The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 968
INTRODUCER:	Banking and Insurance Committee and Senator Detert
SUBJECT:	Employee Health Care Plans
DATE:	March 23, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			CM	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 968 revises and streamlines provisions relating to the 1992 Employee Health Care Access Act (act) which was enacted to promote the availability of health insurance coverage for small employers (fifty or fewer employees) regardless of their claims experience, on a guaranteed issue basis. Many provisions of this act are outdated or conflict with the federal Patient Protection and Affordable Care Act.[1] The bill also amends the stop loss insurance provisions for self-insured small employers and self-insured large employers. The bill removes the following requirements from the act:

- Mandated offer of standard, basic, and high deductible plans to small employers with specified benefits. The PPACA requires health plans to provide coverage for ten essential health benefits and other benefits, which are not included in the standard, basic, or high deductible plans.
- Annual August open enrollment period for one-person employer groups. The PPACA requires continuous open enrollment for small groups.
- Submission by insurers of an annual premium report to the Office of Insurance Regulation (OIR); and
- Submission by insurers of the semiannual rating report to the OIR.

[1] On March 23, 2010, President Obama signed into law Public Law No. 111-148, the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, President Obama signed into law Public Law No. 111-152, the Health Care and Education Affordability Reconciliation Act of 2010, amending PPACA.

II. Present Situation:

The PPACA provided fundamental changes to the U.S. health care system by requiring 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. The PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, and other requirements.[2]

Essential Health Benefits

The PPACA requires coverage[3] offered in the individual and small group markets to provide the following categories of services (essential health benefits package):

- 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

Rating and Underwriting Standards[4]

The PPACA requires that premiums for individual and small group policies may vary only by:

- 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, up to a maximum ratio of 1.5 to 1.
- Geographic rating area.
- Whether coverage is for an individual or a family.

Office of Insurance Regulation

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations, and other risk-bearing entities.[5] The Employee Health Care Access Act (act) under s. 627.6699, F.S., requires insurers in the small group market to guarantee the issuance of coverage to any small employer with 1 to 50 employees, including sole proprietors and self-employed individuals, regardless of their health condition.

The act requires small group carriers to offer the standard health benefit plan and the basic health benefit plan to each small employer applying for coverage. The act lists certain benefits that must

[2] 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.
[3] 42 U.S.C. 300gg-6.
[4] 42 U.S.C. 300gg.
[5] Section 20.121(3)(a), F.S.

be included in each of these policies. These plans do not comply with PPACA essential health benefit requirements; therefore, insurers discontinued offering these policies for sale after January 1, 2014. Insurers are required to provide information regarding their standard and basic plans to the OIR on a quarterly basis.

Employers with fewer than two employees, typically referred to as "one-life groups," are limited to a one-month open enrollment period in August of each year, rather than the year-round guarantee-issue requirement that applies to employers with 2-50 employees. The PPACA requires continuous open enrollment periods for small groups (unless groups strictly comply with market rules and elect to have open enrollment that coincides with open enrollment for the individual market), thus a separate August open enrollment period is no longer necessary.

The Small Employer Health Reinsurance Program was created by this act to facilitate the guaranteed issuance of standard and basic health benefit plans to all small employers by providing optional reinsurance coverage to small employer carriers.[6] The program now operates as the Florida Health Insurance Advisory Board. The board is required to establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The basic reinsurance premium rates must be established by the board, subject to the approval of the OIR, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan.

The act also authorizes the Chief Financial Officer to appoint a health benefit plan committee to make recommendations regarding additional benefits or provisions for the standard and basic health benefit plans.[7] The last report was issued in 2002 and recommendations by the CFO were adopted for all small group coverage effective April 1, 2003.[8]

Insurers are required to file with the OIR an annual premium report for all plans issued to small employers for the prior year.[9] In addition, each small group insurer is required to submit a semiannual report that provides the effects of certain rating factors (modified community rating) in setting premiums for small group employers. Under the act, each carrier is required to submit a semiannual report that shows the effects of certain rating factors in setting premiums.[10] 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.[11]

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.[12] It also permits adjustments to the rate for claims experience, health status, and certain expenses

[6] Section 627.6699(11), F.S.
[7] Section 627.6699(12), F.S.
[8] Florida Department of Financial Services, *Informational Memorandum DFS-03-001M*, Mar. 6, 2003, *available at* www.floir.com/siteDocuments/dfs-03-001m.pdf (last accessed March 20, 2015).
[9] Section 627.6699(5)(e)(4), F.S.
[10] Section 627.6699(6)(b)(5), F.S.
[11] *Id.*
[12] Section 627.6699(3)(o), F.S.

incurred by the carrier.[13] 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.[14]

While these rating factors are allowed in policies that are grandfathered plans[15] or transitional policies under the PPACA, PPACA compliant policies do not use these rating factors to set premiums levels. Therefore, the usefulness of this report has decreased significantly. The data currently received by the OIR mixes grandfathered or transitional data (modified community rating allowed) with fully-PPACA compliant plans (modified community rating not allowed).

