents the number of states including the

District of Columbia but not including Florida that have that benefit in their benchmark plan. Therefore, a "50" indicates that all other states and the District of Columbia include the benefit in their benchmark plan. Column four indicates whether that benefit is considered an EHB by CMS. Items that are included in the benchmark plan but are not considered to be EHBs (such as Routine Adult Dental Services) are not required to be included in health plans offered by carriers. Therefore, removing them from the benchmark would have no regulatory or cost savings effect.

Benefit	Florida	Other States	EHB?
Primary Care Visit to Treat an Injury or Illness	Included	50	Yes
Specialist Visit	Included	50	Yes
Other Practitioner Office Visit (Nurse, Physician Assistant)	Included	50	Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Included	50	Yes
Outpatient Surgery Physician/Surgical Services	Included	50	Yes
Hospice Services	Included	50	Yes
Routine Dental Services (Adult)	Included	18	No
Infertility Treatment	Not Included	19	No
Long-Term/Custodial Nursing Home Care	Not Included	0	No
Private-Duty Nursing	Not Included	22	No
Routine Eye Exam (Adult)	Included	24	No
Urgent Care Centers or Facilities	Included	48	Yes
Home Health Care Services	Included	49	Yes
Emergency Room Services	Included	50	Yes
Emergency Transportation/Ambulance	Included	50	Yes
Inpatient Hospital Services (e.g., Hospital Stay)	Included	50	Yes
Inpatient Physician and Surgical Services	Included	50	Yes
Bariatric Surgery	Not Included	24	No
Cosmetic Surgery	Not Included	4	No
Skilled Nursing Facility	Included	47	Yes
Prenatal and Postnatal Care	Included	50	Yes
Delivery and All Inpatient Services for Maternity Care	Included	50	Yes
Mental/Behavioral Health Outpatient Services	Included	50	Yes
Mental/Behavioral Health Inpatient Services	Included	50	Yes
Substance Abuse Disorder Outpatient Services	Included	50	Yes
Substance Abuse Disorder Inpatient Services	Included	50	Yes
Generic Drugs	Included	50	Yes
Preferred Brand Drugs	Included	50	Yes
Non-Preferred Brand Drugs	Included	49	Yes
Specialty Drugs	Included	50	Yes
Outpatient Rehabilitation Services	Included	50	Yes
Habilitation Services	Included	50	Yes
Chiropractic Care	Included	45	Yes
Durable Medical Equipment	Included	50	Yes
Hearing Aids	Not Included	27	No
Imaging (CT/PET Scans, MRIs)	Included	50	Yes
Preventive Care/Screening/Immunization	Included	50	Yes

Routine Foot Care	Not Included	**10**	**No**
Acupuncture	Not Included	**6**	**No**
Weight Loss Programs	Not Included	**4**	**No**
Routine Eye Exam for Children	Included	**50**	**Yes**
Eye Glasses for Children	Included	**50**	**Yes**
Dental Check-Up for Children	Included	**49**	**Yes**
Rehabilitative Speech Therapy	Included	**50**	**Yes**
Rehabilitative Occupational and Rehabilitative Physical Therapy	Included	**50**	**Yes**
Well Baby Visits and Care	Included	**50**	**Yes**
Laboratory Outpatient and Professional Services	Included	**50**	**Yes**
X-rays and Diagnostic Imaging	Included	**50**	**Yes**
Basic Dental Care - Child	Included	**48**	**Yes**
Orthodontia - Child	Included	**45**	**Yes**
Major Dental Care - Child	Included	**48**	**Yes**
Basic Dental Care - Adult	Included	**17**	**No**
Orthodontia - Adult	Not Included	**1**	**No**
Major Dental Care – Adult	Included	**21**	**No**
Abortion for Which Public Funding is Prohibited	Included	**29**	**No**
Transplant	Included	**50**	**Yes**
Accidental Dental	Included	**43**	**Yes**
Dialysis	Included	**50**	**Yes**
Allergy Testing	Included	**46**	**Yes**
Chemotherapy	Included	**50**	**Yes**
Radiation	Included	**50**	**Yes**
Diabetes Education	Included	**48**	**Yes**
Prosthetic Devices	Included	**49**	**Yes**
Infusion Therapy	Not Included	**47**	**No**
Treatment for Temporomandibular Joint Disorders	Included	**35**	**Yes**
Nutritional Counseling	Included	**38**	**Yes**
Reconstructive Surgery	Included	**50**	**Yes**

Florida's benchmark plan includes 56 of the 67 benefits listed by CMS. Of these 56 benefits, 36 are covered by all other states. Of the remaining 20 benefit categories, five categories are considered by CMS to be non-EHB, meaning they do not have to be part of an ACA-compliant plan. This leaves 15 benefits that are part of the Florida benchmark plan that are not offered in all other states. These benefits are shaded in blue above.

OIR entered into a contract with the Wakely Consulting Group to develop the actuarial claims cost for each of these 15 benefits. This information is summarized in the table below.

