Florida Health Insurance Advisory Board

Board of Directors Meeting

December 18, 2020

FLORIDA HEALTH INSURANCE ADVISORY BOARD MEETING

Friday, December 18, 2020, 2:00 PM
Conference Call
Call-In Number: 866-299-7949
Code: 4288083#

AGENDA

I. Call to Order

II. Roll Call – Attachment

III. Antitrust Statement – Attachment

IV. Chair's Opening Remarks

V. Approval of Minutes, November 17, 2020 – Attachment

VI. Executive Director Selection Committee Status Report

VII. State of the Market Annual Report Approval – Attachment

VIII. Discussion/Approval of Legislative Proposals for 2021 - Attachment

IX. Other Business

X. Public Comment

XI. Adjourn

FLORIDA HEALTH INSURANCE ADVISORY BOARD

November 16, 2020

David Altmaier, Chair
Commissioner
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399
850-413-5914
FAX: 850-488-3334
David.Altmaier@floir.com
Office of Insurance Regulation

Ken Stevenson, Vice Chair
Vice President, Employee Benefits
Earl Bacon Agency
3131 Lonnbladh Road
Tallahassee, FL 32308
850-878-2121
FAX: 850-878-2128
kens@earlbacon.com
Term Ending: 12/31/2022
Agent

Molly McKinstry
Deputy Secretary
Division of Health Quality Assurance
Florida Agency for Health Care Admin.
2727 Mahan Drive, Mailstop #2
Tallahassee, FL 32308
850-412-4334
FAX: 850-922-2897
molly.mckinstry@ahca.myflorida.com
Agency for Health Care Administration

Louisa McQueeney
Communications Director
Florida Voices for Health
9653 El Clair Ranch Road
Boynton Beach, FL 33437
FAX: 561-364-0246
MOBILE: 561-302-0345
louisa@healthyfla.org
Term Ending: 12/31/2023
Individual Policyholder

Christina Lake
Executive Vice President
Datamaxx Group, Inc.
2001 Drayton Drive
Tallahassee, FL 32311
850-558-8102
Christina.lake@datamaxx.com
Term Ending: 12/31/2023
Employers or Employer Representatives

William "Bill" Herrle
Executive Director
NFIB
110 East Jefferson Street
Tallahassee, FL 32301
850-681-0416
FAX: 850-561-6759
MOBILE: 850-728-7356
Bill.Herrle@nfib.org
Term Ending: 12/31/2022
Employers or Employer Representatives

Eric Johnson, PhD, ASA
Chief Actuary & VP of Analytics
& Business Intelligence
AvMed Health Plans
4300 NW 89th Blvd.
Gainesville, FL 32606
800-346-0231
Eric.Johnson@AvMed.org
Term Ending: 12/31/2022
Carrier

Richard B. Weiss, CPA
President, Florida Market
Aetna
261 N University Drive
Plantation, FL 33324
954-858-3434
FAX: 954-858-3479
MOBILE: 954-554-1757
rbweiss@aetna.com
Term Ending: 12/31/2024
Carrier

John J. Matthews
Regional General Counsel, Southeast
UnitedHealthcare
4560 Grove Park Drive
Tallahassee, FL 32311
FAX: 866-480-7774
MOBILE: 850-443-6996
John_J_Matthews@uhc.com
Term Ending: 12/31/2022
Carrier

Seth M. Phelps
Assistant General Counsel
Blue Cross and Blue Shield of Florida, Inc.
4800 Deerwood Campus Parkway
DCC1-7th Floor
Jacksonville, FL 32246
904-905-8747
MOBILE: 904-422-3647
Seth.Phelps@bcbsfl.com
Term Ending: 12/31/2022
Carrier

Rick Wallace
President/CEO
FAMOS, LLC
d/b/a American Academy of Cosmetology
1330 Blanding Blvd, Suite 125
Orange Park, FL 32065
MOBILE: 850-879-2649
Rick@teamwallace.org
Term Ending: 12/31/2024
Employers or Employer Representatives

Robert Muszynski
Vice President – Finance
Orlando Regional Realtor Association
1330 Lee Road
Orlando, FL 32810
MOBILE: 407-617-5261
robertm@orlandorealtors.org
Term Ending: 12/31/2024
Employers or Employer Representatives

