HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/CS/HB 997 Health Plans
SPONSOR(S): Health & Human Services Committee, Insurance & Banking Subcommittee; Health Market Reform Subcommittee; Gregory
TIED BILLS: **IDEN./SIM. BILLS:** SB 1422

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	12 Y, 3 N, As CS	Grabowski	Crosier
2) Insurance & Banking Subcommittee	15 Y, 0 N, As CS	Fortenberry	Luczynski
3) Health & Human Services Committee	11 Y, 5 N, As CS	Grabowski	Calamas

SUMMARY ANALYSIS

The federal government issued regulations in 2018 that would allow for more widespread availability of association and short-term health insurance. The bill amends the Florida Insurance Code to allow for the expanded availability of association and short-term health insurance as permitted under the revised federal regulations.

CS/CS/CS/HB 997 amends the Florida Nonprofit Multiple-Employer Welfare Arrangement Act to allow employers of disparate trades or industries to establish association health plans. Under current law, only employers who share a common trade or business interests may do so and employer associations must serve a primary purpose other than the provision of health insurance benefits. The bill revises this requirement by indicating an association may be established for the purpose of providing health benefits, so long as it serves at least one other professional purpose. The bill eliminates the current statutory requirement that an association be established at least one year prior to offering health benefits to employees of participating employers.

The bill also provides greater flexibility for the use of short-term health insurance by allowing an insurer to provide short-term health insurance for a period of up to 12 months, with the opportunity for renewal up to a total coverage period of 36 months. These extended policy terms are consistent with the parameters on short-term health insurance included in the revised federal regulations. The bill amends the Insurance Code to specify that short-term health insurance is not subject to the state prohibition on placing preexisting condition provisions in individual health insurance contracts. This change will give insurers the opportunity to use some medical underwriting when offering short-term health insurance, and is consistent with the use of short-term health insurance as a bridge between comprehensive policies.

The bill requires the Office of Insurance Regulation (OIR) to evaluate the state's current essential health benefits (EHB) benchmark plan, as required under the Patient Protection and Affordable Care Act (PPACA). Currently, the state must select, or default to, a Florida-based commercial health insurance plan as its method of satisfying the EHB requirements. The study must include a comparison of the overall costs of EHB-benchmark plans used by other states with the overall costs of the current EHB-benchmark plan in Florida.

The bill provides issuers of health insurance with increased flexibility in designing EHB-compliant plans to meet the requirement of providing at least one service or coverage under each of the 10 EHBs. The bill allows insurers to meet the EHB requirements by replacing one or more of its current EHBs coverages with those available in another state; or creating a new EHB plan that meets the federal requirements for the provision of at least one service or coverage under each of the 10 EHB categories.

Finally, the bill further addresses preexisting conditions in health insurance contracts by requiring that, in the event that PPACA is repealed or invalidated, each insurer or health maintenance organization shall offer at least one comprehensive major medical policy or contract that does not exclude or delay coverage based upon preexisting medical conditions.

The bill has no fiscal impact on state or local government.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Association Health Plans (AHPs)

An association health plan (AHP) is a group purchasing arrangement in which members of a trade group or professional association jointly obtain health insurance for employees. These arrangements differ from traditional group insurance by virtue of their unique structure, since they involve the purchase of insurance products across multiple employers.

Federal Regulation of AHPs

Employment Retirement Income Security Act (ERISA)

Congress effectively federalized the regulation of health benefits provided by large employers with the passage of the Employment Retirement Income Security Act of 1974.[1] The law sets parameters on private-sector employee health benefit plans and protects the interests of individuals who enroll in such plans. However, states retain the authority to regulate a substantial share of employer-provided health care benefit plans. ERISA does not prevent a state from regulating the activities of health *insurers*, and can be described as follows:

> *ERISA does not preempt state insurance law. The result is a dual regulatory framework. To the extent that an ERISA plan pays directly out of plan assets (a "self-funded plan"), it is exempt from state regulation. To the extent that the plan purchases insurance to cover some or all of its benefit obligations (an "insured plan"), the state's regulatory authority over the insurance contract results in indirect state regulation of aspects of the plan.*[2]