Benefit	How Many Other States Include in Their Benchmark Plan	Individual Market Per Member Per Month Cost	Small Group Market Per Member Per Month Cost
Urgent Care Centers	48	$0.22	$0.12
Home Health Care	49	$0.91	$0.80
Skilled Nursing Facility	47	$1.09	$0.27
Non-Preferred Brand Drugs	49	$6.15	$6.27
Chiropractic Care	45	$0.23	$0.24
Dental Check-Up for Children	49	$0.01	$0.00
Basic Dental Care for Children	48	$0.02	$0.01
Orthodontia for Children	45	$0.00	$0.10
Major Dental Care for Children	48	$0.02	$0.05
Accidental Dental	43	$0.00	$0.05
Allergy Testing	46	$0.49	$0.35
Diabetes Education	48	$0.03	$0.03
Prosthetic Devices	49	$0.89	$0.86
Treatment for TMJ	35	$0.12	$0.20
Nutritional Counseling	38	$0.09	$0.03
Total		$10.27	$9.38
Total w/o Non-Preferred Brand Drugs		$4.12	$3.11

When reviewing these 15 benefits, OIR noted that coverage for diabetes education is mandated by section 627.6408, Florida Statutes, and coverage for certain adult and child dental treatments is mandated by sections 627.4295 and 627.65755, Florida Statutes. Therefore, these benefits likely could not be removed from the benchmark plan without additional legislative action. The updated totals after removing Major Dental for Children, Accidental Dental, and Diabetes Education from the list of benefits under consideration are:

Total	$10.22 (2.1%)	$9.25 (2.3%)
Total w/o Non-Preferred Brand Drugs	$4.07 (0.84%)	$2.98 (0.75%)

When conducting its analysis, OIR presumed that if Florida were to institute a benchmark plan with fewer benefits, most, if not all, carriers would offer plans with the reduced benefits. This is because the federal government does not pay subsidies for

benefits that are non-EHBs. Therefore, if a plan continued to offer these benefits, the approximate 1.53 million Floridians who receive a subsidy would have to pay for these benefits out of pocket rather than having the federal government pay for the benefits as is currently the case.

While there is not necessarily a one-to-one ratio between a reduction in claims costs and a reduction in premiums, for purposes of this analysis, OIR equated the change in claims costs to the change in premiums as the difference would likely not be significant.

Therefore, if these 12 benefits were cut from the benchmark plan, a family of four with an individual plan that did receive any subsidies could expect to save approximately $41 per month or 2.1% on their health insurance premium or $491 per year. If non-preferred brand name drugs were kept in the benchmark plan but the 11 other benefits were eliminated, the estimated savings for a family of four that does not receive a subsidy would be approximately $16 per month or 0.84% on their health insurance premium or $195 per year. However, as discussed in the next section, the premium impact on consumers who receive subsidies differs considerably from those who do not.

As previously stated, OIR did not attempt to approximate the effects of any behavioral changes that may result in consumers substituting benefits. For example, if carriers stopped providing coverage for urgent care centers, there may be an increase in the use of emergency rooms resulting in the costs benefits of cutting an urgent care benefit not being realized. Similarly, removing coverage for non-preferred brand name drugs may result in increased utilization of other drugs which would reduce the effects of the cut in benefits.

Effects on Subsidies

Removing benefits from the benchmark plan will lower premiums but will also reduce the subsides available for consumers who qualify for them. This should have no net effect on consumers who have silver plans as the decrease in subsidy will be offset by the decrease in premiums. However, those consumers who use the subsidy to purchase a bronze plan may be subject to a significant financial impact by reducing their subsidy amount as illustrated below.

Family of 4 making $54,000	2nd Lowest Silver	FPL Max Premium	Subsidy for Consumer	2nd Lowest Bronze (Unsubsidized)	2nd Lowest Bronze After Subsidy
Miami-Dade	$17,167	$3,829	$13,338	$13,620	$282
Hillsborough	$18,234	$3,829	$14,405	$14,602	$197

Decrease Bronze & Silver	2nd Lowest Silver	FPL Max Premium	Subsidy for Consumer	2nd Lowest Bronze (Unsubsidized)	2nd Lowest Bronze After Subsidy	Bronze % Change
2.10%	$16,806	$3,829	$12,977	$13,334	$357	**26%**
	$17,851	$3,829	$14,022	$14,295	$273	**39%**

Decrease Bronze & Silver	2nd Lowest Silver	FPL Max Premium	Subsidy for Consumer	2nd Lowest Bronze (Unsubsidized)	2nd Lowest Bronze After Subsidy	Bronze % Change
0.84%	$17,023	$3,829	$13,193	$13,505	$312	**11%**
	$18,081	$3,829	$14,252	$14,479	$227	**16%**

Decreasing the benefits by 2.1% results in a post subsidy premium increase for a family of four earning $54,000 in Miami-Dade of 26%. For that same family of four in Tampa, it is a 39% increase.

Decreasing the benefits by 0.84% results in a post subsidy premium increase for a family of four earning $54,000 in Miami-Dade of 11%. For that same family of four in Tampa, it is a 16% increase.

If plans chose to adopt the lower cost benchmark plan, approximately 230,000 consumers who have purchased an individual plan but do not receive a subsidy will have their premiums reduced. However, of the approximately 1.53 million consumers who receive a subsidy, almost all will pay the same or higher premiums for fewer benefits.

If a plan decided to keep the current benefits after the benchmark plan was changed, subsidies would not be available to cover the current benefits as they would no longer be considered EHBs. Therefore, consumers would have to pay extra for the benefits that are currently covered by subsidies.

Comment Letters

OIR solicited comments and substitute plans by Memorandum issued September 6, 2019, to all life and health insurers, health maintenance organizations, and interested parties. The Memorandum is included as Exhibit 2.

OIR received three letters in response to its request for comments on changing the benchmark plan – one from AvMed, a Florida domestic carrier that offers individual and group health plans, and two letters from consumer groups. OIR did not receive any alternative benchmark plans. The letters are included as Exhibit C.

AvMed stated that they “find consistency in products and benefits effectively inspires member confidence in us as a trusted health partner and request that member disruption be considered as part of the study.”

One of the consumer group letters stated, “We are concerned that this effort may lead to an erosion of coverage under the current benchmark plan. Without safeguarding EHB protections individuals will have difficulty accessing critical health services and/or incur burdensome medical debt or health-related bankruptcies. Moreover, as discussed below, rather than reducing Florida’s EHB package, it should be supplemented to meet the needs of thousands of Floridians with disabilities and/or chronic illnesses.”

The other consumer group letter stated that, “Our organizations believe that reducing coverage of any of the EHBs would have a negative effect on patients. We urge stakeholders in Florida to consider other ways to reduce the cost of coverage without harming patients’ care.”

Recommendation

This analysis indicates that benefits could be removed from the benchmark plan, without violating federal law, in an effort to lower health insurance premiums. However, the final determination of that position would be made by CMS and not by OIR.

As noted in the analysis, reducing benefits in Florida’s benchmark plan would have the effect of reducing premiums for those who do not receive a subsidy. OIR recognizes that health insurance premiums are prohibitively expensive for many Floridians. However, reducing benefits in the benchmark plan will have adverse impacts on approximately 1.53 million consumers in the individual market that do receive a subsidy. Consumers in a silver plan who receive a subsidy will pay the same post-subsidy price for less benefits. Consumers in a bronze plan who receive a subsidy will ultimately pay more post-subsidy for less benefits.

Therefore, while the analysis contains options for removing benefits from the benchmark plan, OIR recommends that these options not be enacted. If the Legislature enacts legislation to change Florida’s benchmark plan, OIR will provide assistance in filing the required application with CMS.

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Benchmark Plan Benefit Valuation Report

September 26, 2019

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Table of Contents

Executive Summary

Effective June 25, 2019, Florida Senate Bill 322 requires the Office of Insurance Regulation (OIR) to conduct a study to evaluate Florida's essential health benefits (EHB) benchmark plan and submit a report to that effect by October 30, 2019. The stated purpose of this study is to develop recommendations for changing the current benchmark plan to provide comprehensive care at a lower cost than is currently exhibited.

The Florida Office of Insurance Regulation ("FLOIR") retained Wakely Consulting Group, LLC ("Wakely"), to analyze the estimated claims impact of proposed changes to its state benchmark plan in the individual and small group ACA markets. Using data present in the Wakely ACA (WACA) database as well as public Rate Review information, Wakely calibrated cost models to the claims levels present in the 2017 Florida individual and small group markets.

We then estimated the potential impacts on allowed claims of the following:

- The removal of coverage for specific benefits currently present in the Florida benchmark plan. This list of benefits for consideration was provided by FLOIR for this analysis.
- Potential visit limit changes for a smaller set of specific benefits

Based on our analysis, we estimated that the overall impact of the changes proposed by FLOIR is an approximate 1%-2.5% reduction in allowed claims costs in both the individual and small group markets. The high end of this range is illustrative of the removal of all benefits being considered from coverage - including non-preferred brand drugs, SNF, and IP MHSA - and further assumes that all participating issuers would also remove coverage for these benefits when said coverage is no longer mandated. However, removal of these benefits would likely cause EHB issues with CMS and pursuing such a comprehensive course of action is not advisable. A more likely and more defensible course of action would be to remove a selected suite of covered benefits in conjunction with some reductions to specific services' visit limits, that would likely result in an overall claims reduction of around 1%. It is also possible that FLOIR could elect to remove coverage for non-preferred brand drugs, which in our analysis was worth an additional 1-1.5% of allowed claims; however, in practice this would likely result in some claim cost shift from non-preferred to preferred brand drugs; therefore we would expect that impact to be dampened.

Introduction and Background

The Florida Office of Insurance Regulation ("FLOIR") retained Wakely Consulting Group, LLC ("Wakely"), to analyze the estimated claims impact of proposed changes to its state benchmark plan in the individual and small group ACA markets.

Effective June 25, 2019, Florida Senate Bill 322 requires the Office of Insurance Regulation (OIR) to conduct a study to evaluate Florida's essential health benefits (EHB) benchmark plan and submit a report to that effect by October 30, 2019. The stated purpose of this study is to develop recommendations for changing the current benchmark plan to provide comprehensive care at a lower cost than is currently exhibited.

A state benchmark plan in the context of this legislation refers to the plan that a given state uses in order to define EHBs within that state for individual and small group Non-Grandfathered ACA plans. In order to achieve compliance with EHB requirements prior to 2020, states were given the following four options for defining their benchmark plan:

- One of the three largest (by membership enrollment) small group plans in the state
- One of the three largest state employee health benefit plans in the state
- One of the three largest federal employee health benefit plans (FEHBPs)
- The largest non-Medicaid commercial HMO plan in the state

Starting in 2020, the federal government is allowing the following additional options for defining a state EHB benchmark plan, beyond what has been previously afforded the states:

- Selecting an EHB benchmark plan used by another state in 2017
- Replacing one or more EHB categories in the current plan with those categories as defined by another state in 2017
- Selecting a set of benefits to become the state benchmark plan

Pursuant to the above, FLOIR asked Wakely to value potential changes to benefits currently present in its benchmark plan, Florida Blue's BlueCare Plan 47. In preparation for the requested analysis, FLOIR performed an initial comparison of the available state benchmark plans and identified specific benefit changes to be valued. Specifically, FLOIR requested that Wakely provide the estimated impact of removing twenty specific benefits from the current suite of covered services, as well as changing the benefit limits of 6 specific services.