Liz Miller
President and CEO, Florida
Sunshine Health and WellCare
107 N Burlingame Avenue
Temple Terrace, FL 33617
813-206-1123
Elizabeth.Miller@wellcare.com
Term Ending: 12/31/2023
Carrier

Vacant
Agent

FLORIDA HEALTH INSURANCE ADVISORY BOARD
BOARD MEETING

December 18, 2020

Antitrust Statement

We are here to discuss and act on matters relating to the business of the Florida Health Insurance Advisory Board. We are not here to discuss or pursue the business interests of any individual companies. All of us should proceed with caution and awareness of the requirements and prohibitions of federal and state antitrust laws. We should not engage in discussions, either at this meeting or in private conversation, of our individual companies' plans or contemplated activities. We should concern ourselves only with the business of the Florida Health Insurance Advisory Board, as set forth in the agenda for this meeting and each company's business plans cannot be discussed. If you have questions, please contact the General Counsel.

Florida Health Insurance Advisory Board
Board of Directors Meeting Minutes
Tuesday, November 17, 2020, 2:00 PM
Via Teleconference
Tallahassee, FL

Board Members Present:

Mike Yaworsky, Chair Designee	Ken Stevenson, Vice Chair	Molly McKinstry
Louisa McQueeney	Christina Lake	William "Bill" Herrle
Richard B. Weiss	John J. Matthews	Seth M. Phelps
Robert Muszynski	Liz Miller	

Others Present:

- Amy Hardee, Administrative Assistant II to the Deputy Commissioner – Life & Health, Office of Insurance Regulation (OIR)
- Shannon Doheny, Special Counsel to the Deputy Commissioner – Life & Health, OIR
- John Reilly, Deputy Commissioner – Life &Health, OIR
- Chris Struk, Life & Health Policy Advisor, OIR

I. Call to Order

Mike Yaworsky (Chief of Staff, Office of Insurance Regulation) announced that he had been appointed as the Chair's designee for this meeting by Commissioner and Chair David Altmaier. The Chair then called the meeting to order at 2:00 pm indicating that the meeting was properly noticed to the public in accordance with Florida Law.

II. Roll Call

Amy Hardee conducted a roll call, noting the presence of a quorum.

III. Antitrust Statement

Shannon Doheny was recognized and reviewed the antitrust statement.

IV. Chair's Opening Remarks

The Chair thanked the members for their attendance.

The Chair provided an update on the Executive Director selection process, noting that three resumes have been received and those candidates will be interviewed during a publicly noticed telephone interview meeting scheduled for November 30, to which the Board members are invited.

V. Approval of Minutes, October 14, 2020

The Chair presented the minutes from the October 14, 2020, meeting for adoption, noting that members had been provided with advance copies. Bill Herrle moved to adopt the minutes as written, with a second by Ken Stevenson, and the minutes were adopted without objection.

VI. Discussion of Legislative Proposals for 2021

The Chair noted that the purpose of today's call was to discuss legislative proposals for 2021 and reminded members that only those proposals reaching a full consensus by the members would be submitted to the 2021 Legislature on behalf of the Florida Health Insurance Advisory Board.

The Chair noted that eleven proposals had been received from Louisa McQueeney (Florida Voices for Health). The Chair then asked Ms. McQueeney to review her proposals.

Recommendation #1: Provide a clear legislative directive whereby small group employers be specifically allowed the option to offer "employee/dependent(s)" coverage in the open market, where dependent(s) are dependent children only.

Ms. McQueeney reviewed her proposal, *Employee/Dependent Option Coverage in Small Group Plans*, as submitted. Small group employers are able to do this now; however, some feel like they are not authorized to do so. She wants the statutes to explicitly discuss and allow this option.

Recommendation #2: Require insurance companies to itemize the cost of medical, dental and vision in bundled plans. Require insurance companies to refund consumers and, if applicable the federal government, for dental and/or vision services that cannot be used due to non-accessible provider networks.

Ms. McQueeney reviewed her proposal, *Direct insurance companies to itemize the cost of medical, dental and vision in plans that offer these coverages and control provider networks*, as submitted.

Board members discussed this issue, trying to understand what plans are at issue and why services are not accessible. She mentioned an example of a bundled dental product that didn't have any in-network providers and asked if those networks are being reviewed. OIR and AHCA (Agency for Health Care Administration) will research.