Under ERISA, AHPs are one form of a class of employee benefit plans known as "multiple-employer welfare arrangements" (MEWAs). ERISA defines MEWAs as employee health benefit plans that are established to provide benefits to the employees of two or more employers.[3] Upon meeting certain conditions, these benefit arrangements can be treated as a single employer for regulatory purposes. In order for a MEWA to constitute an "employer" under ERISA, there must be a *bona fide* group or association of employers joined together to provide benefits for their employees.[4] ERISA dictates that a *bona fide* group or association must consist of employers who share a "commonality of interests" with respect to employment relationships, meaning that the employers must be engaged in a similar trade or business activity that links their interests.[5]

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[1] 29 U.S.C. 1001 et seq.
[2] National Association of Insurance Commissioners, "Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation, 2004. Available at https://www.naic.org/documents/prod_serv_legal_ers_om.pdf (last accessed December 12, 2018).
[3] 29 U.S.C. 1002(40).
[4] U.S. Department of Labor, Employee Benefits Security Administration, "Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation", August 2013. Available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf (last accessed December 13, 2018).
[5] The "commonality of interest" test is derived from ERISA section 3(5), 29 U.S.C. 1002(5). Various advisory opinions from the U.S. Department of Labor have used this rationale to determine whether an employer group is *bona fide* under ERISA. See, for example, DOL Advisory Opinion 2017-02AC, available at https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/advisory-opinions/2017-02ac (last accessed December 13, 2018).

Section 514(b)(6) of ERISA provides a special exception for the application of state insurance laws to MEWAs – meaning that such plans are subject to both federal and state regulation.[6]

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA)[7] imposed extensive requirements on health insurers and health insurance policies relating to required benefits, rating and underwriting standards, required review of rate increases, and other requirements.[8] Among its sweeping changes to the U.S. health care system are 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.[9]

Many of the changes in the PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[10] For example, the PPACA requires coverage offered in the individual and small group markets to provide certain categories of services, called essential health benefits.[11]

Also, the PPACA requires that premiums for individual and small group policies may vary only by:[12]

- 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.

The 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.[13]

Additionally, the PPACA established minimum medical loss ratio (MLR) requirements for group and individual health insurance plans.[14] MLR refers to the percentage of insurance premium payments that are actually spent on medical claims by an insurer. In general, MLR requirements are intended to increase price transparency for consumers while promoting efficiency among insurers.[15] Under the PPACA, large group plans must dedicate at least 85 percent of premium payments to medical claims, while small group and individual market plans must dedicate at least 80 percent of premium payments to medical claims.[16]

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[6] 29 U.S.C. 1144(b)(6)(A).
[7] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148.
[8] 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.
[9] Under PPACA, the prohibition on preexisting condition exclusion refers to the fact that health insurance companies cannot refuse coverage or charge higher premiums to those who have a "pre-existing condition" — that is, a health problem that existed before the date that health coverage starts. Prior to passage of the PPACA, employers and insurers could exclude coverage for pre-existing conditions for a period of time if an individual had not maintained continuous insurance coverage, unless prohibited by state law.
[10] 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 s. 1251; 42 U.S.C. s. 18011.
[11] PPACA s. 1302; 42 U.S.C. 300gg-6.
[12] PPACA s. 1201; 42 U.S.C. 300gg.
[13] PPACA s. 1201; 42 U.S.C. s. 300gg-4.
[14] PPACA s. 1001; 42 U.S.C. 300gg-18.
[15] "Explaining Health Care Reform: Medical Loss Ratio (MLR)", Henry J Kaiser Family Foundation, February 29, 2012. Available at https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ (last accessed January 2, 2019).
[16] Supra note 14.

