

2020 LEGISLATIVE PROPOSALS

RECEIVED FROM

FLORIDA HEALTH INSURANCE ADVISORY BOARD

(FHIAB) BOARD MEMBERS

FOR DISCUSSION

Recommendations – Louisa McQueeney, Florida Voices for Health**1. Employee/Dependent Option 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.

Covering a spouse is not mandated by federal law and in the ACA environment, it would be advantageous to have the option to not offer spousal coverage, so that the spouse could qualify for Premium Tax Credits (PTC's). However, in the group market, carriers do not give small groups the option of not offering spousal coverage.

□ *Recommendation: Provide a clear legislative directive whereby small group employers be specifically allowed the option to offer "employee/dependent(s)" coverage in the open market, where dependent(s) are dependent children only.*

2. Deductible Health Credit Transfer.

With the continual rise in annual health insurance deductibles to consumers, having to start a new deductible in the middle of the year creates financial hardship. The deductibles for 2020 could end up being as high as \$8,150 for an individual and \$16,300 for a family. Some policies require the insured to pay the entire deductible before the insurance company pays anything at all.

When consumers change health insurance plans outside of the Open Enrollment period, as a result of an employer changing plans outside of annual renewal, or as a result of a change of employer, or a change in geographic area, annual deductibles start all over again even if a consumer has met part or all of the accumulators out of their own pocket.

□ *Recommendation: Amend and expand statute 627.666 to include individual on- and off-exchange policy holders a Deductible Health Credit Transfer to a new policy equal to the deductible paid by the policy holder to the prior insurer. The Credit Transfer should be for the entire amount paid by the consumer without limitations such as a time frame of 90 days preceding the effective date of the succeeding insurer's plan or recognition of the expenses actually incurred under the terms of the succeeding insurer's plan and subject to a similar deductible provision.*

3. Provide health care consumers with one free copy of their own medical records.

Patients have a right to their medical records under the Health Insurance Portability and Accountability Act (HIPAA). The same law allows providers to charge fees for providing the requested copies. Many requests for records are not honored in a timely fashion if honored at all and some at great expense to the consumer. Obtaining one's own medical records is especially important when disputes arise with insurance companies, resulting in denial of claims, leaving patients in precarious financial positions.

Recommendation: Provide consumer with one free copy of their medical record, to be provided to consumer by mail or electronic mail, at the time of payment request for services provided.

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

Drug pricing remains at the forefront of consumer complaints when accessing health coverage. Consumers often pick a health insurance plan based on the prescription drugs covered and the cost tiers they are classified in.

Consumers enter into a contract with the health insurance plan for a twelve-month period and pay an agreed upon amount per month for this period based on the contract they were presented. Health insurance plans negotiate drug prices with the pharmaceutical companies on behalf of consumers, without any involvement or say of consumers. Insurance carriers then present health plans including drug formularies and premium rates to the Office of Insurance Regulation for approval. Consumer input is never part of this process, however the consumer is expected to pick up the extra cost in the end or go without the prescription(s) they contracted for.

In recent years, insurance carriers have been making changes to their drug formularies during the policy period. Insurers routinely reclassify drugs to more access restrictive drug tiers, increase the consumer's co-payment, co-insurance or deductible, and reclassify drugs to higher cost sharing tiers. There are also instances of certain drugs being dropped from coverage altogether. Consumers are then informed by mail that they will be financially responsible for the entire cost drug in the middle of the policy year.

Recommendation: Prohibit insurance carriers from amending or removing a covered prescription drug during the policy year. This will not preclude the insurance carrier from expanding the formulary and lowering prices throughout the policy year. This would exclude the formulary for Florida Medicaid which is covered under section 409.91195, Florida Statutes)

5. Protect Consumers from uncontrolled health insurance premium rates based on preexisting conditions.

Under the Patient Protection and Affordable Care Act an insurer may not vary rates based on one or more pre-existing conditions. Rates can vary based solely on four factor: family composition, geographic area, age and tobacco use.

During the 2019 session, the Florida Legislature passed CS/CS/SB 322 which includes requirements for insurers in the event the federal Affordable Care Act (ACA) is repealed or invalidated by the U.S. Supreme Court. The new law specifically requires insurers who issue comprehensive major medical policies or contracts in Florida to offer at least one comprehensive major medical policy or contract that does not exclude, limit, deny or delay coverage due to one or more preexisting medical conditions.