Recommendation #3: Expand statute 627.666 to include individual on- and off-exchange policy holders a Deductible Health Credit Transfer to a new policy equal to the deductible paid by the policy holder to the prior insurer. The Credit Transfer should be for the entire amount paid by the consumer without limitations such as a time frame of 90 days preceding the effective date of the succeeding insurer's plan or recognition of the expenses actually incurred under the terms of the succeeding insurer's plan and subject to a similar deductible provision.

Ms. McQueeney reviewed her proposal, *Deductible Health Credit Transfer*, as submitted, noting that this was approved by the Board previously as a legislative recommendation. She stated that this issue also exists with the copay accumulator.

Recommendation #4: Provide consumer with one free copy of their medical record, to be provided to consumer by mail or electronic mail, at the time of payment request for services provided.

Ms. McQueeney reviewed her proposal, *Provide health care consumers with one free copy of their own medical records*, as submitted, noting that this was approved by the Board previously as a legislative recommendation.

<u>Recommendation #5:</u> Prohibit insurance carriers from amending or removing a covered prescription drug during the policy year. This will not preclude the insurance carrier from expanding the formulary and lowering prices throughout the policy year. This would exclude the formulary for Florida Medicaid which is covered under section 409.91195, Florida Statutes.
Ms. McQueeney reviewed her proposal, *Protect Consumers from prescription drug formulary changes during a policy yea*r, as submitted.

Board members discussed this issue, with carrier representatives explaining that various contracts change throughout the year (not just drug pricing), and that this recommendation may not achieve a positive outcome for the consumer as intended.

<u>Recommendation #6:</u> Codify into state law requirements that Florida health plans may not vary rates based on one or more pre-existing conditions. Rates can vary based solely on four factors: family composition, geographic area, age, and tobacco use. Insurers are prohibited from charging an older adult in the oldest age band more than 3 times the rate of a younger person in the youngest age band and from charging tobacco users more than 1.5 times the rate of a non-tobacco-user's rate.
Ms. McQueeney reviewed her proposal, *Protect Consumers from uncontrolled health insurance premium rates based on preexisting conditions*, as submitted.

Seth Phelps noted that while he understands the intention behind this proposal, if the ACA (Affordable Care Act) is overturned, there needs to be a much more comprehensive discussion regarding changes that may or may not be needed to stabilize the Florida marketplace.

<u>Recommendation #7:</u> In inadequate narrow networks where primary care, mental health and hospital services are not within 30 miles or 30 minutes of each enrollee's place of residence or work, treat out-of-network care as in-network care and apply the cost of the care to the annual accumulators, such as the deductible. Improve network adequacy.
Ms. McQueeney reviewed her proposal, *Direct the Florida Office of Insurance Regulation to develop better and more inclusive standards of network adequacy for all group and individual health plans*, as submitted.

Molly McKinstry noted that AHCA handles complaints about network adequacy so this would fit more squarely with AHCA in terms of oversight. She also noted that AHCA is able to resolve issues when they do receive complaints. She would like to understand exactly what the issues are that are being seen with regard to network adequacy to see if they can be addressed within their current authority. The Chair noted that last year, the Board voted to amend this recommendation from "Direct the Florida Office of Insurance Regulation…" to "Direct the Agency for Health Care Administration…" in case they would like to make that change again this

year. Seth Phelps noted that the insurance industry generally tries to provide options and price points for consumers, so he suggested that whatever is recommended should be flexible enough to allow for options to meet the consumers' needs at various price points.

Recommendation #8: Apply the balance bill rules under HB221, signed into law by Governor Scott, to include emergency transportation.
Ms. McQueeney reviewed her proposal, *Prohibit balance billing for emergency medical transportation*, as submitted, noting that this was approved by the Board previously as a legislative recommendation.

John Matthews noted that the balance billing prohibition for air ambulance passed during the last legislative session and is currently in litigation. As a result, Seth Phelps suggested that the Board wait and see what the results of this litigation are before acting on this recommendation.

Recommendation #9: Require a stronger consumer disclosure than is required by federal regulation. Ensure brokers and agents read the full disclosure to the consumer and require the consumer to sign a statement that they have read the disclosure. Institute an external appeal process where a third party will make final appeal determinations.
Ms. McQueeney reviewed her proposal, *Protect Consumers and Insurance Markets from short term plans*, as submitted.

Recommendation #10: Require each carrier authorized to sell health insurance in Florida to include at minimum one plan in each service area to cover Applied Analysis Services as covered by Medicaid.
Ms. McQueeney reviewed her proposal, *Include Applied Behavioral Analysis as a covered benefit in select private insurance plans,* as submitted.

