

Mark McGowan (Florida Blue) Carrier Representative

1. Certificates of Creditable Coverage (COC)

Health insurers are no longer allowed to impose pre-existing condition exclusions. This prohibition makes the current rules requiring plans to provide certificates of creditable coverage unnecessary. As of December 31, 2014, federal law no longer requires issuers and group health plans to issue COCs.

- Recommendation: Revise the state laws to align with the federal and eliminate the requirement.
- References: 627.6561; 641.31071, F.S., F.A.C. 690-154.110, F.A.C. 690-191.039

2. Guaranteed Renewability

Federal law requires issuers to provide 90 day discontinuance at the *product* level. The state law requires a 90 day notice whenever a *policy form* or plan is discontinued.

This means that when a member's policy form or plan is discontinued insurers must send a 90 day state notice of discontinuance. Since this does not qualify as a federal discontinuance insurers must also provide a CMS renewal notice. The two notices (renewal and discontinuance) create confusion due to the inconsistent messaging and timing of the notices.

- Recommendation: Align state law with the new federal law. This will reduce member confusion with multiple notices in the marketplace. It will also lower the amount of unnecessary administrative expenses.
- References: 627.6425(3); 627.6571(3); 641.31074(3), F.S.

3. Outline of Coverage (OOC)

State law requires an outline of coverage to be provided to all individual policyholders. The ACA requires a Summary of Benefit of Coverage (SBC) to also be provided to all members. In addition to the SBC and OOC, members receive a benefit booklet, schedule of benefit, benefit summaries and other collateral. The use of multiple documents for individuals creates confusion and is unnecessary.

- Recommendation: Eliminate the OOC requirement under state law. This will reduce consumer confusion by reducing the number of documents they receive. It will also decrease the number of OIR form filings from insurers.
- Reference: 627.642, F.S.

4. Name & Premium on Contract

Florida law requires the name of the parties on the contract and the premium to be included on every policy. The premium amount is no longer specific to an individual due to the elimination of UW. Additionally, some members receive advanced premium tax credits that subsidize the premium making the amount on the contract inaccurate. Therefore there is little value in customizing contracts for standardized plans.

- Recommendation: Recommend removing the requirements to include name and premium on the member's contract. There is administrative expense of customizing each policy which can be reduced.
- Reference: 627.413 (a),(e); 641.31(6), F.S., F.A.C. 690-191.033.

**Joan Galletta (J.P. Perry Insurance)
Agent Representative**

- 1. We recommend that small group rules be revised to “require” an offer of coverage to employees who works 30 hours or more per week, but allow employers to modify their offer of coverage to include employees who work as few as 25 hours, when desired.**
- 2. We also recommend a clear directive whereby employers are allowed to offer “employee only” coverage in the small group market, whether that remains defined as groups with 2-50 employees, or is redefined as of January 1, 2016 to groups with 2-99 employees.**

Laura Brennaman (Florida CHAIN) Individual Policyholder Representative

1. Require insurers to offer small group plans to businesses that do not include spouse or dependent coverage and to large group plans that do not include spouse.

Small group employers rarely contribute to spouse and/or dependent coverage, making the coverage expensive while simultaneously disallowing the spouse eligibility for premium tax credits on Marketplace plans, due to the family glitch. Insurers should be required to offer an option to employers and be required to provide explanation about the financial effects on employees and their families when employers offer, but do not subsidize coverage for the spouse and/or dependents. Workers for small employers should be able to accept coverage for themselves in an affordable health plan without disqualifying their spouse and dependents from access to premium tax credits applicable for Marketplace plan. Workers for large employers that do not contribute to spouse coverage should be able to accept coverage for themselves and their children, allowing their spouse access to premium tax credits for a marketplace plan.

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

Standards are required for network adequacy to ensure plans provide access to the services for which subscribers pay. Narrow networks that plans create to control costs must be adequate to enable access to multiplicity of necessary health services including, but not limited to, primary care; pediatric care; hospital care; mental health care; oncology care; obstetric and newborn care, and dental care where applicable. The “reasonable access” standard, identified by CMS, is insufficient at ensuring access to consumers, and more specifically, to consumers who are members of vulnerable populations with health disparities. We recognize that reasonable access must allow innovation and technology to improve value, quality, and access for ongoing health services and may not always include time and distance requirements. However, for some services, technology does not exist so time and distance must be considered. Network adequacy should encompass the following elements as identified by Families USA: 1) Accurate Information about Providers; 2) Timely Access to Care; 3) Adequate Numbers of Providers; 4) Adequate Types of Providers; 5) Inclusion of Essential Community Providers; 6) Adequate Geographic Distribution of Providers; 7) Access to Out-of-State Providers; 8) Accessible Hours; 9) Language-Accessible and Culturally-Competent Care; 10) Rights to Go Out-of-Network¹; and 11) Continuity of Care. 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 towards annual out-of-pocket maximums under the ACA. The Florida Network Adequacy rules should identify, in the case of insufficient networks, enrollees’ cost-sharing when going out of network will match the in-network requirements.

