

FLORIDA HEALTH INSURANCE ADVISORY BOARD
Board of Directors Meeting Minutes
Tuesday, February 3, 2015
3:00 P.M.
Via Teleconference
Tallahassee, Florida

Board Members Present:

Kevin M. McCarty, Chair	William "Bill" Herrle	Tamara Meyerson
W. Adam Clatsoff, Vice Chair	Christopher Ciano	Joan L. Galletta
Leah Barber-Heinz	Brad Bentley	Rick Wallace
Seth Phelps for Mark S. McGowan	Molly McKinstry	John Matthews

Others Present:

Michelle Newell, Executive Director
Jeffrey Joseph, Assistant General Counsel, Office of Insurance Regulation
Rich Robleto, Deputy Commissioner, Office of Insurance Regulation

I. Call to Order

Commissioner Kevin McCarty called the telephonic meeting to order at 3:00 p.m. indicating the meeting was properly noticed to the public in accordance with Florida law.

II. Roll Call

Michelle Newell conducted a roll call, noting the presence of a quorum.

III. Antitrust Statement

Jeffrey Joseph was recognized to review the antitrust statement.

IV. Chair's Opening Remarks

Commissioner McCarty opened the meeting by outlining the agenda and format for discussion and presentation of additional research on the outstanding legislative items. Commissioner McCarty also indicated Leah Barber-Heinz would present a proposal on Essential Health Benefits.

V. Approval of Minutes

The Chair presented the minutes from the December 9, 2014, and December 19, 2014, meetings for adoption, noting that members had been provided with advance copies. Joan Galletta moved to approve the minutes as written. The motion was seconded by W. Adam Clatsoff and the minutes were adopted as written without objection.

VI. Legislative Discussion Follow-up Assignments

- 1) Eliminate dependent to age 30 requirement in small group.

After much discussion among the Board regarding tax status of dependents, employer responsibility, Section 125 and ERISA rights, the Board agreed there are advantages to keeping the system intact and compelling arguments to change it. Commissioner McCarty indicated consensus could not be reached at this time.

- 2) Establish 30 hours as the eligibility criteria for employees in small group (allowing 25 hours at employer's discretion).

The Board determined that this issue would be tied to expanded Medicaid. There was discussion regarding provisional language. Mr. Clatsoff made a motion to accept provisional language. Ms. Barber-Heinz seconded the motion. After discussion regarding increasing flexibility for employers only feasible if Medicaid expansion occurs, the motion passed.

Provisional – the Board recommends in the event the Legislature expands Medicaid, establish the eligibility for coverage at 30 hours and allow eligibility to 25 hours at the employer's discretion.

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

OIR contacted AHCA to get information and it has been provided. Also provided information on what the federal government is doing. Federal government is looking at any plans going on the Exchanges. AHCA's Commercial Managed Care Unit reviews all commercial product lines of business as it pertains to Health Maintenance Organizations, Pre-paid Health Clinics, and Exclusive Provider Organizations. Ms. Barber-Heinz indicated the NAIC is working on revising and improving the Health Benefit Plan Network Access and Adequacy Model Act. While the Act is not completed yet, it will be used as model legislation around the country. It will not be ready for our Legislative Session; however, it could be revisited at a later time. The Federal government (HHS) has also indicated they are waiting on the NAIC to finish the Model Act as they will likely adopt it. The Board decided to revisit this issue after passage of the Model Act by the NAIC.

- 4) Accept the state option to expand Medicaid coverage to most adults with incomes less than 138% of the federal poverty level. Explore the possibility of "bridging" Medicaid, CHIP and Marketplace coverage. (OIR/AHCA/other relevant agencies will take on the project.)

There are many gaps that the Medicaid expansion will cover. Bridging is available; however, it is a very complicated system as each member of the family falls into different categories. Ms. Barber-Heinz indicated the bridging as described is a win-win for everyone involved.

The discussion moved to asking the legislature to do a study similar to the Florida Healthy Kids study. In order to do this, the Board would have to be very specific on what the study should encompass. The question was raised as to whether the FHIAB could ask the Legislature to

conduct a study and Commissioner McCarty indicated the OIR and AHCA and other relevant agencies/organizations should do some research first before approaching the legislature.

5) Deletion of Conversion/Continuation Coverage

OIR provided research saying you can cancel a conversion policy on someone who has access to another policy. The discussion moved to the conceivability of eligibility gaps and keeping conversion would ensure continuity of coverage. An employer can terminate policy last day employee worked and could not get coverage until the first of the next month. The Board decided to not recommend this action.

6) PPO Balance Billing Prohibition

Members expressed concerns regarding issues arising from PPO balance billing. Legislation has been introduced by the Senate (Senators Bean and Garcia) to limit balance billing for PPO transitional and emergency services similar to HMOs. Although the legislation doesn't get to the details, it does cover the most pressing issues. The Board recommends that the Legislature address PPO balance billing in emergency and transitional services. Mr. Clatsoff made a motion and it was seconded by Christopher Ciano. The motion passed with no opposition or further discussion.

7) Delivery System Consolidation

After discussion, the Board agreed that this may be something they want to think about and perform a study on and bring back in a future meeting.

VII. Essential Health Benefits Discussion

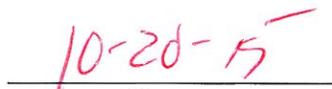
Ms. Barber-Heinz requested the Board plan a workshop during the next meeting this summer so stakeholders can bring forth concerns and public comments so the board can gain an understanding of how the plans are functioning in the marketplace.

VIII. Adjournment

Upon completion of the agenda and there being no further business before the Board, Ms. Galleta motioned adjournment of the meeting at 4:31p.m. Hearing no objection, the Chair adjourned the meeting.



Kevin M. McCarty, Chair



Date

Florida Health Insurance Advisory Board

2015 Legislative Recommendations

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) 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.

5) Small Group Community Rating Report

- 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.
- Recommendation: Eliminate this report as it requires substantial resources and does not provide meaningful information with the implementation of PPACA.
- Reference: 627.6699 (6)(B)5, F.S.

6) Employee Only Coverage in Small Group Plans.

- Current Marketplace Issue: In the small group market, under most employer-sponsored group health plans, employers subsidize the employee's premium but spouse/dependent coverage are offered under the plan completely at the employee's expense, with no employer contribution. In the new environment, it would be advantageous to have the option of not offering spouse/dependent coverage in small group, because the offer of coverage to a spouse and dependents, regardless of the affordability of that coverage, negates the ability of the spouse and dependents to qualify for subsidized coverage in the Marketplace (Exchange). The Affordable Care Act (ACA) does not require that small groups offer spouse or "dependent" coverage. However, in the small group market, carriers have never given small groups the option of not offering spouse/dependent coverage. The option of offering "employee only" coverage is required for carriers participating in the Small Business Health Options Program (SHOP) Marketplace (Exchange).
- Recommendation: The Board is recommending that small group employers be specifically allowed the option to offer "employee only" coverage in the open market as is permitted in the Marketplace (Exchange). This will allow consistency between the Marketplace (Exchange) and open markets and allow spouses and dependents to obtain coverage in the Marketplace (Exchange) where they may qualify for a subsidy, since their coverage is not subsidized by employers in most cases.

7) Small Group Hours Eligibility Criteria

- Current Marketplace Issue: Employers in the small group market are required to offer coverage to employees at 25 hours under Florida law and the ACA requires coverage be offered at 30 hours. As a result, modest income employees may not be able to avail themselves of the benefit of the exchanges and subsidies. It also requires employers to maintain compliance with multiple standards. Absent comprehensive marketplace data and in order to insure a new coverage gap is not created, the Board makes the following provisional recommendation.
- Recommendation: In the event the Legislature expands Medicaid, establish the standard eligibility for coverage at 30 hours and allow eligibility to 25 hours at the employers discretion.

8) PPO Balance Billing

- Current Marketplace Issue: While there is a prohibition against balance billing for the Florida Health Maintenance Organization (HMO) market, there is no such prohibition for the commercial Preferred Provider Organization (PPO) market.
- Recommendation: For the Legislature to address consumer issues arising from balance billing in the PPO market for transitional and emergency services similar to the HMO market.