John Matthews noted that this may result in a fiscal impact to the state. Seth Phelps noted that Florida law requires fully-insured large groups to cover ABA (Applied Behavioral Analysis).

Recommendation #11: Establish clear, meaningful, and accessible procedures for prescribers to override the process by requesting an exemption; Prohibit insurers from requiring insured patients to fail a drug more than once.
Ms. McQueeney reviewed her proposal, *Establish Step Therapy Protocols*, as submitted.

Molly McKinstry requested that Florida Medicaid coverage be excluded from this recommendation. John Matthews noted that the Legislature passed something back in 2019 that should now be in effect and asked if complaints were still being heard, to which Ms. McQueeney replied in the affirmative.

The Chair thanked everyone for their participation and input into the discussion. He then asked that those who were asked to provide additional information submit the requested information as soon as possible to Amy Hardee for distribution to the Board.

VII. Other Business

With there being no further business items on the agenda, the Chair asked if there were any members of the Board with other business to be brought before the Board.

Bill Herrle asked for a status on the Executive Director Search. The Chair obliged re-stating the status he provided during Opening Remarks. Mr. Herrle asked the Search Committee Chairman (Seth Phelps) if he was generally satisfied with the pool of candidates. Chairman Phelps responded that he has not seen the applicant information yet. Mr. Herrle noted that three seems like a small pool of candidates and asked if there was any interest in extending or re-posting the position. Chairman Phelps said he was sure that was an option if the Committee so desired. Mr. Herrle then asked if the Committee had the authority to re-post/extend the advertisement if they so choose and Chairman Phelps responded that the Committee would bring their recommendation back to the Board.

There being no further business, the Chair moved to the next agenda item.

VIII. Public Comment

The Chair asked if there were any members of the public who would like to comment. There being none, the Chair moved to the next agenda item.

IX. Adjourn

The Chair thanked everyone for participating. Having no further business, the meeting was adjourned at 3:23 pm.

_____ _____

Mike Yaworsky, Chair Designee Date

2020 FLORIDA HEALTH INSURANCE MARKET REPORT

BY THE

FLORIDA HEALTH INSURANCE ADVISORY BOARD

Adopted [MONTH DAY, YEAR]

Introduction

One of the responsibilities of the Florida Health Insurance Advisory Board (FHIAB) is to issue an annual report on the state of the health insurance market in Florida.

The following figures present enrollment, premium, and loss ratio summaries in Florida's commercial (non-governmental) major medical health insurance markets as reported and compiled from data filed with the Office by each Accident and/or Health Coverage provider. This report incorporates insurance company data submitted to the Office for the year ending December 31, 2019. Previous reports are available on the FHIAB section of the Office's website at: http://www.floir.com/Sections/LandH/FHIAB.aspx.

