# HOUSE OF REPRESENTATIVES
# FINAL BILL ANALYSIS

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| **BILL #:** | CS/CS/HB 731 | **FINAL HOUSE FLOOR ACTION:** | |
| **SPONSOR(S):** | Insurance & Banking Subcommittee; Health Innovation Subcommittee; Plakon | 113 **Y's** | 0 **N's** |
| **COMPANION BILLS:** | CS/SB 968 | **GOVERNOR'S ACTION:** | Approved |

## SUMMARY ANALYSIS

CS/CS/HB 731 passed the House on April 16, 2015, and subsequently passed the Senate on April 29, 2015.

The Patient Protection and Affordable Care Act (PPACA) made many fundamental changes to the health insurance industry by imposing extensive requirements on health insurers and health insurance policies relating to required benefits, rating and underwriting standards, and required review of rate increases. For example, the PPACA requires coverage offered in small group markets to provide defined essential health benefits and limits or prohibits rate adjustment based on certain factors.

The bill amends the Employee Health Care Access Act, in s. 627.6699, F.S., to remove multiple provisions which are out of date or conflict with PPACA:

- The requirement that a carrier offer standard, basic, and high deductible plans.
- The requirement for an annual August open enrollment period for sole proprietors.
- The requirement for small employer carriers to submit a semiannual report to the Office of Insurance Regulation concerning the use of rating factors to adjust premiums.
- A provision that indexes reinsurance premium rates to approximate gross premium rates of standard and basic health plans.
- A requirement to develop agent compensation standards for sale of basic and standard health plans.
- The requirement for the Chief Financial Officer to appoint the health benefit plan committee, as well as the duties of that committee.

The bill also amends laws governing stop-loss insurance. It defines "stop-loss insurance policy," and requires a stop-loss insurance policy to cover 100 percent of all claims equal to or above the attachment point, which is the dollar amount of claims costs at which the stop-loss policy assumes liability for remaining claim costs. A stop-loss insurance policy is considered health insurance, subject to the EHCAA, if the policy has an aggregate attachment point that is lower than the greatest of:

- $2,000 multiplied by the number of employees;
- 120 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

The bill also requires that a self-insured health benefit plan established or maintained by an employer with 51 or more covered employees be considered health insurance if the plan's stop-loss coverage has an aggregate attachment point that is lower than the greater of:

- 110 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

The bill does not appear to have a significant fiscal impact on state or local governments.

The bill was approved by the Governor on June 10, 2015, ch. 2015-121, L.O.F., and will become effective on July 1, 2015.

# I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

**Background**

Employee Heath Care Access Act

The Employee Health Care Access Act (EHCAA)[1] was enacted in Florida in 1992 to promote the availability of health insurance coverage to small employers with fifty or less employees, regardless of claims experience or employee health status.[2] The EHCAA requires health insurers and health maintenance organizations (carriers) in the small group market to offer coverage to all small employers, including sole proprietors, on a guaranteed-issue basis. For sole proprietors, the offer of coverage may be limited to a one-month open enrollment period in August.[3]

Carriers are required to offer a standard benefit plan, a basic health benefit plan, and a high deductible plan, which meets the requirements of health savings account plans, to any small employer who applies for coverage, regardless of the health status of the employees.[4] A small employer carrier that offers coverage to a small employer must offer to all of the employer's eligible employees and their dependents.[5] The EHCAA establishes limitations on exclusions and mandates various other enrollment and reporting requirements to foster fairness and efficiency in the small group health insurance market.[6]

The EHCAA also created the Florida Small Employer Carrier Reinsurance Program (Program). The Program, now operating as the Florida Health Insurance Advisory Board (Board),[7] recommends to the Office of Insurance Regulation (OIR), among other things, market conduct and other requirements for agents and carriers selling and writing policies in the small group market, including:

- The registration by each carrier of its intention to be a small employer carrier;
- The publication of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;
- The availability of a toll-free telephone number for access by small employers to information concerning the Program;
- Periodic reports by carriers and agents concerning health benefit plans issued; and
- Methods for small employer carriers and agents to demonstrate that they are marketing or issuing health benefit plans to small employers.[8]

The EHCAA mandates that the Chief Financial Officer (CFO) appoint a health benefit plan committee (Committee) to submit recommendations to the board in relation to standard, basic, high deductible, and limited plans.[9] In 2002, following double digit rate increases for small employers, a lag in the offering of small group coverage, and a failure to update plan benefits since the early 1990s, the Committee recommended comprehensive revisions to the standard and basic plans to include more robust benefits that mirrored those benefits offered in plans on the market at the time.[10] The

