HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 543 Small Group Health Insurance
SPONSOR(S): Stark and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 910

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	13 Y, 0 N	Tuszynski	Poche
2) Insurance & Banking Subcommittee	11 Y, 0 N	Peterson	Luczynski
3) Health & Human Services Committee	13 Y, 0 N	Tuszynski	Calamas

SUMMARY ANALYSIS

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, reporting of medical loss ratios and payment of rebates, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements.

The Florida Employee Health Care Access Act (EHCAA) was enacted 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. The EHCAA requires health insurers and health maintenance organizations (small employer carriers) in the small group market to offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer.

A small employer carrier that offers coverage to a small employer must offer coverage to all of the employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees. A small employer is not required by state or federal law to provide insurance to its employees, or, if coverage is provided to employees, to make it available to their dependents.

Under PPACA, if the cost of an employee-sponsored plan would cover an employee for 9.66 percent or less of household income the plan is considered affordable. The definition of "affordable" – for both an individual employee and a family – is based on the cost of individual-only coverage and does not take into consideration the often significantly higher cost of a family plan. This may make the cost of covering the employee's dependents unaffordable because the employee and his or her dependents are not eligible for premium tax credits to purchase a health insurance plan on the Health Insurance Marketplace (Marketplace), nor are they eligible for cost-sharing reductions to lower their out-of-pocket payments for health services once they are offered affordable coverage under this definition.

HB 543 amends s. 627.6699(5)(e)5., F.S., to provide a small employer with the option to offer employee-only coverage to all eligible employees. A small employer may still offer coverage to the spouse and dependents of an eligible employee, but is not required to offer such coverage.

By allowing a small employer to offer only employee-only coverage, dependents would not have an offer of affordable employer-based coverage that otherwise would disqualify them from receiving premium tax credits or other cost-sharing reductions to offset the cost of an insurance plan through the Marketplace. Such coverage through the Marketplace may be less expensive than the cost of the family coverage through employer-sponsored insurance.

This bill does not appear to have a fiscal impact on state or local government.

The bill provides for an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Patient Protection and Affordable Care Act

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.[1] PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, reporting of medical loss ratios and payment of rebates, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements.[2]

Many of the changes outlined in PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[3] For example, PPACA requires coverage offered in the individual and small group markets to provide the following categories of services (essential health benefits package):[4]

- 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

PPACA prohibits an insurer from establishing rules for eligibility based on any of the following health status-related 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.[5]

PPACA – Limited Preemption of State Law

Under the U.S. Constitution's Supremacy Clause, a federal law may preempt state law.[6] Preemption occurs when Congress intentionally enacts legislation that is intended to supersede state law on the same subject.[7] In PPACA, Congress expressed that the federal law preempts state law only to the extent that it prevents the application of a provision of PPACA.[8]

[1] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148. On March 30, 2010, PPACA was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.
[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] 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 § 1251*;* 42 U.S.C. § 18011.
[4] PPACA § 1302; 42 U.S.C. § 300gg-6.
[5] PPACA § 1201; 42 U.S.C. § 300gg-4.
[6] U.S. Const. art. VI, cl. 2.
[7] *West Florida Regional Medical Center v. See*, 79 So.3d 1, 15 (Fla. 2012).
[8] PPACA § 1321(d); 42 U.S.C. § 18041(d).

Title I of PPACA, which includes the requirements related to health insurance regulation, contains the following provision:

> *No Interference With State Regulatory Authority – Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.*[9]

Though expressed in the negative, PPACA preempts any state law that prevents the application of a provision of PPACA. PPACA effectively allows states to adopt and enforce laws that do not directly conflict with PPACA, but preempts any state law that does.[10]

Health Insurance Marketplace

The Health Insurance Marketplace (Marketplace) is a federal online shopping platform for people to purchase insurance if they do not have insurance through their employer, Medicare, Medicaid, the Children's Health Insurance Program, or another source that provides qualifying coverage.[11] An individual may purchase insurance through the Marketplace even if he or she has access to employer-sponsored insurance. However, an individual with access to employer-sponsored insurance is only eligible for premium tax credits if the employer's insurance option does not meet certain standards.[12]

Health Insurance Premium Tax Credits in the Marketplace

Under PPACA, individuals and families with incomes between 100 percent and 400 percent of the Federal Poverty Level ($11,770 - $46,080 for an individual and $24,250 - $ 97,000 for a family of 4)[13] who purchase coverage through the Marketplace are eligible for a tax credit to reduce the cost of coverage. The amount of the tax credit varies based on income such that the premium a person would have to pay for the second least expensive silver plan[14] on the Marketplace would not exceed a percentage of their income, as follows:[15]