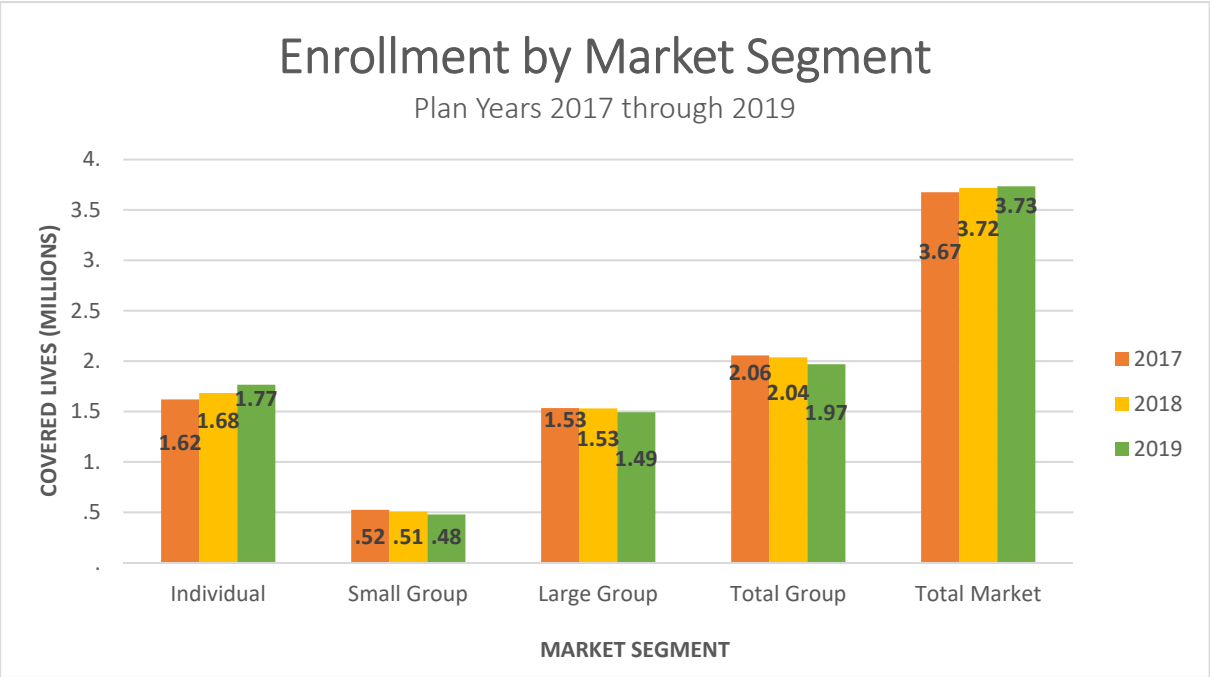
Executive Summary

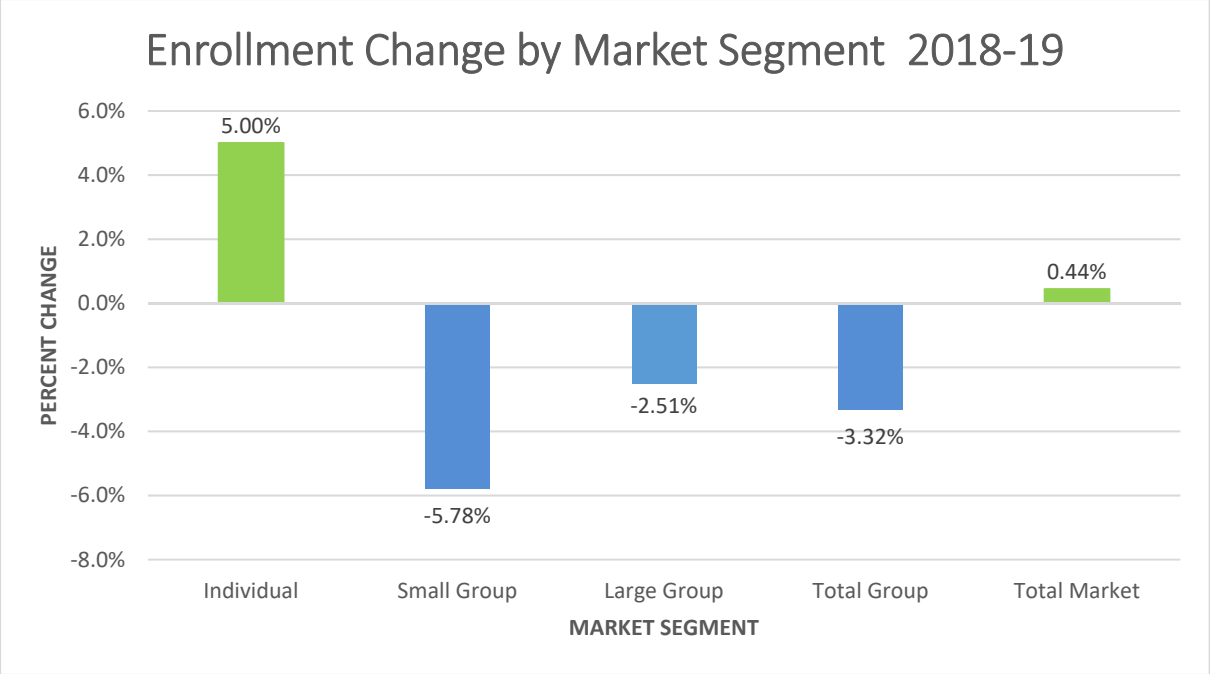
Despite the uncertainty surrounding the future of the Affordable Care Act (ACA), the health insurance market has largely stabilized. After several years of large premium increases, rates have largely stabilized leading to smaller shifts in enrollment although the long-term trend of increasing individual enrollment and decreasing group enrollment remains intact.

