

Legislative Input Discussion

Mark McGowan
Florida Blue

Carrier

1. **Certificates of Creditable Coverage (COC).**

- Health insurers are no longer allowed to impose pre-existing condition exclusions. This prohibition makes the current rules requiring plans to provide certificates of creditable coverage unnecessary. As of December 31, 2014, federal law no longer requires issuers and group health plans to issue COCs.
- Recommendation: Revise the state laws to align with federal law and eliminate the requirement. This will result in reduced administrative expenses.
- References: 627.6561; 641.31071, F.S., F.A.C. 69O-154.110, F.A.C. 69O-191.039

2. **Guaranteed Renewability.**

- Federal law requires issuers to provide 90 day discontinuance at the *product* level. The state law requires a 90 day notice whenever a *policy form* or plan is discontinued.
- This means that when a member's policy form or plan is discontinued insurers must send a 90 day state notice of discontinuance. Since this does not qualify as a federal discontinuance insurers must also provide a CMS renewal notice. The two notices (renewal and discontinuance) create confusion due to the inconsistent messaging and timing of the notices.
- Recommendation: Align state law with the new federal law. This will reduce member confusion with multiple notices in the marketplace. This will also result in reduced administrative expenses.
- References: 627.6425(3); 627.6571(3); 641.31074(3), F.S.

3. **Outline of Coverage (OOC).**

- State law requires an outline of coverage to be provided to all individual policyholders. The ACA requires a Summary of Benefit of Coverage (SBC) to also be provided to all members. In addition to the SBC and OOC, members receive a benefit booklet, schedule of benefit, benefit summaries and other collateral. The use of multiple documents for individuals creates confusion and is unnecessary.
- Recommendation: Eliminate the OOC requirement under state law. This will reduce member confusion by reducing the number of documents they receive. It will also decrease the number of OIR form filings from insurers and will result in reduced administrative expenses.
- Reference: 627.642, F.S.

4. **Name & Premium on Contract.**

- Florida law requires the name of the parties on the contract and the premium to be included on every policy. The premium amount is no longer specific to an individual due to the elimination of underwriting. Additionally, some members receive advanced premium tax credits that subsidize the premium making the amount on the contract inaccurate. Therefore there is little value in customizing contracts for standardized plans.
- Recommendation: Remove the requirements to include name and premium on the member's contract. This will result in reduced administrative expenses.
- Reference: 627.413 (a),(e); 641.31(6), F.S., F.A.C. 69O-191.033.

5. **Standard and Basic.**

- FL law requires insurers to offer small group Standard and Basic health plans. These plans' benefits do not comply with the ACA market reforms.
- Recommendation: Eliminate the requirements under state law related to Standard and Basic.
- Reference: 627.6699 (12), F.S.

Joan Galletta
J.P. Perry Insurance

Employee Benefits
Consultant

Eliminate dependent to age 30 requirement in small group. Could allow at employer's discretion. Establish 30 hours as the eligibility criteria for employees in small group, with carriers allowing eligibility at 25 hours, at the employer's discretion.

Allow employers, at their discretion, to offer employee- only coverage in small group.

- 1) Eliminate dependent to age 30 requirement in small group. Could allow at employer's discretion.

Dependent to age 30 is no longer necessary, due to guarantee issue with no pre-ex. Offer of coverage might complicate dependent's eligibility for subsidized coverage (?)

- 2) Establish 30 hours as the eligibility criteria for employees in small group, with carriers allowing eligibility at 25 hours, at the employer's discretion
Eligibility in small group should be established at 30 hours, and allow eligibility down to 25 hours at the employer's discretion. This frees up employees working low hours who have modest incomes to seek subsidized coverage in the Exchange. Also, by allowing eligibility at 25 hours at employer's discretion, rather than requiring it, reductions in hours of lower-hour employees may be discouraged and/or avoided.
- 3) Allow employers, at their discretion, to offer employee- only coverage in small group. Allowing employers in small group market to offer employee-only coverage will allow dependents of those employees to go to the Exchange and perhaps qualify for a subsidy. Employers don't usually make a contribution to the premium of dependents in a small group, so the coverage can be expensive. *No offer of coverage* frees up dependents up to qualify for subsidized coverage in the Exchange. SHOP exchange is able to offer employee-only coverage in small group. Should be consistent in both markets.

Leah Barber-Heinz
Florida CHAIN

Individual Policyholder

1. Decline to increase the minimum number of hours per week that an employee must work in order to be considered a full-time employee for purposes of determining eligibility for health insurance benefits from 25 to 30 hours per week.

Such a change would create a net adverse impact for Florida workers and their families and is unjustified.

The current income eligibility limit for Medicaid for working parents is 35% of the federal poverty level (FPL). In short, no one with income at or below 35% FPL is working 25 or more hours per week.

The vast majority of non-elderly adults working 25-29 hours per week are employed in service sector and/or low-wage jobs. The vast majority earn an hourly wage of between \$8 and \$13 per hour, with most earning toward the lower end of the wage range.

These workers qualify for coverage now, would no longer qualify if this change were made, and many would have no access whatsoever to alternative coverage because they would fall into the “coverage gap” resulting from Florida’s refusal to expand Medicaid coverage as provided for under PPACA. The proposed change would strand many workers without hope of coverage.

More specifically, all of these workers who are also single parents of two or more children universally fall into the coverage gap and would not have coverage if the threshold were increased to 30 hours. Single parents with one child fall into the gap up at any hourly wage of up to \$12 at 25 hours per week and up to \$10.40 at 29 hours. It is clear is that this change will cause harm to single parents trying to work and singlehandedly support their families. Furthermore, because child support is not counted under new income rules, even those who are receiving financial assistance will nevertheless remain stranded in the coverage gap.

By contrast, although many married workers would have sufficient income to escape the coverage gap and therefore seem to be eligible to obtain subsidized coverage in the Marketplace, a significant portion may in fact ineligible, namely those whose spouses have an affordable offer of coverage through their own employment, as a consequence of the so-called “family glitch” in PPACA regulations. In these jobs, more workers seem likely to be caught in the family glitch as a spouse than to cause a spouse to be caught.

No evidence has been offered that such a change would not create a significantly adverse aggregate impact on these workers and their families. With respect to the impact on employers, the threshold is a longstanding requirement in state law. There is no evidence whatsoever that this threshold is curtailing the creation of jobs or the hiring of new workers.

Rather, the primary justification for the law appears to be that many employers are not complying with current law and are may be attesting falsely that they are. Willful non-compliance is not a valid reason for eliminating it.

2. Decline to eliminate the provision extending coverage for certain adult children under their parents' coverage up to age 30.

This provision, enacted in 2008, is one of the few requirements in the State Insurance Code that goes beyond the minimum requirements of PPACA. Even if it were necessary to take legislative action to align with PPACA up to age 26, there is no reason that Florida could not remain above the federal floor to ensure affordable access to coverage for the small number of 26 to 30 year olds who meet the criteria and need to access coverage this way.

Florida does not need to take a step backwards in providing access to coverage. Furthermore, the marginal cost of continuing coverage for this small number of Floridians is almost certainly negligible, and we have not seen any actuarial analysis supporting the assertion that this is somehow prohibitive.

3. Require carriers in the small group market allow employers to offer "employee only" coverage.

Such a change, which is consistent with the rules for the SHOP Marketplace, would reduce the adverse impact of PPACA's family glitch without destabilizing the market. Specifically, if workers could accept affordable, quality coverage for themselves without disqualifying their spouses and dependents from access to Premium Tax Credits in the Marketplace, the result would be increased participation in both the small group market and the individual Marketplace, benefitting consumers and the industry alike.

Support Medicaid expansion as a means of ensuring that almost 800,000 uninsured Floridians who do not otherwise have access to affordable, quality coverage. This is a stated mission of the Office of Insurance Regulation. Furthermore, this coverage is already paid for and Florida is losing money it has already paid.

Second, the ACA's 30-hour threshold has more to do with large businesses. Under the ACA, businesses with at least 50 employees who do not offer coverage to employees working 30+ hours per week must pay an annual penalty of \$2,000 for each worker who obtains coverage through the Marketplace.

4. Review, recommend changes to, and consider codifying Florida's Essential Health Benefits package.

5. Establish mechanism for monitoring plans' provider network adequacy and develop minimum standards to be enforced by OIR.

Little attention has been paid to the issue of plan network adequacy and its impact on access to care and value for consumers, particularly in comparison with the scrutiny of premiums and out-of-pocket costs.

A clear, inextricable relationship exists between plan network robustness and consumer costs. As a result, pressure on plans to lower premiums, particularly in the Marketplace, has resulted in the narrowing of

networks. Narrow networks are not inherently problematic if the plan selection is the result of an informed choice and access to care is not impaired. However, reports have surfaced that some plan networks are so narrow as to threaten delayed or denied access to services. In some cases, these plans appear to have adequate networks on paper, but the reality is much different for consumers who seek to access providers on the list. Provider networks should be filed with OIR and reasonable efforts should be made to monitor the adequacy of those networks.

