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 1170
INTRODUCER:	Banking and Insurance Committee and Senator Detert
SUBJECT:	Health Plan Regulatory Administration
DATE:	January 27, 2016 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/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. 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;
- 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. Under current law, insurers are required to issue certificates of coverage to individuals switching health insurance plan that would allow the individual to use this credit to offset some preexisting condition exclusion period. Effective December 31, 2014, federal regulations no longer require the issuance of certificates of creditable coverage; and
- Provides technical and conforming changes.

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 federal PPACA regulates major medical, or 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 like limited scope dental, hospital indemnity, specified disease, etc.

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., that 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

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; 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 information concerning the percent of premium revenue spent on claims for clinical services and activities (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 OIR, that the projected minimum loss ratio for small group and individual policies is 65 percent.[7] 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 HHS and the Department of 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 U.S. Department of Health and Human Services 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 Health Insurance Portability and Accountability Act of 1996 (HIPAA)[8] 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,[9] 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 one health insurance plan 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

[6] 45 C.F.R. part 158.
[7] Section 627.411(3)(a), F.S.
[8] Pub.L. 104–191.
[9] Ch. 97-179, Laws of Fla.

longer contain preexisting condition exclusions because of the PPACA.[10]

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.

Florida Kidcare Program

The Florida Kidcare Program[11] (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.[12]

III. Effect of Proposed Changes:

Section 1 amends s. 408.909, F.S., to revise a cross references to excepted benefits, limited benefit, 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., revise cross references to sections amended by the bill.

Section 5 deletes provisions within s. 627.411, F.S. The section removes a ground for disapproval of a major medical health insurance policy for failure to meet a 65 percent medical loss ratio and removing the definition of incurred claims. The PPACA requires major medical health insurance to have an 80 percent loss ratio. Since the PPACA requires insurers that write specific types of coverage to meet certain medical loss ratios, the only portion of this section that needs to be removed is subsection (3)(a). Removal of the whole section removes the definition of incurred claims under (3)(b), which the OIR indicates is needed to review the company's request for any rating action (increase or decrease).

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.

[10] 45 C.F.R. 148.124.
[11] See http://floridakidcare.org/#eligible (last visited Jan. 23, 2016).
[12] Section 409.812, F.S.

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., but it only applies to group health insurance. The bill deletes the s. 627.6561(5)(a)2., F.S., reference and refers to s. 624.603, F.S., the general section defining health insurance. Since the bill would delete s. 627.6561(5)(a)2., F.S., and since ch. 641, F.S., is part specific, individual HMO major medical insurance would be governed under the guaranteed renewable requirements in Rules 69O-149 and 69O-191, Florida Administrative Code. The PPACA requires guaranteed issuance and guaranteed renewability.

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 required.

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.

Sections 14 and 21 repeal ss. 627.6561 and 641.31071, F.S., relating to relating to preexisting conditions and creditable coverage. The federal law prohibits insurers from excluding preexisting conditions and certificates of coverages are no longer required to be issued; so these provisions are unnecessary.

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 were delineated in s. 627.6561, F.S., that 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," as provided in s. 627.6561(1)(b), F.S. The section eliminates provisions relating to preexisting condition exclusions.

Sections 18 and 19 amend ss. 627.6741 and 641.185, F.S., to update cross references to sections amended by the bill and eliminate a provision relating to preexisting conditions.

Section 20 amends s. 641.31, F.S. to delete current language, which exempts individual or large group HMO contracts from any law restricting or limiting deductibles, coinsurance, copayments

or annual or lifetime maximum payments. The federal law establishes deductibles, annual and lifetime limits and provides that copayments are not allowed for certain essential health benefits.

Sections 22 and 23 amends ss. 641.3111 and 641.312, F.S., relating to extension of benefits relating to conversion policies and update a cross reference to a section amended by the bill.

Section 24 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:

The effective date of this bill is July 1, 2016. According to the OIR, implementing the changes proposed in this 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. [13]

C. Government Sector Impact:

Indeterminate. Not addressed in the OIR analysis.

VI. Technical Deficiencies:

Section 5 of the bill deletes 627.411(3)(a)and (b), F.S. According to the OIR, only subsection (3)(a) needs to be deleted. The removal of subsection (3)(b) removes the definition of incurred claims, which is needed to review the company's request for any rating action (increase or decrease and needs to be reinstated.[14]

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

VII. Related Issues:

Section 22, which amends s. 641.3111, F.S., deletes a provision relating HMO extension of benefits.

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, 627.6515, 627.6562, 627.65626, 627.6699, 627.6741, 641.185, 641.31, 641.3111, and 641.312.

This bill repeals the following sections of the Florida Statutes: 627.64871, 627.6561, 627.6675, and 641.31071.

IX. Additional Information:

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

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.