Individual policies continue to grow as a share of the overall market enrollment and premium. This is primarily the result of the fact that under the ACA, all individual policies must be guaranteed issue; no application can be rejected based on the health status of the applicant. The individually underwritten policies reported herein are either grandfathered policies, which means they were issued before the passage of the ACA and can be renewed indefinitely, or transitional policies, which means they were issued after passage of the ACA. Transitional policies must currently end coverage by December 31, 2021. However, the Center for Medicare & Medicaid Services has extended the deadline for transitional policies to end several times and is expected to allow transitional policies to remain in effect. Regardless, many individual policyholders have already moved to an ACA-compliant policy due to the subsidies available on the Federal Marketplace reducing the market share of grandfathered and transitional policies.

The small group market has continued to contract - particularly grandfathered and transitional policies - as enrollment shifts to other types of coverage. The small group market represents 12.8% of the total market enrollment and 13.3% of the total market premium. It is expected that this segment will continue to shrink as it has for over a decade. Enrollment in the large group market also continues to shrink. The reduction in group enrollment is partially due to carriers being active in developing products that help employers reduce costs by self-insuring.

Commercial Enrollment





As illustrated above and shown in Table 1 below, total enrollment in Florida's commercial health insurance markets had a modest increase in 2019 of 16,471 covered lives or 0.44%. This follows an increase from the previous year of 43,522 covered lives or 1.18%. While the overall market remains significantly larger than before the ACA, the number of covered lives has remained fairly stable over the last several years.

According to the United States Census Bureau, the uninsured population in Florida has declined from 3.2 million (16.6% rate) at the end of 2014 to 2.7 million (13.0% rate) at the end of 2018.

As of year-end 2019, coverage by market segment consisted of:

- **Individual Coverage –** 1,765,807, an increase of 84,097 covered lives or 5.00%
- **Small Group** (1-50 members) **–** 477,190, a decrease of 29,272 covered lives or 5.78%
- **Large Group** (51+ members) **–** 1,491,683, a decrease of 38,354 covered lives or 2.51%
- **Total Market –** 3,734,680, an increase of 125,407 covered lives or 0.44%

The individual market enrollment continues to grow despite the tax penalty (individual mandate) being set to $0 and recent changes to federal and state law that encourage the growth of other products such as short-term limited duration policies and health care sharing ministries. In general, the individual market remains attractive for those with income levels that qualify for subsidies on the Marketplace but less attractive for those who do not qualify for subsidies. The individual market is larger than either the small group or large group market separately although it still lags total group enrollment.

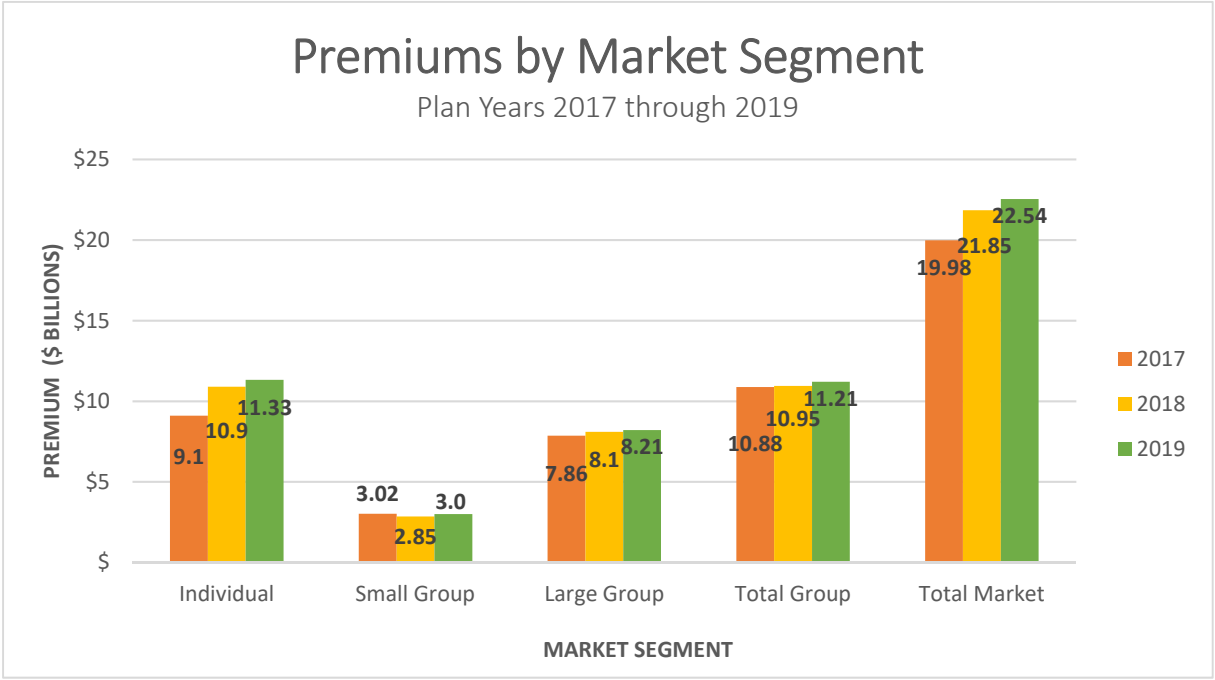
In contrast to the individual market, the small group market continues to decline. The declining trend in small group coverage was in effect prior to the implementation of the ACA as enrollment was 1,073,683 in 2005 but had dropped to 598,361 in 2014. Since the implementation of the ACA, enrollment has continued to decline but at a slower pace. It is thought that small group employers are opting to self-insure or are no longer offering coverage for their employees and their dependents as their employees can often pay less by purchasing a policy through the Federal Marketplace if those employees qualify for a subsidy.

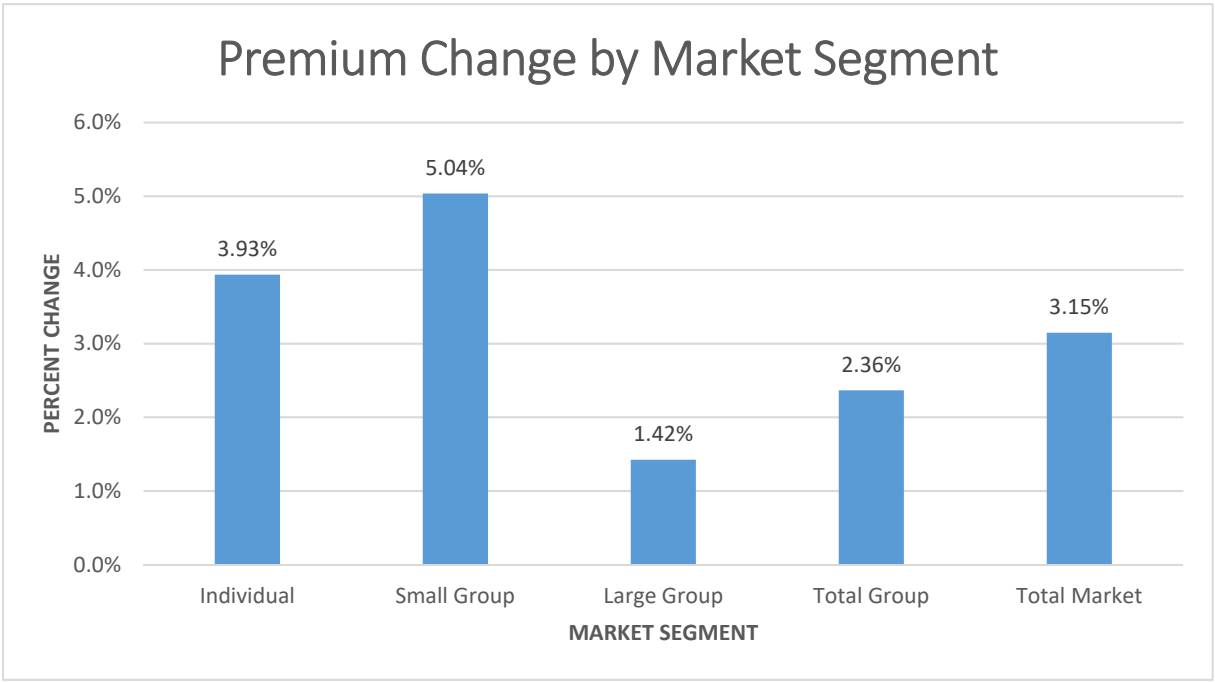
The large group market has also experienced many years of declines (2005 enrollment was 2,468,056 compared to 1,628,198 in 2014), but its declining trend has been at a slower pace since the implementation of the ACA. It is thought that large employers are opting to self-insure in order to save money as the administrative costs and costs for stop loss insurance have become more affordable.

