

FHIAB 2019 LEGISLATIVE PROPOSALS RECEIVED FROM BOARD MEMBERS

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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 (PTCs). 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 2019 could end up being as high as \$7,900 for an individual and \$15,800 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: Allow consumers a Deductible Health Credit Transfer to the new policy equal to the deductible paid by the consumer.

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.

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.

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.

5. 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 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. Improve network adequacy.

6. 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.

7. Standardize the Prior Authorization Process

Prior authorization (PA) requirements are used by health plans to eliminate or minimize treatments that are potentially ineffective, wasteful, or even harmful. However, navigating the process can be challenging for both healthcare providers and patients, because often payers require different forms for different plans, which may be specific to the type of drug, and their requirements for authorization may also vary.

For people with chronic illnesses like MS, barriers related to prior authorization requirements can have a negative impact on their lives and their health outcomes. It can cause a delay in receiving an MRI or accessing a prescribed medication, for weeks or even months until their insurer's prior authorization forms are submitted, reviewed, and approved.

On the healthcare provider side, frustration and confusion surrounding the process are common. A study published in *Health Affairs* (as cited by the [American Medical Association](#)) reported that processing these requests used around 20 hours each week of physician, nurse, and clerical staff time.

Recommendation: Establish a process for creating a standardized prior authorization form to be used by providers and insurance plans in the state. Allow for electronic submissions of prior authorization forms.

8. 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.