[1] S. 627.6699, F.S.
[2] Ch. 92-33, Laws of Fla.
[3] S. 627.6699(5)(c)2., F.S.
[4] S. 627.6699(12)(b)1., F.S.
[5] S. 627.6699(5)(h)5., F.S.
[6] S. 627.6699, F.S.
[7] The Board's responsibilities were expanded in 2005 to include an advisory role on health insurance issues to OIR, the Agency for Health Care Administration, the Department of Financial Services, executive departments and the Legislature. *See* s. 627.6699(11)(o), F.S.
[8] SS. 627.6699(11)(e)1. through 5., F.S.
[9] S. 627.6699(12)(a)1., F.S.
[10] Florida Small Employer Benefits Plan Committee, Nov. 2002, *available at* www.floir.com/siteDocuments/Sm_Emp_Grp_Benefit_Comm_Rpt_%20Nov02.pdf

recommendations were adopted by the CFO for all small group plan coverage effective April 1, 2003.[11] It appears that the 2002 report may have been the last work of this Committee.

Under the EHCAA, each carrier is required to submit a semiannual report that shows the effects of certain rating factors in setting premiums.[12] The report allows OIR to compare the actual adjusted aggregate premiums charged to policyholders by each carrier to the premiums that would have been charged if the carrier's approved modified community rates were applied.[13] A modified community rate allows a carrier to spread financial risk across a large population using separate rating factors such as age, gender, family composition, and tobacco usage.[14] It also permits adjustments to the rate for claims experience, health status, and certain expenses incurred by the carrier.[15] If the aggregate premium actually charged exceeds the premium that would have been charged by applying the modified community rate by 4 percent or more, the carrier is limited in the application of rate adjustments.[16]

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA)[17] made many fundamental changes to the health insurance industry by imposing extensive requirements on health insurers and health insurance policies relating to required benefits, rating and underwriting standards, required review of rate increases, and other requirements.[18] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors.

Many of the changes outlined in the PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[19] For example, the PPACA requires coverage offered in the individual and small group markets to provide the following categories of services (essential health benefits package):[20]

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse 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

Also, the PPACA requires that premiums for individual and small group policies may vary only by:[21]

- Age, up to a maximum ratio of 3 to 1. This means that the rates for older adults cannot be more than three times greater than the rates for younger adults.
- Tobacco use, up to a maximum ratio of 1.5 to 1.
- Geographic rating area.

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[11] Florida Department of Financial Services, *Informational Memorandum DFS-03-001M*, Mar. 6, 2003, *available at* www.floir.com/siteDocuments/dfs-03-001m.pdf.
[12] S. 627.6699(6)(b)(5), F.S.
[13] *Id.*
[14] S. 627.6699(3)(o), F.S.
[15] *Id.*
[16] S. 627.6699(6)(b)(5), F.S.
[17] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148.
[18] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), 42 U.S.C. § 300gg et seq.
[19] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. *See* PPACA s. 1251; 42 U.S.C. § 18011.
[20] PPACA s. 1302; 42 U.S.C. § 300gg-6.
[21] PPACA s. 1201; 42 U.S.C. § 300gg.

- Whether coverage is for an individual or a family.

The PPACA prohibits an insurer from establishing rules for eligibility based on any of the following factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or any other health-status related factor deemed appropriate by the U.S. Department of Health and Human Services.[22]

Small employer carriers are required, under the PPACA, to have continuous open enrollment.[23]

Stop-Loss Insurance Coverage

Florida law defines stop-loss insurance as an arrangement in which an insurer insures a policyholder against the risk that any one claim will exceed a specified dollar amount or that an entire self-insurance plan's loss will exceed a specified amount.[24] Stop-loss insurance is more fully defined in Rule 69O-149.0025(23), F.A.C., as coverage purchased by an entity, generally an employer, for the purpose of covering the entity's obligation for the excess cost of medical care provided under a self-insured health benefit plan. Such insurance coverage takes effect once a claim cost or total plan loss reaches a certain amount, known as the attachment point. Small employers who are self-insured for health care coverage of their employees purchase stop-loss insurance to limit their financial risk in the case of catastrophic medical costs incurred by their employees.