AHPs are subject to a "look through" provision that dictates how a participating employer is categorized for PPACA compliance purposes. Guidance released by the Centers for Medicare and Medicaid Services (CMS) in 2011 describes the "look through" concept as follows:

> *CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market* rules.[17]

This means that each employer participating in an AHP is considered to have established a separate group health plan for its own employer and each employer is independently subject to PPACA's coverage requirements – unless the AHP is determined to be a *bona fide* association under ERISA. Since many PPACA coverage requirements are only applicable to the individual and small group markets, the self-employed and small employers cannot use AHPs as a vehicle to gain flexibility without meeting the ERISA definition of "employer".[18]

Revised Federal Rule on AHP Participation

On June 21, 2018, the Employee Benefits Security Administration within the federal Department of Labor (DOL) issued a final rule amending the parameters for AHPs,[19] consistent with the directives of a 2017 Presidential Executive Order.[20] The revised regulations are intended to give an employer greater flexibility to participate in an AHP. The new federal rule:

- Revises the commonality of interest requirement by allowing AHPs to be established based on either industry or geography;
- Permits an AHP to be established for the explicit purpose of providing health insurance, so long as the association has another legitimate purpose for members;
- Allows for participation in an AHP by the self-employed and sole proprietors; and,
- Eliminates the "look-through" approach previously adopted by CMS for the categorization of employer-sponsored health benefits.[21]

This new federal rule is designed to offer an expanded pathway for the establishment of an AHP. Employers who do not operate in the same trade or industry now have the option to initiate an AHP, so long as the association is limited to members within a single state or metropolitan area. Moreover, the rule opens the door to participation by self-employed individuals, who were not previously eligible to participate because they had not been considered "employers" as that term is defined under ERISA.[22]

The new rule also diverges from previous ERISA interpretation by allowing AHPs to form for the primary purpose of providing health insurance benefits to employees of participating employers. The Department of Labor had previously held that the provision of health benefits could not be the principal purpose underlying establishment of an AHP. The new rule eases this standard by indicating that an

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[17] Centers for Medicare and Medicaid Services, "Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations," *Insurance Standards Bulletin Series—INFORMATION.* September 1, 2011. Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf (last accessed December 14, 2018).
[18] Alden J. Bianchi, "Association Health Plan Perspectives (Part 2): The Look-Through Rule and the Limits of State Regulatory Power", *The National Law Review*. October 3, 2018. Available at https://www.natlawreview.com/article/association-health-plan-perspectives-part-2-look-through-rule-and-limits-state (last accessed December 14, 2018).
[19] Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans, 83 FR 28912. June 21, 2018.
[20] Promoting Healthcare Choice and Competition Across the United States, 82 FR 48385. October 21, 2017.
[21] Milliman, Inc. "Association health plans after the final rule", August 22, 2018. Available at http://www.milliman.com/insight/2018/Association-health-plans-after-the-final-rule/ (last accessed December 6, 2018).
[22] Supra note 19.

AHP must only satisfy some legitimate purpose for member employers, above-and-beyond the provision of health benefits.[23]

Lastly, the 2018 federal guidance affirms the ability of states to regulate AHPs, so long as existing ERISA law does not preclude them from doing so.[24]

State Regulation of AHPs

The regulatory oversight of health insurance is generally reserved to the states, except when explicitly preempted by federal law. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code.[25]

All health insurance policies issued in Florida, with the exception of certain self-insured policies,[26] must meet certain requirements that are detailed throughout the Florida Insurance Code. Chapter 627, F.S., sets parameters and requirements for health insurance policies and ch. 641, F.S., provides requirements for health plans issued by HMOs. At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[27]

Florida Nonprofit Multiple-Employer Welfare Arrangement Act

The Florida Nonprofit Multiple-Employer Welfare Arrangement Act (MEWA Act) was enacted in 1983 to regulate self-funded MEWAs operating in the state.[28] Under this law, a MEWA is an employee welfare benefit plan maintained for the purpose of offering health insurance benefits to employees of two or more employers, or to their beneficiaries.[29] This definition is consistent with the federal standard included in ERISA. Among other requirements, a MEWA must have a certificate of authority issued by OIR, must be operated in accordance with sound actuarial principles, must maintain appropriate loss reserves, and must maintain a fund balance equal to 10 percent of its total liabilities.[30] Current law provides an exception to the MEWA regulatory laws for a MEWA which is fully insured by an authorized insurer or an arrangement exempt under the provisions of ERISA.[31]

There are currently two self-funded MEWAs operating in the state, accounting for approximately 21,000 covered lives.[32] The participation parameters currently in the MEWA Act limit the ability of unrelated employers to form MEWAs. MEWAs may only be established among employers who share a common trade or profession,[33] in keeping with federal ERISA standards. At present, statutes prevent employers from exercising the additional flexibility provided to them under the revised federal rule on AHPs. If the statutes are amended to mimic the federal rule, additional employers may seek to form MEWAs in an effort to obtain more affordable employee health benefits.

[23] Avalere Health, "Association Health Plans: Projecting the Impact of the Proposed Rule", prepared for America's Health Insurance Plans (AHIP). February 28, 2018. Available at http://go.avalere.com/acton/attachment/12909/f-052f/1/-/-/-/-/Association%20Health%20Plans%20White%20Paper.pdf (last accessed December 14, 2018).
[24] Supra note 18.
[25] S. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[26] 29 U.S.C. 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida. These plans cannot be regulated by state law.
[27] S. 627.413(1)(d), F.S.
[28] Ss. 624.436 – 624.446, F.S.
[29] S. 624.437(1), F.S.
[30] Ss. 624.426–624.446, F.S.
[31] S. 624.437(3), F.S.
[32] E-mail correspondence from Caitlin Murray, Director of Government Affairs for OIR, December 18, 2018.
[33] S. 624.438(1), F.S.

Short Term Health Plans (STHPs)

Short-term health insurance has traditionally been available to individuals seeking to fill a temporary gap in health coverage due to a period of unemployment or temporary ineligibility for employer-sponsored coverage.[34] STHPs tend to provide coverage that is limited in scope relative to comprehensive health insurance. Many STHPs are, however, associated with much lower premiums than comprehensive health plans, making them attractive to many healthy individuals who may not have significant health care needs.[35]

Federal Regulation of STHPs

Health Insurance Portability and Accountability Act

Statutory definitions of short-term health insurance are primarily derived from the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[36] and its associated regulations. While HIPAA is most often associated with standards relating to the security of personal health information, the law also established initial limits on the ability of health plans to deny coverage to individuals with certain preexisting health conditions. In doing so, HIPAA made revisions to the definition of "individual health insurance coverage" included in the Public Health Service Act.[37] HIPAA specified that short-term health insurance would be exempt from certain coverage requirements – such as guaranteed availability and renewal – but also set a clear limit on the length of health insurance policies that qualified as STHPs.[38]

In implementing HIPAA, the federal Department of Health and Human Service (HHS) issued regulations defining short-term, limited duration health insurance as follows:

> *Short-term, limited duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within **12 months** of the date such contract becomes effective. (emphasis added)*[39]

Under the HIPAA standard, insurers were allowed to offer STHPs to consumers, but only for a term period of 12 months or less. HIPAA does not allow renewal of such policies, as STHPs were intended to fill temporary gaps in primary coverage.[40]

Patient Protection and Affordable Care Act

The PPACA does not explicitly define or refer to short-term health insurance. STHPs are not subject to many PPACA coverage requirements – such as the prohibition on medical underwriting, the elimination of preexisting conditions exclusions, the mandated essential health benefits, and the MLR standards. Federal guidance issued in 2016[41] indicated that STHPs may occasionally be purchased in lieu of primary coverage – since it is often much less expensive than PPACA-compliant health insurance.