Income Level	Premium as a Percent of Income
Up to 133 percent FPL	2.03 percent of income
133 – 150 percent FPL	3.05 – 4.07 percent of income
150 – 200 percent FPL	4.07 – 6.41 percent of income
200 – 250 percent FPL	6.41 – 8.18 percent of income
250 – 300 percent FPL	8.18 – 9.66 percent of income
300 – 400 percent FPL	9.66 percent of income

[9] Id.
[10] National Association of Insurance Commissioners, *"Preemption and State Flexibility in PPACA" available at* http://www.naic.org/documents/index_health_reform_general_preemption_and_state_flex_ppaca.pdf (last visited February 11, 2016).
[11] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *A quick guide to the Health Insurance Marketplace*, available at: https://www.healthcare.gov/quick-guide/ (last viewed February 11, 2016).
[12] *Id.*
[13] HEALTHCARE.GOV, *Federal Poverty Guidelines*, *available at* https://aspe.hhs.gov/2015-poverty-guidelines (last visited February 11, 2016).
[14] PPACA designates required coverage levels as bronze, silver, gold, or platinum. Each of these tiers corresponds to an actuarial value of the qualified health plans within that tier. The actuarial value corresponds to the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70 percent, on average, an individual would be responsible for 30 percent of the costs of all covered benefits through co-pays and other cost-sharing mechanisms. The corresponding actuarial values to PPACA tiers are: Bronze – 60 percent; Silver – 70 percent; Gold – 80 percent; and Platinum – 90 percent.
[15] INTERNAL REVENUE SERVICE, *Internal Revenue Bulletin: 2014-50*, Dec. 8, 2014, *available* at https://www.irs.gov/irb/2014-50_IRB/ar11.html (last visited February 11, 2016).

Florida Employee Heath Care Access Act

The Employee Health Care Access Act (EHCAA)[16] was enacted 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.[17] The EHCAA requires health insurers and health maintenance organizations (small employer carriers) in the small group market to offer and issue all small employer benefit plans on a guaranteed-issue basis to every eligible small employer.[18] The EHCAA defines a small employer in terms of businesses with 50 or fewer employees.[19]

A small employer carrier that offers coverage to a small employer must offer coverage to all of the small employer's eligible employees[20] and their dependents.[21,22] A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.[23] In the small group market, under most employer-sponsored group health plans, employers subsidize the employee's premium but dependent coverage is offered under the plan completely at the employee's expense.[24]

A small employer is neither required by state or federal law to provide insurance to its employees, nor, if coverage is provided to employees, to make it available to their dependents.[25] Thus, a small employer could decline the dependent coverage that a small employer carrier is required by the EHCAA to offer. The Office of Insurance Regulation (OIR) indicates that there is confusion in the insurance market as to whether a small employer has the option to offer only employee-only coverage.[26] The confusion is that, in the open market, small employer carriers have never given small employers the option of not offering dependent coverage; however, carriers who participate in the Small Business Health Options Program Marketplace under PPACA are required to offer employee-only coverage.[27]

Employer-Sponsored Insurance Offered to Dependents

Eligibility for federal premium tax credits to purchase health insurance from the Marketplace is not solely determined by income. It is also subject to whether a family has access to affordable employer-sponsored insurance.[28] Under PPACA, an individual and family members who can enroll in "affordable" employer-based health insurance are not eligible for federal tax subsidies to reduce the price of a Marketplace plan or for cost-sharing reductions to lower their out-of-pocket payments for health services. However, the federal definition of "affordable" – for both an individual employee and a family – is based on the cost of individual-only coverage and does not take into consideration the often significantly higher cost of a family plan.[29]

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[16] s. 627.6699, F.S.
[17] Ch. 92-33, Laws of Fla.
[18] s. 627.6699(5)(b), F.S.
[19] s. 627.6699(3)(v), F.S.
[20] Section 627.6699(3)(g), F.S., defines an "eligible employee" as an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements or other requirements of this act. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.
[21] Section 627.6699(3)(f), F.S., defines a "dependent" as the spouse or child of an eligible employee, subject to the applicable terms of the health benefit plan covering that employee.
[22] s. 627.6699(5)(e)5., F.S.
[23] Id.
[24] Infra. note 36, at 2.
[25] Florida Office of Insurance Regulation, *Agency Analysis of 2016 House Bill* 543, p. 2 (Dec. 18, 2015). *See generally* HEALTHCARE.GOV, *How the Affordable Care Act affects small businesses,* https://www.healthcare.gov/small-businesses/health-care-law-and-business/how-aca-affects-businesses/ (last visited February 11, 2016).
[26] OIR Analysis of HB 543, *Supra note 25,* at 4.
[27] Infra. Note 36, at 2.
[28] Health Affairs, *Health Policy Briefs, The Family Glitch*, at 1, *available at:* http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129 (last visited February11, 2016).
[29] Id.

