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:	SB 1170
INTRODUCER:	Senator Detert
SUBJECT:	Health Plan Regulatory Administration
DATE:	January 25, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

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 exclusions for preexisting conditions since the federal act requires guaranteed issue of coverage and prohibits preexisting condition exclusions;
- Repeals the requirement that insurers provide an outline of coverage for individual or family accident and health insurance policies. Federal regulations prescribe summary of benefits to be included in individual and small group major medical policies;
- Eliminates provisions relating to health maintenance organization (HMO) conversion policies, which require health insurers to offer their insureds "conversion" rights, which is the right to convert coverage under a health insurance policy to have guaranteed access to health insurance when an insured loses his or her eligibility under their own policy. In 2013, all other conversion products were eliminated. Under PPACA, health insurers are no longer able to deny coverage to those who apply for coverage based on pre-existing conditions; and
- Eliminates provisions relating to medical loss ratios since the federal act prescribes such standards and requires rebates if certain conditions are met.

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

II. Present Situation:

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.

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. The concept of excepted benefits was introduced in the federal Health Insurance Patient Protection and Affordability Act of 1996, which imposed many requirements on health insurance unless that insurance was considered an excepted benefit. Florida adopted many of these requirements and modeled its statutory language on HIPAA, which in part, is codified in s. 627.6561, F.S. The PPACA does not directly regulate these excepted benefits.

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 section 627.6425(1), F.S., that applies to coverage defined in Section 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

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.

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 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.

Conversion Policies or Contracts

The federal Health Insurance Portability and Accountability Act (HIPAA requires insurers issuing individual health insurance policies to guarantee the issuance of coverage to persons who previously were covered for at least 18 months and meet other requirements. In 1997, Florida enacted legislation to conform state law to HIPPA.[8] In order to be eligible for guaranteed-issuance of individual coverage under HIPAA and Florida's conforming legislation, an individual must have prior creditable coverage for at least 18 months without a break in coverage of more than 63 days, and not be eligible for any other group coverage, Medicare or Medicaid. Florida law provides two methods for guaranteeing access to individual coverage to persons who lose their eligibility for prior coverage. One method requires the insurer or HMO that issued the group plan to offer an individual conversion policy to persons who lose their eligibility for group coverage.[9] The other method is to guarantee access to individual coverage is by allowing an

[5] PPACA s. 1251; 42 U.S.C. s. 18011 and 45 C.F.R. s. 147.140.
[6] 45 C.F.R. part 158.
[7] Section 627.411(3)(a), F.S.
[8] Ch. 97-179, L.O.F.
9 Section 627.6675, F.S. (group insurance policies) and s. 641.3921, F.S. (group HMO contracts).

eligible individual to purchase an individual policy from any insurer or HMO issuing individual coverage in the state.

In 2013, the Legislature passed legislation that eliminated statutory conversion rights. However, subsequent to the passage of this act, the OIR interpreted the legislation to eliminate statutory conversion rights with the exception of HMO products. The OIR has interpreted that insurer products do not qualify as "similar like coverage in the case of an individual losing HMO coverage where another HMO product was not available, As a result, 14,052 conversion lives are still covered as of calendar year 2014.

It has been argued that the PPACA eliminated the need for conversion policies because health insurance issuers are no longer able to deny those who apply for coverage based on pre-existing conditions or health concerns.

Health Flex Plans

The health flex plan program[10] was established in 2002 as a pilot program to offer basic affordable health care services to low-income uninsured state residents "by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services." Health flex plans are not insurance products. Plan providers are not subject to the Florida Insurance Code. The plans are also not required to offer the mandated health benefits found in chapter 627, F.S., or chapter 641, F.S., as applicable. Health flex plans provide coverage for basic health care services.

Florida Kidcare Program

The Florida Kidcare Program (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. Initially authorized for 10 years and then re-authorized through 2019 with federal funding through September 30, 2015, CHIP provides subsidized health insurance to uninsured children who do not qualify for Medicaid but who have family incomes under 200 percent of the federal poverty level (FPL) and meet other eligibility criteria.[11] The Florida Kidcare program is 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]

Mandated Benefits and Coverage

Section 627.6011, F.S., provides that mandated benefits regulated under ch. 627, F.S., are not intended to apply to the coverages specified in s. 627.6561(5)(b)-(e), F.S. These include:

[10] Section 408.909(1), F.S.
[11] See http://floridakidcare.org/#eligible (last visited Jan. 23, 2016)
[12] Section 409.812, F.S.