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[34] Karen Pollitz et al., "Understanding Short-Term Limited Duration Health Insurance", Henry J. Kaiser Family Foundation, April 23, 2018. Available at https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/ (last accessed December 18, 2018).
[35] "State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Short-Term Health Plans," Georgetown University Center on Health Insurance Reforms and the Robert Wood Johnson Foundation, December 2017. Available at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf441920 (last accessed December 18, 2018).
[36] Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191.
[37] Public Health Service Act, Pub. L. No. 78-410, As Amended Through P.L. 115–302.
[38] "The Short-Term, Limited-Duration Coverage Final Rule: The Background, The Content, And What Could Come Next", Health Affairs Blog, August 1, 2018. Available at https://www.healthaffairs.org/do/10.1377/hblog20180801.169759/full/ (last accessed January 2, 2019).
[39] Interim Rules for Health Insurance Portability for Group Health Plans, 62 FR 16894. April 1, 1997.
[40] Supra note 3.
[41] Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 FR 38019. June 10, 2016.

However, federal regulations limited the policy term of STHPs to 3 months and required such plans to include a disclosure on application materials indicating that short-term health insurance does not constitute minimum essential coverage under PPACA.[42] This new standard took effect on January 1, 2017, and represented a significant shift from the 12-month limit that had previously been applied to STHPs.

Revised Federal Rule on STHPs

A new federal rule issued in 2018 amended the parameters under which STHPs may operate,[43] consistent with the directives of a 2017 Presidential Executive Order.[44] The revised rule is intended to encourage the availability of short-term health insurance to individuals who require flexible policy terms or who may not require fully comprehensive health insurance subject to PPACA compliance.[45] The revised rule:

- Extends the maximum term of STHPs from three months to 12 months;
- Provides for the renewability of STHPs, up to a maximum duration of 36 months; and,
- Requires that STHPs include an explicit consumer notice that such policies may not be PPACA compliant and may not cover the full range of health care benefits required by that law.[46]

The revised rule reverts to the pre-2017 standard for the initial contract term for STHPs, reasoning that a 12-month policy term offers greater flexibility to individuals seeking temporary coverage, while simultaneously giving certain individuals a more affordable alternative to PPACA-compliant coverage. However, the rule acknowledges that STHPs will not likely provide coverage as comprehensive as PPACA-compliant plans, nor will coverage be guaranteed for consumers with preexisting health conditions and a gap in coverage. For these reasons, the rule requires that STHPs include the following disclaimer in application materials and contract documents:

> *This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.*[47]

State Regulation of STHPs

The 2018 federal regulations on STHPs reaffirm the rights of states to adopt regulatory standards that are more stringent than the federal rule. The regulations do not preempt state laws related to the sale of STHPs and afford states significant flexibility in the regulation of such products.[48]

At present, the Florida statutes do not include a formal definition of short-term health insurance, nor do the statutes set specific parameters on the availability of such coverage. The OIR, by rule, defines "short-term, limited duration insurance" as health insurance coverage with an issuer that has specified in the contract an expiration date that is within 12 months of the date the contract becomes effective,

[42] Id.
[43] Short-Term, Limited-Duration Insurance, 83 FR 38212. August 3, 2018.
[44] Supra note 20.
[45] Supra note 42.
[46] Id.
[47] Id.
[48] Supra note 5.

taking into account any extensions that may be elected by the policyholder without the issuer's consent.[49] Florida law is silent on the renewability of STHPs, so federal law has dictated policy terms in this regard.

Two insurance carriers currently offer short-term, limited duration insurance policies in Florida, accounting for roughly 16,000 policies statewide.[50] Under the 2018 federal regulations, additional carriers may seek to expand this market segment, though current statutes may limit their ability to do so. Inconsistencies in the statues regarding the maximum policy term and renewability of STHPs may presently limit the ability of carriers to offer such policies to a broader population.

Essential Health Benefits (EHBs)

PPACA requires health insurance offered in the individual and small group markets to provide coverage across ten categories of services:

- 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.[51]

Rather than define a uniform, national set of essential health benefits, the federal government allows each state to choose a benchmark plan on which to base their EHB package. States can select a plan among various options that reflected the scope of services offered by a "typical employer plan."[52] The plan must be supplemented, if necessary, to cover all categories of essential benefits. States may mandate additional benefits but must defray the expenses of enrollees for the additional cost of these benefits. Florida did not make a selection, resulting in a default to a benchmark plan which is the small group plan with the largest enrollment in the state.