This document has been prepared for the sole use of FLOIR. This report documents the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

Summary

Wakely analyzed the impact on allowed claims of removing twenty specific service lines from the benchmark plan (i.e., assuming that those benefits would no longer be covered), as well as proposed changes to benefit limits affecting 6 specifically identified services - including 2 services present in the twenty referenced above. The impacts of these proposed changes to the

benchmark plans are provided in terms of allowed claims as a proxy for premiums. Allowed claims were chosen as the reporting metric as plan liability will necessarily vary by plan and issuer due to plan design differences. We performed this analysis separately for the individual and small group ACA markets.

We show the results below. For the removal of specific services, we show three different values:

- The impact of removing all twenty identified services
- The impact of removing only those services that were not further identified for additional analysis regarding potential changes to benefit limits (this includes 18 of the services described above)
- The impact of removing the services not identified for benefit limit analysis, other than non-preferred drugs

Note that for the second scenario above, the impacts listed exclude all claim costs associated with non-preferred brand drugs. However, in practice excluding this coverage would likely result in existing non-preferred brand drug claims shifting at least partially into preferred brand drug claims, which would dampen that impact. Additionally, the impacts listed below assume that participating issuers in each market remove the same covered services as the benchmark plan.

A full list of the affected services and the individual impacts of each can be found in Appendix A. Note that five benefits (as identified in the aforementioned Appendix) among those considered are non-EHBs, meaning that regardless of inclusion in or exclusion from the state benchmark plan, ACA plans may elect to exclude coverage for those services. These benefits were included in our analysis at the request of FLOIR.

<u>Removal of Specific Services</u>

- The projected impact to allowed claims of removing all identified services is a 2.4% reduction in the individual market / 2.6% for small group
- The projected impact of removing only those services not identified for visit limit changes is 2.1% / 2.5% for individual / small group, respectively
- The projected impact of removing only **medical** services not identified for visit limit changes is 0.9% for both individual and small group

<u>Benefit Limit Changes</u>

- The projected impact to allowed claims of reducing the Inpatient Day limit for Mental Health / Substance Abuse stays from 60 to 30 days is a 0.01% reduction for both individual and small group
- The projected impact to allowed claims of reducing the Inpatient Day limit for Skilled Nursing Facility stays from 30 to 7 days is a reduction of 0.06% / 0.01% for individual / small group, respectively
- The projected impact of changing the combined 35 visit limit for Outpatient Rehab / Physical Therapy / Occupational Therapy / Speech Therapy / Chiropractor to individual

limits of 20 visits for each service (10 for Chiropractor) is a reduction of 0.02% / 0.03% for individual / small group, respectively.

The most impactful (from a claims perspective) medical services considered for removal, excluding those being considered for visit limit changes, are shown in Table 1:

Table 1: Most Impactful Medical Services by % of Total Allowed

Benefit	% Total Allowed	
	Individual	Small Group
Routine Eye Exam (Adult)	0.24%	0.18%
Home Health Care Services	0.19%	0.20%
Prosthetic Devices	0.18%	0.22%
Allergy Testing	0.10%	0.09%

The impacts shown above are given in relation to 2017 allowed claims in the state of Florida, as reported on 2019 filed Unified Rate Review Templates (URRTs). We did not trend values forward to 2021 or any other year, instead assuming that any given service lines would comprise a consistent percentage of total allowed dollars. This information includes URRTs filed by 9 individual and 14 small group insurers, and is summarized below as Tables 2 and 3.

Table 2: 2017 Individual Allowed Claims by Service Category

Service Category	PMPM Allowed
Inpatient	$116.44
Outpatient	$125.85
Professional	$108.70
Other	$32.37
Capitation	$10.00
Prescription Drugs	$90.17
Total	**$483.53**

Table 3: 2017 Small Group Allowed Claims by Service Category

Service Category	PMPM Allowed
Inpatient	$82.26
Outpatient	$109.87
Professional	$98.14
Other	$18.32
Capitation	$12.63
Prescription Drugs	$74.61
Total	**$395.83**

When assessing the potential impact of the changes described above, it should be noted that the listed values are likely to be on the high end of the range. For the impacts that include the removal of all identified services from the benchmark plan, we assume that all issuers will cease coverage of these services once they are no longer mandated. In practice, it is likely that some issuers will continue to cover some listed services for continuity of coverage or other competitive reasons; for instance, non-preferred brand drugs will likely continue to be covered. For this reason, we specifically provided estimates that exclude non-preferred brand drugs; however, the reader of this report should also keep in mind that there may be additional services for which some issuers elect not to cease coverage.

We also assumed that any issuers who currently employ richer benefits than the state-mandated levels, will keep their current benefit (e.g. an issuer that currently allows more than 60 Inpatient MHSA days will continue to do so if the benchmark plan benefit limit is reduced to 30 days).

Methodology

Wakely first calibrated a cost model to the 2017 Florida allowed claims levels noted above. To do this, Wakely completed the following steps:

1. Wakely pulled 2017 allowed information by service line from its 2017 Wakely ACA (WACA) experience database and used this data to create a cost model. We used information in the EDGE files including (but not limited to) CPT / HCPCS codes, Revenue Codes, and Inpatient DRGs to assign claims to Wakely-defined service lines and broad service categories.