- Excepted benefits coverage, such as, coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement for liability insurance, workers'
- Limited benefits coverage, such as limited scope dental or vision benefits, benefits for long-term care, home health care, and other similar limited benefits coverage.
- Coverage only for specified disease or illness and Hospital indemnity or other fixed indemnity insurance.

III. Effect of Proposed Changes:

Sections 1 amends s. 408.909, F.S., relating to flex plans, to revise a cross reference to excepted benefits, limited benefit, and specified independent, non-coordinated 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, which is prohibited under federal law.

Sections 3 and 4 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, which is needed to review the company's request for any rating action (increase or decrease). Subsection (3)(b) contains an appropriate definition of incurred claims, which is needed for rate review.

Section 6 repeals Section 627.6011, F.S., which exempts excepted benefits from having to cover certain state mandated benefits. As a result, this would require those mandated benefits to be covered in all health insurance policies.

Section 7 updates cross references to sections amended by the bill.

Section 8 repeals 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. The PPACA requires a summary of benefits be included in individual and small group major medical policies. Therefore, excepted benefit health insurance policies and large group certificate holders would no longer receive an outline of coverage and would not be eligible for a summary of benefits.

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

Section 10 repeals s. 627.646, F.S., which contains conversion requirements.

Section 11 amends a provision relating to the Florida Comprehensive Health Association, which was repealed effective October 1, 2015.

Section 12 deletes provisions related to conversion and updates cross references to sections amended by the bill.

Section 13 repeals s. 627.64871, F.S., which requires major medical insurers to issue certifications of coverage necessary for conversion since conversion provisions are being repealed.

Sections 14 and 15 amend provisions relating to the Florida Comprehensive Health Association (FCHA), which were repealed effective October 1, 2015. (ss. 627.6488 and 627.6498, F.S.)

Section 16 updates cross references to sections amended by the bill.

Section 17 amends Section 627.6513, F.S., to revise a cross reference to excepted benefits, which is amended by the bill.

Section 18 updates cross references to sections amended by the bill.

Sections 19 and 27 repeal the sections governing when an insurer or HMO may exclude pre-existing conditions under s. 627.6561, F.S., or s. 641.31071, F.S. The federal law prohibits insurers from excluding pre-existing conditions.

Section 20 defines "creditable coverage," as it relates to dependent coverage.

Section 21 updates cross references to sections amended by the bill.

Section 22 repeals provisions related to conversion policies.

Section 23 amends 627.6699, F.S., relating to the Employee Health Care Access Act, to update cross references to sections amended by the bill, provides a definition of "late enrollee" and deletes a provision related to pre-existing conditions.

Sections 24 and 25 update cross references to sections amended by the bill.

Section 26 deletes 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.

Section 28 deletes provisions related to conversion.

Section 29 updates cross references to sections amended by the bill.

Sections 30 and 31 repeal provisions related to conversion.

Section 32 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:

According to the OIR, the right to convert coverage continues to be a significant and important benefit for some insureds. Maintenance of a statutory right to conversion is still necessary to ensure that individuals do not have a lapse in coverage after leaving employment or losing eligibility under their own policy.[13]

The effective date of this bill is July 1, 2016. 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.[14]

Section 8 repeals the requirement to provide an outline of coverage and summary of benefits for policies. Therefore, excepted benefit health insurance policies and large group certificate holders would no longer receive an outline of coverage and would not be eligible for a summary of benefits.

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

C. Government Sector Impact:

None.

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 the whole section removes the definition of incurred claims, which is needed to review the company's request for any rating action (increase or decrease). Subsection (3)(b) contains an appropriate definition of incurred claims which is needed health insurance and for rate review and needs to be reinstated.

Sections 11, 14, and 15 amend ss. 627.6486, 627.6488, and 627.88, F.S., relating to the Florida Comprehensive Health Association, which were repealed effective October 1, 2015 by ch. 2013-11, L.O.F.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 408.909, 409.817, 624.123, 627.402, 627.411, 627.6425, 627.6486, 627.6487, 627.6488, 627.6498, 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: 627.6011, 627.642, 627.646, 627.64871, 627.6561, 627.6675, 641.31071, 641.3921, and 641.3922.

IX. Additional Information:

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

None.

B. Amendments:

None.