On April 17, 2018, the federal Centers for Medicare and Medicaid Services (CMS) issued a final rule amending the parameters for state selection of an EHB plan.[53] Beginning with 2020 plan year, the rule gives states additional flexibility to define their EHB benchmark plan and allows them to do so on an annual basis. Under the new federal rule, states have three options to select an EHB benchmark plan:

- States may select another state's entire 2017 EHB plan;
- State may replace one or more of its EHB categories using another state's 2017 EHB plan; or,
- States may select an entirely new EHB plan. States can, however, only select a plan that is 1) at least equal in scope to a typical employer plan (a minimum EHB standard); but 2) no more generous than the most generous comparison plan (a maximum EHB standard).

The federal deadline for selecting a 2020 benchmark plan has already passed, but the additional flexibility exists for subsequent years. Noting that states are the primary enforcers of EHB policy, the

[49] Rule 69O-154.104(16), F.A.C.
[50] E-mail correspondence from Caitlin Murray, Director of Government Affairs for OIR, December 18, 2018.
[51] Supra note 11.
[52] 45 CFR 156.100(a).
[53] 45 CFR 156.111.

federal government will defer to a selecting state's implementation of any benefits and limits.[54] Although Florida has not previously taken an active role in the selection of a state EHB benchmark, the revised federal standards offer the state additional options for the development of future EHB plans.

Revised federal regulations also provide greater flexibility to issuers of insurance plans subject to EHB requirements. Beginning on January 1, 2020, an issuer of a plan offering EHB may substitute benefits for those provided in the EHB-benchmark plan under the following conditions:

- The substituted benefit is not a prescription drug benefit.[55]
- An issuer may substitute a benefit within the same benefit category, unless prohibited by state law.
- An issuer may substitute benefits between benefit categories if the state in which the plan will be offered has notified HHS that substitution between EHB categories is permitted.

Any plan with substitutions would still be required to provide benefits that are substantially equal to the EHB benchmark plan, to provide an appropriate balance among the EHB categories such that benefits are not unduly weighted towards any category, and to provide benefits for diverse segments of the population.[56]

Preexisting Condition Exclusions

PPACA prohibits group and individual health insurance plans from imposing preexisting condition exclusions.[57] This requirement of PPACA preempts state laws that allow insurers to implement preexisting condition exclusions. In general, Florida law, which has been preempted by PPACA, prohibits individual health policies from excluding preexisting conditions for more than 24 months.[58] Such excluded conditions may only relate to conditions during that 24-month period immediately prior to the effective date of coverage that would have caused an "ordinarily prudent person" to seek medical advice or treatment, and to pregnancy.[59] Individual health policies may exclude coverage for named or specific conditions without any time limit.[60] Group policies are prohibited from excluding preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee, and may only relate to conditions that manifested themselves during the six-month period prior to coverage.[61]

Effect of Proposed Changes

The bill makes several changes to the Florida Insurance Code to allow for the expanded availability of AHPs and STHPs as permitted under revised federal regulations. It also addresses the requirement that health insurance plans provide EHBs.

Association Health Plans

The bill amends s. 624.438, F.S., by deleting the requirement that a state-regulated MEWA must be established by a trade organization, industry association, or professional association for a period of at least one year prior to providing health insurance benefits. The bill further amends this section of law by eliminating the current prohibition on the establishment of a MEWA that includes employer members from disparate trades, industries, or professions. Per the revised federal regulations on AHPs, such

[54] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 74, 16930 (April 17, 2018). Available at https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019 (last accessed March 7, 2019).
[55] 45 CFR s. 156.115
[56] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 FR 16930. April 17, 2018.
[57] 42 U.S.C. s. 300gg-3
[58] S. 627.6045, F.S.
[59] *Id.*
[60] S. 627.607(2), F.S.
[61] S. 627.6561, F.S.

employer associations may include employers of various trades and industries, so long as the participating employers are all located in the same state or metropolitan area.[62]

The bill likewise amends s. 627.654, F.S., to bring the statutory parameters on labor union, association, and small employer health alliance groups into conformity with the revised federal regulations. The bill deletes the requirement that a health alliance group is established at least one year prior to providing health insurance benefits, and also deletes the requirement that such groups exist for a primary purpose other than the provision of health insurance benefits to employees of participating employers. The bill eliminates a ceiling of the number of employees that may be employed in order for an employer to qualify as a "small employer" for purposes of participating in a small employer health alliance group, since the revised federal regulations do not limit participation based on employer size.