An employer-sponsored plan is deemed "affordable" if the coverage to the employee costs less than 9.66 percent of household income, even if the cost for family coverage is substantially higher.[30] For example, if an employee can purchase an employee-only plan and the cost is only 9.5 percent of his or her household income, but the family option costs 13 percent of household income, the family members are still ineligible for premium tax credits. This is referred to as the "family glitch"[31] in PPACA – the family is priced out of the Marketplace because they have been offered an affordable employee-sponsored plan and are not eligible for premium tax credits, yet the employer-based family option is out of the family's budget.

Florida Health Insurance Advisory Board

The Florida Health Insurance Advisory Board (Board) was established in 1992 as the Small Employer Health Reinsurance Program.[32] Its purpose was to promote the availability of health care coverage to small employers.[33] At that time, Board members were primarily representatives of health insurers licensed under ch. 624 or 641, F.S.[34] In 2005, the Legislature expanded the composition of the Board to include representatives of employers, an individual policyholder, and a representative from the Agency for Health Care Administration (AHCA). [35] The Board's responsibilities were expanded to include an advisory role on health insurance issues to the Office of Insurance Regulation (OIR), AHCA, the Department of Financial Services, other executive departments and the Legislature.[36]

In its legislative recommendations for 2014, [37] 2015, [38] and 2016[39] the Board recommended that Florida law be amended to clarify that small group employers may offer only employee-only coverage, which would allow spouses and dependents to obtain coverage in the Marketplace, where they may qualify for a premium tax credit.

Effect of the Proposed Changes

HB 543 amends s. 627.6699(5)(e)5., F.S., to provide a small employer with the option to offer only employee-only coverage to all eligible employees and not offer dependent coverage. The bill clarifies that a small employer may offer coverage to the spouse and dependents of an eligible employee, but is not required to offer such coverage.

This clarification allows employers to inform small group carriers that they have made the choice to offer employee-only coverage. This, in turn, allows the small group carrier to offer such coverage and not extend an offer of coverage to dependents of an eligible employee.

By clarifying that a small employer is not required to offer dependent coverage, dependents will not have an offer of affordable employer-based coverage that would otherwise disqualify them from obtaining premium tax credits to offset the cost of an insurance plan through the Marketplace. Insurance through the Marketplace, subsidized by the premium tax credits, may be cheaper than the cost of the family coverage through employer-sponsored insurance.

B. SECTION DIRECTORY:

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[30] Id.
[31] Id.
[32] FLORIDA OFFICE OF INSURANCE REGULATION, *Florida Health Insurance Advisory Board*, *available at* http://www.floir.com/sections/landh/fhiab.aspx (last visited February 11, 2016).
[33] Id.
[34] Id.
[35] Ch. 2005-231, Laws of Fla.
[36] Id.
[37] FLORIDA OFFICE OF INSURANCE REGULATION, *Florida Health Insurance Advisory Board*, *2014 Legislative Recommendations*, *available at* http://www.floir.com/siteDocuments/FHIABLegRecommendations2014.pdf (last visited February 11, 2016).
[38] FLORIDA OFFICE OF INSURANCE REGULATION, *Florida Health Insurance Advisory Board*, *2015 Legislative Recommendations*, *available at* http://www.floir.com/siteDocuments/FHIABLegRecommendations2015.pdf (last visited February 11, 2016).
[39] FLORIDA OFFICE OF INSURANCE REGULATION, *Florida Health Insurance Advisory Board*, *2016 Legislative Recommendations*, *available at* http://www.floir.com/siteDocuments/FHIABLegRecommendations2016.pdf (last visited February 11, 2016).

Section 1: Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act.
Section 2: Provides for an effective date of July 1, 2016.

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:

For low to moderate-income families that qualify for premium tax credits to purchase health insurance through the Marketplace, dependents of employees of a small employer may have access to less expensive coverage as compared to the cost of family coverage through the employer. The OIR has expressed concern, however, that the effect of the bill may be for small employers to drop dependent coverage, even under circumstances where a less expensive option may not be available in the Marketplace.[40]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

[40] OIR Analysis of HB 543, Supra. note 25, at 4.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES