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 Appropriations

BILL: PCS/SB 1170 (899852)

INTRODUCER: Appropriations Committee (Recommended by Appropriations Subcommittee on Health and Human Services); Banking and Insurance Committee; and Senator Detert

SUBJECT: Health Plan Regulatory Administration

DATE: February 24, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Brown	Pigott	AHS	**Recommend: Fav/CS**
3.	Brown	Kynoch	AP	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/SB 1170 revises provisions in the Insurance Code and other Florida Statutes that conflict with the federal Patient Protection and Affordable Care Act (PPACA) and provides other changes. These changes include:

- Eliminates provisions relating to preexisting condition exclusions since the federal act requires guaranteed issue of coverage and prohibits preexisting condition exclusions;
- Removes the requirement that insurers provide an outline of coverage for individual or family accident and health insurance policies;
- Requires insurers to provide an outline of coverage for a large group policy or policy offering excepted benefits;
- Eliminates provisions relating to medical loss ratios since the federal act prescribes such standards and requires rebates if certain conditions are met;
- Eliminates the requirement for insurers to issue certificates of creditable coverage; and
- Provides technical and conforming changes.

The bill has no fiscal impact.

The effective date of the bill is July 1, 2016.

II. Present Situation:

Federal Patient Protection and Affordable Care Act (PPACA)

The federal Patient Protection and Affordable Care Act was signed into law on March 23, 2010.[1] The federal law made significant changes to the U.S. health care system such as providing 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. The PPACA imposes many insurance requirements, including required benefits, rating and underwriting standards, required review of rate increases, establishing and reporting of medical loss ratios and payment of rebates, covering adult dependents, internal and external appeals of adverse benefit determinations, and other requirements on individual and group coverage.[2] All health insurance coverage sold in the individual and group market must include the benefits in the essential health benefits benchmark with some exceptions. Excepted benefits are not subject to these requirements.[3]

Generally, health insurance is divided into two types of coverage: major medical coverage and excepted benefits. The PPACA regulates major medical, also known as comprehensive health insurance. Health insurance that provides benefits on a limited or ancillary basis have been referred to as excepted benefits. The Florida Insurance Code delineates the excepted benefits in s. 627.6561(5)(b), F.S. Excepted benefits include coverage such as limited scope dental, hospital indemnity, and specified disease coverage.

Guaranteed Availability and Renewability of Coverage

Individual major medical health maintenance organization (HMO) coverage is guaranteed issue and renewable. That is, the PPACA requires health insurers to accept every individual and every employer that applies for coverage, commonly referred to as offering coverage on a guaranteed-issue basis. The PPACA also requires health insurers to renew or continue in force the coverage with exceptions.[4] In Florida, this requirement is found in s. 627.6425(1), F.S., and applies to coverage defined in s. 627.6561(5)(a)2., F.S., which includes insurer policies and HMO contracts.

Grandfathered Health Plans

The PPACA exempts “grandfathered health plan coverage” from many of its insurance requirements (as specified in the summary of the key insurance provisions, below). 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.[5] Grandfathered health plan coverage is tied to the individual

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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.

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. s. 300gg-91.

4 45 C.F.R. s. 147.104 and 45 C.F.R. s. 147.106.

5 PPACA s. 1251; 42 U.S.C. s. 18011 and 45 C.F.R. s. 147.140.

or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010. The conditions for maintaining grandfathered status are specified in the rule.

Medical Loss Ratio and Payment of Rebates

Effective for plan years beginning January 1, 2011, the PPACA requires health insurers to report to the federal Department of Health and Human Services (HHS) information concerning the percent of premium revenue spent on claims for clinical services and activities. This percentage is also known as the medical loss ratio, or MLR. Insurers must provide a rebate to consumers if the MLR is less than 85 percent in the large group market and 80 percent in the small group and individual markets. [6] Grandfathered health plans are not exempt from this requirement. Florida law requires as a condition of prior approval of rates by the Office of Insurance Regulation[7] (OIR) that the projected minimum loss ratio for small group and individual policies is 65 percent,[8] and rebates are not required if the MLR is not met. The calculation of Florida's MLR is not consistent with federal regulations.

Summary of Benefits and Coverage

The PPACA directs the HHS and the U.S. Department of the Treasury to develop standards for insurers and HMOs to use in compiling and providing a summary of benefits and coverage (SBC) that ''accurately describes the benefits and coverage under the applicable plan or coverage." On June 16, 2015, the HHS issued final rules relating to the summary of benefits and coverage disclosures that insurers and HMOs are required to provide for individual and group coverage. Section 627.6482, F.S., requires insurers to provide an outline of coverage for individuals and family accident and health policies.

Preexisting Conditions and Certificates of Coverage

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)[9] was enacted to provide guaranteed availability of coverage for certain employees and individuals, and to increase portability through the limitation of preexisting condition exclusions. Generally, group plans were allowed to impose a preexisting condition exclusion for up to 18 months after the enrollment date. The exclusion period could be reduced by the aggregate periods of creditable coverage applicable to the individual as of the enrollment date. Creditable coverage included group health plan and other specified coverage. Creditable coverage did not include excepted benefits. In 1997,[10] Florida adopted many of the requirements of HIPAA, which, in part, is codified in s. 627.6561, F.S.

Insurers were required to issue certificates of creditable coverage to individuals switching from

[6] 45 C.F.R. part 158.
7 Florida's Office of Insurance Regulation licenses and regulates the activities of insurers, health maintenance organizations, and other risk-bearing entities.
[8] Section 627.411(3)(a), F.S.
[9] Pub.L. 104–191.
[10] Ch. 97-179, Laws of Fla.

one health insurance plan to another that would allow the individual to mitigate or avoid preexisting condition exclusions. Effective December 31, 2014, certificates of creditable coverage are no longer required to be provided. After December 31, 2014, most health insurance plans will no longer contain preexisting condition exclusions because of the PPACA.[11]

Florida Kidcare Program

The Florida Kidcare Program[12] (Kidcare) was created in 1998 by the Florida Legislature in response to the federal enactment of the Children's Health Insurance Program (CHIP) in 1997. The Florida Kidcare program was created to provide a defined set of health benefits to uninsured, low-income children through the establishment of a variety of affordable health benefits coverage options from which families may select coverage and through which families may contribute financially to the health care of their children.[13]

III. Effect of Proposed Changes:

Section 1 amends s. 408.909, F.S., to revise a cross-references to excepted benefits and limited benefits, which are amended in the bill.

Section 2 amends s. 409.817, F.S., relating to Kidcare, to eliminate an exception to the prohibition on preexisting condition exclusions, since PPACA prohibits such exclusions.

Sections 3 and 4 amends ss. 624.123 and 627.402, F.S., to revise cross-references to sections amended by the bill.

Section 5 repeals subsection (3) of s. 627.411, F.S. The bill removes a ground for disapproval of a major medical health insurance policy for failure to meet a 65 percent medical loss ratio and removes the definition of incurred claims. The PPACA requires major medical health insurance to have an 80 percent loss ratio.

Sections 6 and 7 amend ss. 627.6011 and 627.602, F.S. to update cross-references to sections amended by the bill.

Section 8 amends s. 627.642, F.S., to eliminate the requirement that insurers provide an outline of coverage for individual or family accident and health insurance policies. Instead, insurers are required to provide an outline of coverage for a large group policy or policy offering excepted benefits. The PPACA requires a summary of benefits be included in individual and small group major medical policies.

Section 9 amends s. 627.6425, F.S., to remove the guaranteed renewable requirements for individual HMO major medical policies. Currently, s. 627.6425(1), F.S., applies to health insurance coverage as defined in s. 627.6561(5)(a)2., F.S., which includes HMO contracts. Additionally, the only guaranteed renewable statute in the HMO chapter is s. 641.31074, F.S.,

[11] 45 C.F.R. 148.124.
[12] See http://floridakidcare.org/#eligible (last visited Jan. 23, 2016).
[13] Section 409.812, F.S.

but it only applies to group health insurance. The bill deletes the reference to s. 627.6561(5)(a)2., F.S., and refers to s. 624.603, F.S., which includes the definition of health insurance.

Section 10 amends s. 627.6487, F.S., to update cross-references to sections amended by the bill.

Section 11 repeals s. 627.64871, F.S., which relates to creditable coverage and the issuance of certifications of coverage by insurers, since PPACA prohibits preexisting condition exclusions and such certificates are no longer needed.

Section 12 amends s. 627.6512, F.S., relating to the exemption of certain policies from regulations imposed on health insurance policies, to update cross-references to sections amended by the bill.

Section 13 amends s. 627.6513, F.S., to delineate excepted benefits and provide that excepted benefits do not apply to group policies.

Section 14 amends s. 627.6561, F.S., to delete provisions relating to creditable coverage and to update cross-references to sections amended by the bill.

Section 15 amends s. 627.6562, F.S., relating to dependent coverage, to provide a definition of creditable coverage, which delineates what type of coverage qualifies as "creditable coverage" and what coverage does not qualify as creditable. These provisions are currently delineated in s. 627.6561, F.S., which is being repealed by the bill.

Section 16 amends s. 727.65626, F.S., to update a cross-reference to sections amended by the bill.

Section 17 amends s. 627.6699, F.S., to revise a cross-reference to excepted benefits, which is amended by the bill. The section also provide a definition of "late enrollee" and eliminates provisions relating to creditable coverage.

Section 18 amends s. 627.6741, F.S., to update cross-references to sections amended by the bill.

Section 19 amends s. 641.31, F.S. to delete a provision that exempts individual or large group HMO contracts from any law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments. Federal law establishes deductibles and annual and lifetime limits and provides that copayments are not allowed for certain essential health benefits.

Section 20 amends s. 641.31071, F.S., to delete provisions relating to creditable coverage and to update cross-references to sections amended by the bill.

Section 21 amends s. 641.31074, F.S., to revise provisions relating to the guaranteed renewability of health maintenance organization coverage to conform to changes made under the bill.

Section 22 amends s. 641.312, F.S., to update a cross-reference to a section amended by the bill.

Section 23 provides an effective date of July 1, 2016.

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:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Section 5 of PCS/SB 1170 deletes s. 627.411(3)(a)-(b), F.S. According to the OIR, only paragraph (3)(a) needs to be deleted. The elimination of paragraph (3)(b) removes the definition of incurred claims, which is needed by OIR to review a company's request for rating action (increase or decrease), and therefore paragraph (3)(b) needs to be retained.[14]

VII. Related Issues:

The effective date of the bill is July 1, 2016. According to the Office of Insurance Regulation, implementing the bill in the middle of a plan year may create policyholder confusion and market disruption. Making these provisions effective at the beginning of the calendar year could avoid these negative outcomes.[15]

[14] Office of Insurance Regulation, 2016 Agency Legislative Bill Analysis, Jan. 13, 2016. (on file with Banking and Insurance Committee).
[15] *Id*.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 408.909, 409.817, 624.123, 627.402, 627.411, 627.6011, 627.602, 627.642, 627.6425, 627.6487, 627.6512, 627.6513, 627.6561, 627.6562, 627.65626, 627.6699, 627.6741, 641.31, 641.31071, 641.31074, and 641.312.

This bill repeals the following section of the Florida Statutes: 627.64871.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS by Appropriations Subcommittee on Health and Human Services on February 11, 2016:
The committee substitute makes numerous technical corrections throughout the bill relating to preexisting conditions and creditable coverage. The PCS also provides for additional conforming changes to s. 641.31074, F.S., relating to the guaranteed renewability of health maintenance organization coverage.

CS by Banking and Insurance on January 26, 2016:
The CS reinstates provisions relating to HMO conversions and provides technical and conforming changes.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.