   The WACA data repository is comprised of issuer EDGE server data and included over 7 million member lives in 2017. The data itself is available at the Regional level; for this analysis we used South US data as the starting point for both the individual and small group markets (considered separately).

2. The data was calibrated to 2017 Florida-specific URRT reported claims:
   a. URRT Worksheet 1 information for filing issuers (9 issuers for the individual market / 14 for the small group market) was collected from the CMS Rate Review Data files[1] and subsequently aggregated. The results of this aggregation are given in Tables 2 and 3 of this document.

      Although Worksheet 1 of the 2019 URRT may include Transitional experience, we used this aggregate information as the calibration target for the WACA South region data as we felt it was the most reliable source for Florida-specific experience by broad service category, that we had available. A requisition of ACA-only claims experience data from all issuers in Florida would have been necessary to achieve an ideally accurate calibration; however, this would have been time, budget, and resource prohibitive in the context of the scope of this project. We would not expect results to differ materially from those presented here, should the calibration described above have occurred.

   b. Wakely cost model claims levels by broad service category were calibrated to those present in the URRT data:
      i. Capitated claims were not considered, as this information is not included in the WACA database

      ii. Separate calibration factors were calculated for Inpatient, Outpatient, Professional, and Prescription Drug claims

      iii. The overall medical claims differential was applied to Ancillary (Other) claims as a separately-defined calibration factor. After discussion with FLOIR, we determined that the PMPM allowed amounts reported for Ancillary claims on the URRTs were more volatile than those reported for other broad service categories, due to both being smaller totals than those exhibited for the other categories, and being more dependent on give issuers' definitions of what constitutes an Ancillary service.

      iv. After applying the calibration factor described above to the Ancillary / Other services, any remaining difference (here explained as being due to services being classified as Ancillary on the URRT that would be classified differently by the Wakely claim grouping process) was allocated across Inpatient, Outpatient, and Professional claims, proportional to the previously calibrated levels of each of those categories.

   The resulting final PMPM Allowed claim amounts were then used to derive final calibration factors to be applied to the WACA data pull results. The result of this calibration was a

[1] https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2019-URR-PUF.zip

Wakely cost model exhibiting service line relativities exhibited by actual 2017 South region ACA data, and whose total claims matched reported 2017 Florida specific experience. A separate, calibrated cost model was created using the methodology described above for both the individual and small group market analyses.

3. We then estimated the impact of removing specific benefits from coverage:
   - For each of the identified benefits, we identified a candidate list of CPT / DRG / Revenue codes for use in identifying those specific lines in the WACA data. This was done via research with Wakely's existing code sets, as well as publicly-available procedure code information repositories.
   - We used the above information to identify service-line specific claims PMPM from the WACA data, for each of the requested benefits.
   - We then applied the calibration factors derived in step 2, to each service line appropriate for its broad service category.

   The resulting values were compared by service line and in aggregate to the total allowed claims present in the URRTs (and now-calibrated cost models) in order to derive the estimated impact of removing those benefits.

4. Finally, we estimated the impact of changing benefit limits on existing covered services:
   a. A member-level Length of Stay (LOS) table was created for both IP MHSA and IP SNF, for both individual and small group. These were again derived from the WACA database.
      i. For IP MHSA, allowed claims for members who had between 30 and 60 IP days were capped at 30 days' worth, assuming each day cost a uniform amount. As an example, total allowed claims for members who had 45 days of IP MHSA stays were capped at (30/45) * the reported allowed amount.

         We did not cap allowed claims for members with more than 60 IP MHSA days, as we assumed that these were covered by issuers who allowed more than the benchmark plan's 60 day limit requirement. As such, we further assumed that these issuers would continue to allow the higher limit should the benchmark plan limit be reduced to 30 days.

      ii. For IP SNF, allowed claims for members who had between 7 and 30 IP days were capped at 7 days' worth, assuming each day cost a uniform amount.

         We did not cap allowed claims for members with more than 30 IP SNF days, for the same reasons described under the IP MHSA section.

   b. For the Therapy and Chiropractic visit limit changes, we first identified members who had at least one visit under any of the identified services:

- Outpatient Rehab
- Physical / Occupational Therapy
- Speech Therapy
- Chiropractic

We then applied the proposed visit limit changes as follows:

i. For members with more than 35 total visits across all categories, we assumed no change would be made as they were covered by issuers with more generous benefit limits than the benchmark plan

ii. For members with fewer than 35 total visits across all categories, we looked at visits for each individual service, and capped total allowed for each service at the proposed level (10 visits for chiropractic, 20 for all others). As an example, if a member had 28 speech therapy visits and 6 chiropractic visits, we capped speech therapy allowed dollars at (20 / 28) * the reported speech therapy allowed total (but did not make any changes to the projected chiropractic allowed total).

iii. For members with exactly 35 total visits across all services, we acknowledged that these likely were covered by issuers who adhered to the exact benchmark plan comparison. We also assumed that these members, if given the opportunity, would use the maximum visits allowed for each service that they utilized. Subsequently, we grossed up all services for which they had at least one visit, to the maximum As an example, if a member had 35 total visits with 2 physical therapy, 17 speech therapy, and 16 occupational therapy visits (but no chiropractor), we assumed that under the new benchmark plan they would have utilized 20 each of physical, speech, and occupational therapy visits (but still no chiropractor) and adjusted allowed claims accordingly.