However, the new law does not prohibit insurers from charging higher premium rates based on health status. Without this protection, pre-ACA history shows that plans offered to people with pre-existing conditions will be substantially costlier. Policies may be out of reach for most people with pre-existing conditions and they will be at serious risk of losing coverage.

It is estimated that over 7 million Floridians live with one or more than one pre-existing conditions. Without this protection other stakeholders are at risk, such as hospitals likely to incur more uncompensated care and employers by increasing premiums due to cost shifting.

Recommendation: Codify into state law requirements that Florida health plans may not vary rates based on one or more pre-existing conditions. Rates can vary based solely on four factors: family composition, geographic area, age and tobacco use. Insurers are prohibited from charging an older adult in the oldest age band more than 3 times the rate of a younger person in the youngest age band and from charging tobacco users more than 1.5 times the rate of a non-tobacco-user's rate.

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

Network adequacy standards are required to ensure that health plans provide access to the services for which subscribers pay. Insurers have created narrow networks to control costs. However, every network should be minimally adequate to enable access to a 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 timely access to consumers as well as culturally and linguistically appropriate competency among providers. These standards are even more insufficient for consumers who are members of vulnerable populations with health disparities for instance in rural areas, where travel distances are an additional problem.

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 where primary care, mental health and hospital services are not within 30 miles or 30 minutes of each enrollee's place of residence or work, treat out-of-network care as in-net-work care and apply the cost of the care to the annual accumulators, such as the deductible. Improve network adequacy.

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.

8. Protect Consumers and Insurance Markets from short term plans.

Short term insurance plans were intended to fill gaps when consumers were in between coverage. They are now being sold as a replacement for comprehensive coverage. Short term plans with an initial term of 364 days can be renewed for up to 36 months, are not subject to the protections of the Affordable Care Act such as coverage for pre-existing conditions or no annual limit as to how much the policy would have to pay for a claim. Short term plans are not required to cover the ten essential health benefits.

Many consumers do not have the health literacy to understand the concept of short term plans, their coverage limitations and the cost implications to them if a claim arises. The appeal of the short term plan is the lower cost, but consumers still expect comprehensive coverage with protections.

In addition, short term plans are likely to cause rates of ACA compliant health insurance plans to increase since younger, healthier consumers are more likely to purchase cheaper plans, thereby decreasing the ACA compliant plans risk pool.

Recommendation: Require a stronger consumer disclosure than is required by federal regulation. Ensure brokers and agents read the full disclosure to the consumer and require the consumer to sign a statement that they have read the disclosure. Institute an external appeal process where a third party will make final appeal determinations.

9. Establish Step Therapy Protocols

Step therapy or “fail first” policies allow health plans to control the order in which patients take certain therapies. Step therapy protocols require that patients must try one or more medications selected by their insurer before the plan will grant coverage for the drug originally prescribed by the healthcare provider. Patients and healthcare providers have voiced concern regarding the potential adverse effects of step therapy, when it is not paired with protections for patients.

When patients are required to cycle through and document a “step”—or in some cases, more than one step or medication—the process may result in substantial delays in treatment deemed appropriate by their healthcare provider. The use of ineffective treatment has been associated with higher costs due to additional office visits, increased drug costs, and even the increased likelihood of needing additional treatment

or hospitalization. The risk profile of the medication as well as side effects and the ability for an individual to adhere to the medication must also be taken into account.

Recommendation: Establish clear, meaningful, and accessible procedures for prescribers to override the process by requesting an exemption; Prohibit insurers from requiring insured patients to fail a drug more than once.

Recommendations – Ken Stevenson, Florida Association of Health Underwriters**1. Access to insurance issue –**

A recurring problem is happening when a consumer is using the Share of Cost program within Medicaid (the Medically Needy Medicaid is another name we have seen used). The Share of Cost program typically has a high deductible the consumer must meet each month before they qualify for the remainder of that particular month for Medicaid. That high deductible resets each month. Many of those consumers incorrectly state they are covered on Medicaid and could be unaware they may be eligible for Advance Premium Tax Credits (APTCs) in the individual Marketplace. Agents, brokers and navigators, who are not familiar with the Share of Cost program may incorrectly determine the person is not eligible for APTCs in the individual Marketplace, even though it is a month to month determination only when their deductible threshold is met for that one month. These consumers, in many instances, would qualify for the APTCs under the affordability calculations set forth by the Federal regulatory agencies each year. In qualifying for the APTCs, these consumers would pay reduced premiums for medical insurance. Under the Marketplace plans, they would additionally benefit from only one deductible per year according to the plans schedule of benefits they enrolled in, versus a monthly deductible under the Share of Cost program which is likely to be much higher when each months deductible amount is added together for the year.