Short-Term Health Plans

The bill provides greater flexibility for consumers who may wish to consider purchasing short-term health insurance. The bill creates a new section of law defining "short-term health insurance" as coverage provided by an issuer for a period of up to 12 months, with the opportunity for renewal up to a total coverage period of 36 months. These extended policy terms are consistent with the parameters on short-term health insurance included in the revised federal rules. In practice, this change will allow individuals to purchase short-term health insurance during extended periods of transition, such as unemployment that lasts several months or even a year. In addition, short-term health insurance my serve as an alternative to comprehensive coverage for individuals who may not require or may not be able to afford such coverage.

The bill amends s. 627.6045, F.S., to specify that short-term health insurance is not subject to the state prohibition on placing preexisting condition provisions in individual health insurance contracts. This exemption exists today, but is limited to "policies of no more than a 6 month policy term". The bill clarifies that the exemption applies to all short-term health insurance, giving insurers the flexibility to offer STHPs that may exclude applicants with preexisting health conditions as allowed under the revised federal regulations. This change should, in theory, allow for the availability of lower-cost short-term health insurance to individuals without preexisting conditions.

Essential Health Benefits

The bill requires that requires the OIR to conduct a study to evaluate the state's current EHB-benchmark plan for non-grandfathered individual and group plans and options for changing the EHB-benchmark plan, as allowed under federal regulations. The study must include a comparison of the overall costs of EHB-benchmark plans used by other states with the overall costs of the current EHB-benchmark plan in Florida. The OIR is required to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives that includes recommendations for changing the current EHB-benchmark plan. The report is due by October 30, 2019.

The bill also creates a new section of Florida law reflecting the additional flexibility provided to the state by the revised federal rules regarding EHB benefit requirements. The bill allows insurers to meet the EHB requirements by replacing one or more of its current EHBs coverages with those available in another state; or creating a new EHB plan that meets the federal requirements for the provision of at least one service or coverage under each of the 10 EHB categories. The bill authorizes an insurer or HMO to include any combination of services or coverages required in other states to provide the 10 categories of EHBs required under PPACA.

[62] Supra note 19.

Preexisting Conditions

The bill creates a new section of Florida law addressing preexisting conditions in health insurance contracts. It requires that insurer or HMO issuing major medical policies or contracts in Florida must offer, no later than 30 days after PPACA is repealed or invalidated, at least one comprehensive major medical policy or contract that does not exclude, limit, deny, or delay coverage due to one or more preexisting medical conditions. The policy offered must be one that the insurer or HMO actively marketed in Florida as of the date PPACA was repealed or invalidated and during the year immediately prior to that date.

The bill defines preexisting medical condition as a condition that was present before the effective date of coverage and includes conditions identified during a preenrollment period. The bill prohibits insurers and HMOs from limiting or excluding benefits based upon an individual's health status before the effective date of coverage. The bill also establishes that these preexisting conditions policy requirements do not apply to an insurer that issues only limited benefit, disability income, specified disease, Medicare supplement, or hospital indemnity policies.

The bill takes effect upon becoming law.