Additional Considerations / Conclusion

The most likely range of impacts for the proposed benefit changes valued in this report is a 1%-1.5% reduction in claims. Actual realized claim impacts resulting from any action on the part of FLOIR are also highly dependent on external variables that could not be modeled as part of the scope of this project. These include issuer and member behavior, including the extent to which issuers follow suit with any changes to the state benchmark plan, as well as (should FLOIR elect to remove any drug coverage from the benchmark) the extent to which drug claims shift categories or the removal of drug coverage impacts the utilization of related or unrelated medical procedures. Therefore, we believe the 1-1.5% claim impact to be an upper bound for the potential reduction in allowed claims arising from any changes discussed or modeled herein.

Appendix A

Benefits Modeled

The benefits identified by FLOIR for consideration in this analysis, along with the respective percentage of total allowed dollars that each comprised in both the individual and small group markets, is as follows (Greyed services were considered separately for visit limit changes):

Individual

	Allowed Claims		
Benefit	*PMPM*	*Util/1000*	*% Total*
Abortion for Which Public Funding is Prohibited[2,3]	$0.15	1.3	0.03%
Accidental Dental	$0.00	0.1	0.00%
Allergy Testing	$0.49	21.6	0.10%
Basic Dental Care - Adult[3]	$0.00	0.3	0.00%
Basic Dental Care - Child	$0.02	2.9	0.00%
Chiropractic Care	$0.23	92.9	0.05%
Dental Check-Up for Children	$0.01	2.1	0.00%
Diabetes Education	$0.03	3.9	0.01%
Home Health Care Services	$0.91	56.1	0.19%
Major Dental Care – Adult[3]	$0.01	0.4	0.00%
Major Dental Care – Child	$0.02	0.6	0.00%
Non-Preferred Brand Drugs	$6.15	263.7	1.27%
Nutritional Counseling	$0.09	16.8	0.02%
Orthodontia - Child	$0.00	0.0	0.00%
Prosthetic Devices	$0.89	35.6	0.18%
Routine Dental Services (Adult)[3]	$0.03	7.7	0.01%
Routine Eye Exam (Adult)[3]	$1.15	131.7	0.24%
Skilled Nursing Facility	$1.09	6.5	0.23%
Treatment for Temporomandibular Joint Disorders	$0.12	6.8	0.02%
Urgent Care Centers or Facilities	$0.22	19.7	0.04%
Total	**$11.61**	**670.5**	**2.40%**

[2]The minimum allowable premium allocation for non-Hyde abortion services is $1 PMPM, per: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf

[3]Non-EHB Service included at the request of FLOIR

Small Group

Benefit	Allowed Claims		
	PMPM	*Util/1000*	*% Total*
Abortion for Which Public Funding is Prohibited[4,5]	$0.22	1.5	0.06%
Accidental Dental	$0.05	4.8	0.01%
Allergy Testing	$0.35	15.9	0.09%
Basic Dental Care - Adult[5]	$0.01	0.9	0.00%
Basic Dental Care - Child	$0.01	1.4	0.00%
Chiropractic Care	$0.24	96.8	0.06%
Dental Check-Up for Children	$0.00	1.1	0.00%
Diabetes Education	$0.03	2.1	0.01%
Home Health Care Services	$0.80	46.2	0.20%
Major Dental Care – Adult[5]	$0.12	4.6	0.03%
Major Dental Care – Child	$0.05	1.4	0.01%
Non-Preferred Brand Drugs	$6.27	200.5	1.58%
Nutritional Counseling	$0.03	4.8	0.01%
Orthodontia - Child	$0.10	0.6	0.02%
Prosthetic Devices	$0.86	28.7	0.22%
Routine Dental Services (Adult)[5]	$0.01	4.2	0.00%
Routine Eye Exam (Adult)[5]	$0.73	87.3	0.18%
Skilled Nursing Facility	$0.27	2.4	0.07%
Treatment for Temporomandibular Joint Disorders	$0.20	8.0	0.05%
Urgent Care Centers or Facilities	$0.12	18.2	0.03%
Total	**$10.47**	**531.5**	**2.64%**

[4]The minimum allowable premium allocation for non-Hyde abortion services is $1 PMPM, per: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf

[5]Non-EHB Service included at the request of FLOIR

Appendix B

Reliances and Caveats

The following is a list of the data Wakely relied on for the analysis:

- The 2017 Wakely ACA Database
- 2019 CMS Individual and Small Group Rate Review Data[6]
- Benefits and Benefit Changes provided by FLOIR

The following caveats in the analysis should be considered when relying on the results.

- **Data Limitations.** As discussed in the body of this report, the WACA database is comprised of EDGE server data. There are some variances in the EDGE data compared to other data sources that may be used to check the reasonability of the EDGE data; however, the variances were reasonable and not expected to impact the results. Additionally, it is possible that some portion of the data used may have been truncated due to state-specific EHB limits that are stricter than Florida's current limits. Our analysis indicated any potential impact of such truncation to be low, if not negligible.

- **Enrollment Uncertainty.** This report was produced based on 2017 experience data. To the extent that the risk profile, mix of services utilized, size, or any other significant characteristic or combination of characteristics of the insured population changes significantly between 2017 and any year for which these projections are being used, the data on which this report is based may no longer be applicable

- **Mental Health Parity.** Any testing for compliance with the requirements of the Mental Health Parity Act of 1996 was outside the scope of this project, and therefore was not performed. Changes in benefit coverage may affect such compliance; as such, FLOIR should be aware of any potential effects and take appropriate measures and / or precautions in order to ensure no issues arise.