¹Standards for Health Insurance Provider Networks: Examples from the States. (2014). Issue brief: Affordable Care Act. FamiliesUSA. Available online: <http://familiesusa.org/product/standards-health-insurance-provider-networks-examples-states>

We understand the NAIC is creating a model for network adequacy. Inadequate networks are a problem today that should be addressed immediately through enforcement of regulations. The requirement to enforce network adequacy for all plans will reduce or eliminate the risk of adverse selection of non-marketplace plans, thereby reducing the risk of increasing the costs of marketplace plans.

A case study in Collier County illustrates the need for the state to monitor network adequacy compliance. Some subscribers in Immokalee must travel 75 miles to the east coast of Florida for the nearest participating hospital to deliver a baby – and prenatal care is unavailable locally from a provider with delivery privileges at a participating hospital. Adults in the area must travel at least 20 miles to access a primary care provider. The plan does not include the Immokalee branch of the Collier County FQHC in its network, requiring travel by members of vulnerable populations of more than 20 miles to obtain preventive and primary care.

3. Authorize the Florida Office of Insurance Regulation to protect consumers from discrimination on the basis of health conditions by plans.

Access to standard of care therapies for consumers with chronic health conditions should be required by all plans in consistence with HHS regulations for Marketplace qualified health plans. Pharmacy tiers or cost-sharing for standard-of-care therapies should be available to all subscribers to each plan that are consistent with the plan's cost-sharing requirements across the spectrum of covered health care services. For any chronic condition or class of medication, there should be an option for pharmacy or other therapy that meets the health plan's actuarial value, i.e. not more than 30% cost sharing for a silver level plan. This should include single tablet, extended release therapies when they are the accepted standard-of-care. See attached document for examples of potential discriminatory practices from which the FL OIR should have authority to protect consumers in Florida.

4. Prohibit balance billing for hospital contracted providers when delivering care to a PPO or EPO enrollee in a contracted hospital.

HMO members in Florida are currently protected from balance billing for emergency care provided at an in-network hospital. Subscribers to PPOs and EPOs should also have this protection. Additionally, for non-emergent care in an in-network hospital, all managed care plan subscribers should not be subject to balance billing for services provided by contracted hospital-based providers for which the consumer has no choice for alternative in-network providers.

Christopher Ciano (Aetna/Coventry of Florida) Carrier Representative

1. Certificates of Creditable Coverage (COC)

Health insurers are no longer allowed to impose pre-existing condition exclusions.^[1] This prohibition makes the current rules requiring plans to provide certificates of creditable coverage unnecessary as the purpose of these certificates is to show no gaps in a person's coverage that could lead to pre-existing condition exclusions. As of December 31, 2014, federal law no longer requires issuers and group health plans to issue COCs.

- Statutory citations: Sections 627.6561; 641.31071, Florida Statutes.
- Action required: delete Sections 627.6561 and 641.31071, Florida Statutes.

2. Outline of Coverage (OOC)

State law requires an outline of coverage to be provided to all individual policyholders. Under federal regulation, insurers must also provide a Summary of Benefit of Coverage^[2] (SBC) to also be provided to all members. In addition to the SBC and OOC, members receive a benefit booklet, schedule of benefit, benefit summaries and other collateral. The use of multiple documents for individuals creates confusion and is unnecessary as they have they cover the same information and are redundant to each other.

- Statutory citations: Section 627.642, Florida Statutes.
- Action Required: delete Section 627.642 Florida Statutes.

3. Conversion/continuation coverage

Statutory conversion rights are redundant, obsolete and an administrative burden. Federal law now requires all individual health insurance products to be issued on a guarantee issue basis and no preexisting conditions can be excluded. Prior federal conversion/ continuation coverage rights were developed and adopted into state statute to protect individuals from losing *similar like* health insurance coverage when leaving a group insurance product. The rationale for this was to prevent an individual from being subject to a *preexisting conditions exclusion*. Pursuant to federal law, individuals who lose group coverage would now be eligible for a special enrollment period.^[3] The coverage would be guarantee issue and all preexisting conditions would be covered.

- Statutory citations: Sections 627.646, 627.6675, 641.3921, 641.3922 Florida Statutes.
- Action required: delete Sections 627.646, 627.6675, 641.3921, 641.3922 Florida Statutes.

4. PPO Balance Billing Prohibition

While there is currently is a prohibition against balance billing for the Florida HMO commercial market place, there is no such prohibition that exist for Florida PPO commercial business.

- Statutory citations: N/A
- Action required: this would require new statutory authority.

^[1] Pursuant to 45 CFR 147.108

^[2] Pursuant to 45 CFR 147.200

^[3] 45 CFR 155.420