B. SECTION DIRECTORY:

Section 1: Amends s. 624.438, F.S., relating to general eligibility.
Section 2: Creates s. 627.443, F.S., relating to essential health benefits.
Section 3: Amends s. 627.6045, F.S., relating to preexisting condition.
Section 4: Creates s. 627.6046, F.S., relating to limit on preexisting conditions.
Section 5: Creates s. 627.6426, F.S., relating to short-term health insurance.
Section 6: Creates s. 627.6525, F.S., relating to short-term health insurance.
Section 7: Amends s. 627.654, F.S. relating to labor union, association, and small employer health alliance groups.
Section 8: Creates s. 627.65612, F.S., relating to limit on preexisting conditions.
Section 9: Amends s. 641.31, F.S., relating to health maintenance contracts.
Section 10: Creates unnumbered section, relating to study of state essential health benefits benchmark plan; report.
Section 11: Provides that the act shall take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None. It is possible that OIR may experience an increase in regulatory duties if the bill leads to an expansion of AHPs and STHPs in the state, but this could be absorbed within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that AHPs provide employers with a less expensive alternative to traditional group health coverage, they may incur a positive fiscal impact. Likewise, consumers who find STHPs to be a viable alternative to traditional comprehensive health insurance may experience financial benefits.

If Florida implements a new method of compliance with the EHB requirements, insurers and insureds may experience positive or negative financial impacts.

While the bill requires (if PPACA is repealed or invalidated) every health insurer and HMO to offer at least one policy or contract without preexisting medical conditions, the coverage provided by these policies or contracts may be expensive for some individuals with preexisting medical conditions because of adverse selection.[63] Individuals purchasing these policies or contracts would be expected to have a preexisting condition. By law, insurers would be permitted to pool policies or contracts covering preexisting conditions separately from other policies that do not offer preexisting conditions coverage and to underwrite these policies or contracts in a way that factors in the higher loss probability for these individuals.

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:

The bill neither authorizes nor requires administrative rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 7, 2019, the Health Market Reform Subcommittee considered the bill, adopted two amendments, and reported the bill favorably as a committee substitute. The first amendment made technical corrections to the bill to clarify that:

- Employers have the option of choosing between two paths in forming an AHP, including the original path under ERISA and the more flexible path outlined in recent federal rule.
- STHPs are not subject to guaranteed renewal requirements. Federal rule allows for the renewability of these plans up to a total term of 36 months.

[63] Adverse selection is defined as an imbalance in an exposure group created when persons who perceive a high probability of loss for themselves seek to buy insurance to a much greater degree than those who perceive a low probability of loss. IRMI, https://www.irmi.com/term/insurance-definitions/adverse-selection (last accessed Mar. 20, 2019).

The second amendment reflected revised federal guidance regarding EHBs by allowing Florida to comply with the requirement to provide at least one service or coverage under each of the 10 EHBs in one of the following ways:

- Selecting another state's plan for compliance with the EHB requirements;
- Replacing one or more of its EHBs with that from another state's plan; or
- Creating its own plan for compliance with the EHB requirements.

On March 19, 2019, the Insurance & Banking Subcommittee considered the bill, adopted one amendment, and reported the bill favorably as a committee substitute. The committee substitute addresses preexisting conditions in health insurance contracts by:

- Requiring that each insurer or HMO issuing major medical policies or contracts in Florida must offer, no later than 30 days after the PPACA is repealed or invalidated, at least one comprehensive major medical policy or contract that does not exclude, limit, deny, or delay coverage due to one or more preexisting medical conditions. The policy offered must be one that the insurer or HMO actively marketed in Florida as of date PPACA was repealed or invalidated and during the year immediately prior to that date.
- Defining preexisting medical condition as a condition that was present before the effective date of coverage and includes conditions identified during a preenrollment period.
- Prohibiting insurers and HMOs from limiting or excluding benefits based upon an individual's health status before the effective date of coverage.
- Establishing that these preexisting conditions policy requirements do not apply to an insurer that issues only limited benefit, disability income, specified disease, Medicare supplement, or hospital indemnity policies.

On April 9, 2019, the Health and Human Services Committee adopted a strike-all amendment to the bill. The amendment:

- Requires OIR to conduct a study comparing the state's essential health benefits benchmark plan under the ACA to benchmark plans selected by other states.
- Clarifies language allowing issuers of health insurance increased flexibility in meeting the essential health benefits requirements, as allowed under federal regulations.
- Makes technical changes to clarify the applicability of language requiring insurers to offer products that cover preexisting conditions.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.