Stop-loss coverage is an arrangement whereby an insurer insures against the risk that any one claim will exceed a specific dollar amount or that an entire self-insurance plan's loss will exceed a specific amount.[16] Employers that self-insure may purchase stop-loss coverage as provided in Rule 69O-149.0025(23), F.A.C., which contains standards for stop-loss coverage purchased by a self-insured employer group and prescribes when such coverage is considered stop-loss coverage and when it is considered health insurance coverage under s. 627.6699, F.S. Rule 69O-149.0025 (23), F.A.C., provides such coverage is considered as a health insurance policy, rather than a stop-loss coverage if the policy:

- Has an attachment point for claims incurred per individual which is lower than $20,000; or
- For insured employer groups with 50 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.

Under such a stop-loss arrangement, the self-insured employer is solely responsible for employee health claims below the attachment point and the stop-loss insurer provides coverage for employee health claims above the attachment point. There are no minimum surplus requirements for self-insured employer plans and no guaranty fund protection for the claims obligation of the self-insured employer.

III. Effect of Proposed Changes:

Section 1 removes the following requirements that apply to insurers offering coverage in the small group market: an annual August open enrollment period for one person employer groups; mandatory offering of standard, basic, and high deductible plans to small employers; submission by insurers of information regarding standard and basic plans to the OIR; and the submission by

[13] Small group carriers are allowed to adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium can be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these factors.
[14] Section 627.6699(6)(b)(5), F.S.
[15] Pursuant to s. 627.402, F.S., a "grandfathered health plan" has the same meaning as provided in 42 U.S.C. s. 18011, subject to the conditions for maintaining status as a grandfathered health plan specified in regulations adopted by the federal Department of Health and Human Services in 45 C.F.R. s. 147.140. "A nongrandfathered health plan" is a health insurance policy or health maintenance organization contract that is not a grandfathered health plan and does not provide the benefits or coverages specified under s. 627.6561(5)(b)-(e), F.S.
[16] Section 627.6482(14), F.S.

the insurers of small group experience rating report to the OIR. The bill provides conforming changes to eliminate provisions relating to standard, basic, and high-deductible plans.

Section 2 revises requirements for the use of stop-loss insurance policies by small employers, as defined in s. 627.6699, F.S., and large employers. The section provides that a self-insured health benefit plan established or maintained by a small employer is exempt from s. 627.6699, F.S., and may use a stop-loss insurance policy. A "stop-loss insurance policy," means an insurance policy issued to a small employer, which covers the employer's obligations for the excess cost of medical care on an equivalent basis per employee provided under a self-insured health benefit plan.

However, a small employer stop-loss insurance policy is considered a health insurance policy and is subject to s. 627.6699, F.S., if the policy has an aggregate attachment that is lower than the greatest of:

- $2,000 times the number of employees;
- 120 percent of expected claims; or
- $20,000.

Once claims under a small employer benefit plan reach the aggregate attachment point, the stop-loss policy must cover 100 percent of all claims that exceed the aggregate attachment point.

A self-insured health benefit plan established or maintained by a large employer (51 or more employees) is considered health insurance if the plan's stop-loss coverage, as defined in s. 627.6482(14), F.S., has an aggregate attachment point that is lower than the greater of 110 percent of expected claims or $20,000.

Stop-loss insurance carriers are required to use a consistent basis for determining the number of covered employees of an employer. Such basis may include, but is not limited to, the average number of employees employed annually or at a uniform date.

Sections 3- 9 provide technical, conforming changes.

Section 10 provides the bill takes effect July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The elimination of the mandatory outdated reports will reduce the regulatory burden of insurers.

C. Government Sector Impact:

The elimination of outdated reports will reduce administrative burden for the OIR.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.6699, 627.642, 627.6475, 627.657, 627.6571, 627.6675, 641.31074, and 641.3922.

This bill creates section 627.66997 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on March 23, 2015:
The bill revises provisions relating to stop-loss insurance for small and large employers.

B. Amendments:

None.