Unfortunately, the Federal training programs for the individual Marketplace are not able to educate the agents, brokers or navigators on state specific programs like the Share of Cost.

One option for a partial solution might be to utilize current legislation for agents and brokers, under §626.2815 Continuing education requirements, using the required 5-hour update course. That statute speaks to determining suitability of products and services, where this could potentially be inserted on a regulatory basis, or possibly amending the statute language to include a section on educating agents on this specific issue.

The Navigators do not have a state specific training requirement, only the Federally mandated annual educational course(s), under FL Statute Chapter 626, Part XIII Navigators. A legislative addition or change might be necessary in order to require a brief overview of the Share of Cost program.

2. Cost of insurance issue –

At least one medical insurance carrier in Florida utilizes a partnership with a dental carrier to provide small group market pediatric dental benefits under the Essential Health Benefits requirement within the ACA. There is a separate premium amount invoiced for each child that is enrolled with the carrier, which is assessed even on newborns that will not be utilizing those benefits for several years. The premiums charged can be significantly higher than what may be obtained from other carriers,

depending upon the benefits offered under those other plans. For consumers, these additional premiums cause strains on their family budgets. The consumers are not allowed to waive the additional dental coverage for their children, even if the only child covered is a newborn or infant that has no need for dental care.

Several years ago, at least one other state enacted legislation to prevent their consumers from being charged additional premiums for this un-bundled approach on the pediatric benefits. The legislation enacted in Virginia in 2014 (effective January 1, 2015) is listed below to show the language used. In essence, it defined what would be considered a qualified dental plan for the purpose of the pediatric dental requirements. As a result of the passage of the law, consumers monthly premiums were reduced as they were not required to purchase the pediatric dental benefit separately (those plans only needed to be available for purchase). The specific language is highlighted in Section B.

Code of Virginia

[Table of Contents](#) » [Title 38.2. Insurance](#) » [Chapter 34. Provisions Relating to Accident and Sickness Insurance](#) » [Article 6. Federal Market Reforms](#) » § 38.2-3451. Essential health benefits

Section

§ 38.2-3451. Essential health benefits.

A. Notwithstanding any provision of § [38.2-3431](#) or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or small group health insurance coverage shall provide that such coverage includes the essential health benefits as required by § 1302(a) of the PPACA. The essential health benefits package may also include associated cost-sharing requirements or limitations. No qualified health insurance plan that is sold or offered for sale through an exchange established or operating in the Commonwealth shall provide coverage for abortions, regardless of whether such coverage is provided through the plan or is offered as a separate optional rider thereto, provided that such limitation shall not apply to an abortion performed (i) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (ii) when the pregnancy is the result of an alleged act of rape or incest.

B. The provisions of subsection A regarding the inclusion of the PPACA-required minimum essential pediatric oral health benefits shall be deemed to be satisfied for health benefit plans made available in the small group market or individual market in the Commonwealth outside an exchange, as defined in § [38.2-3455](#), issued for policy or plan years beginning on or after January 1, 2015, that do not include the PPACA-required minimum essential pediatric oral health benefits if the health carrier has obtained reasonable assurance that such pediatric oral health

benefits are provided to the purchaser of the health benefit plan. **The health carrier shall be deemed to have obtained reasonable assurance that such pediatric oral health benefits are provided to the purchaser of the health benefit plan if:**

1. At least one qualified dental plan, as defined in § 38.2-3455, (i) offers the minimum essential pediatric oral health benefits that are required under the PPACA and (ii) **is available for purchase** by the small group or individual purchaser; and

2. The health carrier prominently discloses, in a form approved by the Commission, at the time that it offers the health benefit plan that the plan does not provide the PPACA-required minimum essential pediatric oral health benefits.

2013, c. [751](#); 2014, cc. [307](#), [369](#).