- **Non-Preferred Drugs.** The estimated impact of removing coverage for Non-Preferred Drugs specifically assumes that all associated costs would be completely eliminated. In practice, a majority of non-preferred drug claim costs would likely shift into other drug tiers rather than being eliminated completely.

- **Issuer Conformity.** The estimated impacts of removing coverage for specific benefits assumes that any changes to the Florida Benchmark plan will be adopted by all issuers present in the state, with respect to their covered benefits offered to members.

[6] https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2019-URR-PUF.zip

Appendix C

Disclosures and Limitations

Responsible Actuaries. Andy Large is the actuary responsible for this communication. He is a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. He meets the Qualification Standards of the American Academy of Actuaries to issue this report. Kelsey Stevens, MAAA, FSA and Julie Andrews, FSA, MAAA also contributed to this report.

Intended Users. This information has been prepared for the sole use of FLOIR. Distribution to parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that FLOIR will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of FLOIR.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and reliances.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. Material changes as a result of Federal or state regulations may also have a material impact on the results. There are no specifically known relevant events subsequent to the date of engagement that would impact the results of this report.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

FLORIDA OFFICE OF INSURANCE REGULATION

DATE: September 6, 2019

TO: All health insurers and health maintenance organizations authorized to write health insurance products in Florida

RE: Florida Essential Health Benefits Benchmark Plan Study

Senate Bill 322, passed during the 2019 Legislative Session, requires the Florida Office of Insurance Regulation ("Office") to conduct a study to evaluate Florida's current Essential Health Benefits Benchmark Plan. The study will consider the other 49 states' Benchmark Plans and related benefits and compare the costs of the benefits and overall costs of those plans to Florida's current Benchmark Plan. Upon completion of this study, and no later than October 30, 2019, the Office will submit a report to the Governor, the President of the Senate, and the Speaker of the House with any recommendations to change Florida's current Benchmark Plan to lower costs while still providing comprehensive benefits.

As a part of the study, the Office is interested in receiving comments from health insurers and health maintenance organizations that offer individual and group health plans. If you have comments you would like the Office to consider, please submit them to Chris Struk at Christopher.Struk@floir.com by September 20, 2019.

The full text of Senate Bill 322, now Chapter 2019-129, Laws of Florida, may be found at https://www.flsenate.gov/Session/Bill/2019/322/BillText/er/PDF.

Information on the Benchmark Plans for Florida and other states may be found at https://www.cms.gov/cciio/resources/data-resources/ehb.html

For questions related to any of the above information, please contact:

Chris Struk – Life & Health Policy Advisor
850-413-2480
Christopher.Struk@floir.com

FLORIDA OFFICE OF INSURANCE REGULATION

AvMed Embrace better health.

4300 NW 89th Blvd.
Gainesville, FL 32606

September 18, 2019

Chris Struk
Life & Health Policy Advisor
Florida Office of Insurance Regulation
Tallahassee, FL 32399

RE: Florida Essential Health Benefits Plan Study

Dear Mr. Struk,

Thank you for the opportunity to provide comments on the evaluation of the Essential Health Benefits (EHBs) Benchmark Plan currently being performed by the Florida Office of Insurance Regulation (OIR) pursuant to Senate Bill 322 of the 2019 Florida Legislative Session.

As one of Florida's oldest and largest not-for-profit health maintenance organizations, AvMed has been providing health plans to Florida residents since 1973. Our service to the citizens of Florida continues through the offering of non-grandfathered health plans in more than 30 counties across the state.

AvMed values being a service-driven organization that is focused on helping our members live a healthier life by building trust through everything we do. As part of that service mindset, our products provide comprehensive healthcare coverage for our members including EHBs consistent with the benchmark plan. We find that consistency in products and benefits effectively inspires member confidence in us as a trusted health partner and request that member disruption be considered as part of the study.

AvMed greatly values the predictable regulatory environment created by the OIR and requests market stability and equity be strongly considered as you contemplate changes to the EHB Benchmark Plan.

Thank you again for the opportunity.

Regards,

Eric D. Johnson
Chief Actuary & VP of Business Intelligence
AvMed Health Plans

September 20, 2019

Chris Struck
Life and Health Policy Advisor
Florida Office of Insurance Regulation
200 E Gaines St
Tallahassee, FL 32399

Re: Florida's Essential Health Benefits Benchmark Plan

Dear Mr. Struck:

Our organizations represent millions of patients facing serious, acute and chronic health conditions in Florida. We believe that health insurance must be **affordable, adequate and accessible** for all residents. As the Florida Office of Insurance Regulation prepares to make recommendations on Florida's Essential Health Benefits Benchmark Plan, the undersigned organizations urge you to protect quality healthcare by protecting the ten essential health benefits.

Health plans sold through Florida's individual insurance marketplace are required to cover ten essential health benefits without annual or lifetime limits. The Essential Health Benefits (EHBs) are critical for the health of our patients, many of whom have complex medical conditions. The EHBs ensure that health plans cover the care that patients need. Before all health plans were required to cover the EHBs, 9 percent of people with healthcare had plans that didn't cover prescription drugs and 34 percent had plans without substance use disorder coverage.[1]

If Florida weakened coverage of the EHBs in its Benchmark Plan, insurers could limit benefits and our patients could be forced to pay out of pocket for their medical needs, ration treatment or even go without care at all. Weakening EHBs could also contribute to the segmentation of the health insurance market. Healthier patients would be drawn to cheaper and skimpier plans, while patients managing acute and chronic illnesses would need the comprehensive plan. Splitting the risk pools like this would further drive health care costs up for patients with serious and chronic conditions.