6. Conform/align the State Insurance Code to/with PPACA and associated federal regulations.

The Legislature should take up and approve a simple “PPACA conforming bill” that appropriately updates the Insurance Code and related state laws without seeking to undermine them. More than a dozen examples of state-federal incongruity have been identified. In most cases, the state provisions are pre-empted by PPACA, and so the federal requirements simply supersede any requirements that remain in Florida Statutes today. Leaving these obsolete provisions on the books only serves to promote confusion and provide purported justification for non-compliance with the higher PPACA standards.

7. Accept the state option to expand Medicaid coverage to most adults with incomes less than 138% of the federal poverty level.

We obviously support the extension of the Medicaid coverage umbrella to include most non-elderly adults with incomes up to 138% FPL, as envisioned by PPACA before the U.S. Supreme Court decision that made such expansion a state option. (Variations on expansion are possible, including options requiring some recipients to obtain coverage through the Marketplace rather than through Medicaid *per se*.)

In addition to the obvious benefit for uninsured Floridians who have no other access to meaningful, affordable coverage, the fiscal and economic case for expansion is compelling and undeniable. The federal government would contribute 100 percent of the cost of the newly eligible through 2016, after which the federal share would gradually decrease, reaching a *minimum* of 90 percent in 2020 and beyond.

Furthermore, although confusion abounds on this point, the vast majority of the newly eligible under Medicaid expansion would be required to enroll in a managed care plan administered by an HMO or related entity. Medicaid expansion would clearly benefit the insurance industry. Furthermore, like plans sold in the individual and small group markets, most of the expansion population would enroll in plans that must cover all Essential Health Benefits.

8. Explore the possibility of “bridging” Medicaid, CHIP and Marketplace coverage

As noted above, the preponderance of the Medicaid expansion population (as well as the CHIP population) would be enrolled in a form of capitated managed care, creating the potential for some level of integration of the Medicaid managed care and individual markets.

In particular, federal CMS has indicated that states may establish “bridge plans” and other mechanisms that promote continuity of coverage and leverage market forces. Bridge plans in particular allow individuals who are transitioning from Medicaid or CHIP coverage to Marketplace coverage to remain with the same plan and provider network. The use of such mechanisms would reduce expensive and harmful "churning" between programs.

The Legislature should consider empowering OIR and AHCA to work in collaboration to establish parameters for bridge plans or other mechanisms that encourage the use of market forces to promote continuity of coverage.

Christopher Ciano
Aetna/Coventry of FL

Carrier

Deletion of the Small Group Community Rating Report

- o Semiannually small group carriers are required to report to OIR information that enables them to monitor the relationship of aggregate adjusted premiums actually charged to policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates.
- o This report requires substantial resources and does not provide meaningful information with the implementation of PPACA.
- o Statutory Citations:
 - Section 627.6699 (6)(B)5., Florida Statutes.

Deletion of the Standard and Basic Plan

- o Currently Florida Law requires insurers to offer small group standard and basic health plan that is not PPACA compliant and cannot be sold in Florida.
- o This creates an unnecessary burden upon carriers to maintain current rates and forms for a product that cannot be sold in Florida.
- o Statutory citations:
 - Section 627.6699(12), Florida Statutes.

Deletion of Conversion/Continuation Coverage

- o Conversion rights are redundant and unnecessary based guaranteed issued policies being available in all 67 counties in Florida due to PPACA.
- o Statutory Citations:
 - Sections 627.646, 627.6487, 627.6675, 627.6692, 641.3921 and 641.3922, Florida Statutes.

PPO Balance Billing Prohibition

- o While there is currently is a prohibition against balance billing for the Florida HMO commercial market place, there is no such prohibition that exist for Florida PPO commercial business.
- o Statutory citations:
 - This would require new statutory authority.

Delivery System Consolidation

- o In 2012, the number of specialty physicians who see patients at hospitals and are employed by the hospitals more than quadrupled (from 5% to 25%) and the equivalent share of primary-care physicians doubled (from 20% to 40%), from 2000 numbers. This was largely due to hospital acquisitions of physician practices.
- o Hospitals state that these acquisitions help “eliminate duplication, improve coordination, and reduce hospitalizations: and are part of “more proactive management of patients”. Typically, acquired medical groups come under the contractual arrangements of the entity they join, so services performed by physicians are paid at hospital systems' rates, sometimes more than doubling the cost.
- o Statutory citations:
 - This would require new statutory authority.

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Medicaid Expansion