3. Cost of insurance/access to insurance issue –

For a significant number of employers, there are cost of insurance issues and, as a result, access to insurance issues. This stems from the current definitions used in FL Statutes, specifically §627.6699(3)(v)(2) ((1) is also listed below).

(v) “Small employer” means, in connection with a health benefit plan with respect to a calendar year and a plan year:

1. For a grandfathered health plan, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year, the majority of whom were employed in this state, employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single employer. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.

2. For a nongrandfathered health plan, any employer that has its principal place of business in this state, employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year. As used in this subparagraph, the

terms “employee” and “employer” have the same meaning as provided in s. 3 of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. s. 1002.

The nongrandfathered definition lists “employees”, not eligible employees, therefore each employee is counted as “1” to determine if the employer is a small employer. This method of counting includes part-time, temporary, seasonal and other employees that would not be eligible for coverage. In many instances, employers with high numbers of part-time, temporary and seasonal employees are not being considered small employers. As a result, they are underwritten as a large group, subject to rate variations based on gender, medical conditions and other factors. The employer may not be considered an Applicable Large Employer (ALE), and would not be subject to any penalties under the Employer Shared Responsibility (ESR) provisions of the ACA, however they realize in order to retain quality employees they need to offer coverage.

For example, assume an employer with 5 full-time employees under the ACA guidelines (working on average 130 hours or more per month), 15 seasonal employees (who work 120 or fewer days each year due to peak demand for a particular industry) and 45 part-time employees (assume that each worked 15 hours per week, which would equate to 24.4 full-time equivalents under the ACA). Under the ACA count, this employer would not be an ALE and as a result would not face any penalties for not offering coverage, as their full-time plus full-time equivalent count would equal 29.4 employees (the seasonal would not be counted, if they were to push them over the 50 threshold). Under the current definition in the FL Statutes, this employer would not be considered a small employer, as they would count the 5 FT + 45 PT + 15 seasonal for a total number of employees of over 50 (understanding this is a simplified calculation only using 1 month of counts, versus the average of 12 that would be used). In this instance, the group is underwritten in the large market and if even one of the five eligible employees had a major health condition, their rates would be raised significantly. Those rates could cause them to not purchase insurance coverage in the group market and they might not purchase in the individual or Marketplace markets due to limited networks, not qualifying for Advance Premium Tax Credits (APTCs), fewer plan choices, etc. However, if they qualified as a small employer, their rates could be significantly lower with access to a large number of plans, and several networks to choose from in the small group market.

If the example above were to change slightly in that 4 of the part-time employees worked on average at least 25 hours or more per week, and the definition of a small employer were changed, the following would occur:

- the 4 employees working on average at least 25 hours or more per week would be offered coverage based on small group market law

- those 4 employees would have greater access to coverage (if the employer were an ALE, they may not be offered coverage)

- with the small group rating requirements being used, medical conditions within the smaller group would not be considered, therefore they would enjoy lower costs of insurance

In addition, the definition used in (3)(v)(2) seems to not be consistent with (5)(b) (in 627.6699), which states:

(5) AVAILABILITY OF COVERAGE.—

(a) A small employer carrier that does not offer coverage but renews or continues coverage in force must provide coverage to newly eligible employees and dependents on the same basis as small employer carriers that offer coverage.

(b) Every small employer carrier must, as a condition of transacting business in this state, offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

To give another example (an employer that I was very recently called to work on), the employer has 38 eligible employees (full-time), 32 part-time employees, and 5 seasonal employees. They are being underwritten in the large group market, having an average total number of employees of over 70. For ACA purposes, they have 51 FTEs, making them an ALE. Based on 2 medical conditions within the group (even though 1 of them is no longer employed there), with 28 enrolled employees, using their lowest plan offered, the medical plan rate is just under \$550 per month per employee. If the definition were changed to use eligible employees, placing them in

the small group market, they could have enjoyed a rate of less than \$370 per month per employee. For this one employer, that would have equated to a savings of almost \$61,000 annually (just under \$2,700 per employee per year). With this employer being subject to penalties if they do not offer affordable coverage, as an ALE, they are having to pay the 150% higher rates in order to not face penalties. Also, three of the employees in the full-time count work less than 30 hours a week, but more than 25 hours per week. The employer did not want to remove the offer of coverage to those employees, even though they are not required to do so.