Our organizations believe that reducing coverage of any of the EHBs would have a negative effect on patients. We urge stakeholders in Florida to consider other ways to reduce the cost of coverage without harming patients' care. For example, a recent analysis by Avalere of the seven states that have created reinsurance programs through Section 1332 waivers found that these states reduced individual market premiums by an average of 19.9 percent in their first year.[2] Our organizations encourage stakeholders in

Florida to look at ways to reduce costs without harming patients' access to quality and affordable healthcare.

Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Cancer Society Cancer Action Network
American Lung Association
Arthritis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Psoriasis Foundation
Susan G. Komen

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[1] https://www.healthaffairs.org/do/10.1377/hblog20170323.059343/full/

[2] Avalere. *State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average.* March 2019. Retrieved from https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average.

FLORIDA POLICY INSTITUTE

Anne Swerlick
Senior Policy Analyst

September 10, 2019

Craig H. Wright, ASA, MAAA
Deputy Commissioner and Chief Actuary
Life & Health Insurance
Florida Office of Insurance Regulation
Craig.Wright@floir.com

Re: Study & Report on Benchmark Plan under CS/CS/SB 322, Chap. No. 2019-129, Laws of Florida

Dear Mr. Wright:

I write on behalf of Florida Policy Institute (FPI) and Florida Voices for Health (FVH).

FPI is an independent, nonpartisan, nonprofit organization dedicated to advancing policies and budgets that improve the economic mobility and quality of life for all Floridians. We are deeply committed to public policies which ensure that all people can obtain quality affordable health care without facing discriminatory barriers.

FVH is a non-profit health care advocacy organization. FVH coordinates a diverse statewide coalition of over 70 active partners including grassroots and direct service organizations, patient advocacy groups, providers, hospital and health industry stakeholders, and individuals from impacted communities.

We understand that the Office of Insurance Regulation (OIR) is currently conducting a study of Florida's Essential Health Benefits (EHB) benchmark plan and a report must be submitted to the Governor, Speaker of the House and President of the Senate by October 30, 2019. The report must include "…recommendations for changing the current EHB-benchmark plan to provide comprehensive care at a lower cost than this state's current EHB-benchmark."

We are concerned that this effort may lead to an erosion of coverage under the current benchmark plan. Without safeguarding EHB protections individuals will have difficulty

accessing critical health services and/or incur burdensome medical debt or health-related bankruptcies.

Moreover, as discussed below, rather than reducing Florida's EHB package, it should be supplemented to meet the needs of thousands of Floridians with disabilities and/or chronic illnesses.

The purpose of EHBs is to ensure that health plans cover a core set of basic services. This requirement has closed health care coverage gaps that for years had left individuals underinsured.

Prior to the ACA, services like maternity care, mental health and substance use disorder services, habilitation services and devices and pediatric oral and vision care were generally not covered by individual and small group market plans. These benefits are now covered. Critics have complained that these services significantly add to the cost of health plans. Yet, research shows otherwise. A Milliman White Paper illustrates that these four services are a small percentage of benefit costs compared to services such as outpatient and inpatient hospital care.

Likewise, preventive health services, also among the EHBs, are critical for an effective health care system, both in terms of health status and cost control. Without these services, conditions may be more advanced when detected and lead to unnecessary hospitalizations and costly management of acute and chronic conditions.

Not only should the benefits under the current benchmark plan be preserved, we recommend that certain limitations and exclusions be eliminated--particularly those needed to bring parity between physical and mental health coverage.

For example, according to the Plan Summary posted on the Center for Consumer Information and Insurance Oversight (CCIO) there is an annual cap of 20 visits for mental/behavioral health outpatient services and 30 days for mental/behavioral health inpatient services. Yet there isn't any corresponding limitation for outpatient or inpatient medical/surgical procedures.

Similarly, there are exclusions for inpatient mental health stays received in a residential treatment facility and for expenses for " prolonged care and treatment for Substance Dependency in a specialized inpatient of residential treatment facility."

In addition, the EHB plan does not include autism services or applied behavior analysis (ABA) -widely recognized to be a highly cost-effective treatment covered by many other plans including Medicaid. There is also an exclusion for coverage of psychological testing

associated with the evaluation and diagnosis of learning disabilities or for mental retardation. There is no similar testing prohibition for any physical health condition.

Finally, given the urgent need to address the opioid epidemic, it's critical to ensure that Florida's benchmark plan cover methadone - the "gold standard" for treatment of opioid use disorder (OUD). It is not clear from the Plan Summary whether methadone is covered. In addition, there is no coverage for any opioid reversal agent.

In sum, we recommend that benefits included in the current EHB benchmark be maintained and the above-described quantitative caps and coverage exclusions be eliminated.

We appreciate this opportunity to provide these recommendations. Please don't hesitate to contact us if you have questions or need additional information.

Sincerely,

/s/ Anne Swerlick
Anne Swerlick
Senior Health Policy Analyst & Attorney
Swerlick@floridapolicy.org
407-440-1421 x703

/s/ Louisa McQueeney
Louisa McQueeney
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