Rule 69O-149.0025(23), F.A.C., establishes standards to distinguish a small group health insurance policy, which is subject to the provisions of the EHCAA, from a stop-loss insurance policy, which is exempt from the provisions of the EHCAA. Such coverage is considered a health insurance policy, rather than a stop-loss insurance policy, if it:

- Has an attachment point for claims incurred per individual which is lower than $20,000; or
- For insured employer groups with fifty or fewer covered employees, has an aggregate attachment point which is lower than the greater of:
  - $4,000 times the number of employees;
  - 120 percent of expected claims; or
  - $20,000; or
- For insured employer groups with fifty-one or more covered employees, has an aggregate attachment point which is lower than 110 percent of expected claims.[25]

Insurers are required to determine the number of covered employees of an employer, for purposes of applying the appropriate attachment point, on a consistent basis. An insurer can base its determination of the number of employees employed on an annual basis or at a specific time.[26]

[22] PPACA s. 1201; 42 U.S.C. § 300gg-4.
[23] 45 C.F.R. § 147.104.
[24] S. 627.6482(14), F.S.
[25] Rule 69O-149.0025(23), F.A.C.
[26] Rule 69O-149.0025(23)(b)3., F.A.C.

**Effect of Proposed Changes**

The bill deletes s. 627.6699(12), F.S., which removes the requirement that a carrier offer standard, basic, and high deductible plans to a small employer. Federal law requires all small group health plans, except those plans with grandfather status, to include essential health benefits. The plans required to be offered to small group employers in s. 627.6699(12), F.S., do not include essential health benefits and cannot be sold in Florida. However, because the requirement remains in statute, insurers are required to submit plan forms to OIR, which are then rejected. By removing the requirement, insurers will not be required to submit the plan forms to OIR for review, and OIR will not be required to review the forms. The bill also removes the requirement that a small group carrier submit information regarding standard and basic plans on a quarterly basis to the OIR.

The bill removes the requirement for an annual August open enrollment period for sole proprietors. Federal law now requires small employer carriers to have continuous open enrollment, which supersedes the annual open enrollment period in statute.

The bill also removes the requirement for small employer carriers to submit a semiannual report to OIR with information related to actual aggregate premiums charged to policyholders and the aggregate premiums that would have been charged using the carrier's approved modified community rating, which is based on certain factors in statute. Federal law allows premiums for individual and small group policies to be adjusted using a much narrower group of factors. Because carriers adjust rates using the same limited factors set out in federal law, the semiannual report no longer includes useful information.

The bill deletes language that bases reinsurance premium rates on the approximate gross premium rates of standard and basic health plans. Standard and basic health plans can no longer be offered or sold under federal law because such plans do not include essential health benefits. As a result, keying reinsurance premium rates to rates of plans that are not offered or sold is moot. While no other basis for these rates is provided, any rate set by the board is subject to the approval of OIR.

The bill deletes language that requires the board to develop standards for compensation of agents for the sale of basic and standard health plans. As those plans do not include essential health benefits and cannot be sold in Florida, these compensation standards are unnecessary.

The bill also removes the requirement for the CFO to appoint the health benefit plan committee, as well as the duties of that committee to make recommendations concerning basic and standard health plans. Federal law removes the ability to sell standard, basic, high deductible and limited plans, so recommendations by the committee as to those plans are unnecessary. Furthermore, it does not seem that the Committee has made any recommendations to the board since 2002.

The bill defines “stop-loss insurance policy” and exempts such policies from the EHCAA.

The bill requires that a small employer stop-loss insurance policy be considered a health insurance policy and subject to the EHCAA if the policy has an aggregate attachment point that is lower than the greatest of:

- $2,000 multiplied by the number of employees;
- 120 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

The bill requires any small employer stop-loss insurance policy authorized under the bill to cover 100 percent of all claims equal to or above the attachment point.

The bill requires that a self-insured health benefit plan established or maintained by an employer with 51 or more covered employees be considered health insurance if the plan’s stop-loss coverage has an aggregate attachment point that is lower than the greater of:

- 110 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

The bill also requires a carrier to use a uniform methodology for determining the number of employees to calculate the attachment point. The bill permits the methodology to be based on the number of employees employed on an annual basis or at a specific point in time during the year.

The bill also corrects cross-references and makes other conforming changes.

The bill provides for an effective date of July 1, 2015.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill deletes the requirement that a small group carrier offer standard and basic health benefit plan and high deductible plan to each small employer, upon request. The carrier may realize a decreased administrative burden in creating these plans and forms and submitting them to OIR. OIR may realize a decrease in workload as a result of no longer requiring the submission of the plan forms. The bill removes multiple reporting requirements, which may lower the administrative burden on carriers and decrease the workload of OIR in creating and reviewing of these reports.