Table 1
Commercial Insurance Enrollment 2017-2019

Market Segments	2017	2018	2019
Individual Guaranteed Issue			
ACA On-Exchange	1,229,207	1,366,560	1,480,060
ACA Off-Exchange	178,771	136,329	128,162
Grandfathered (In-State and Out-of-State)	564	524	339
Transitional (In-State and Out-of-State)	120	91	75
Total Guaranteed Issue	1,408,662	1,454,071	1,608,636
Individually Underwritten			
Grandfathered (In-State and Out-of-State)	58,192	47,943	41,278
Transitional (In-State and Out-of-State)	151,605	130,054	115,703
Total Individually Underwritten	209,797	177,997	156,981
Conversion			
Total Conversion	274	209	190
Small Groups (1-50)			
Self-Employed or Sole Proprietor	3,680	1,578	110
2 – 50 Member Groups	519,354	504,884	476,080
Total Small Groups	523,034	506,462	477,190
Large Groups (51+)			
Total Large Groups	1,532,920	1,530,037	1,491,683
Market Totals			
Total Individual Market	1,618,733	1,681,710	1,765,807
Total Group Market	2,055,954	2,036,499	1,968,873
Total Commercial Market	3,674,687	3,718,209	3,734,680

Commercial Premium



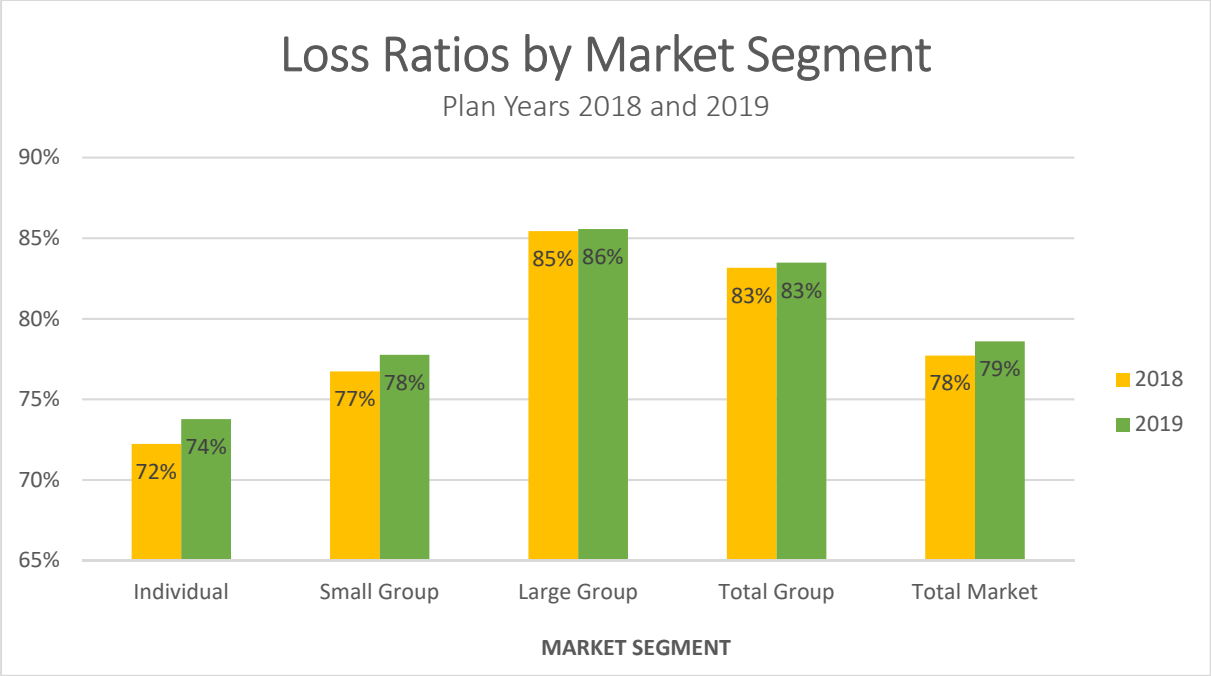


As illustrated above and shown in Table 2 below, the overall commercial market generated $22,536,261,610 in premiums in 2019, a 3.15% increase from 2018. This follows a 9.36% increase the prior year. The increase is largely the result of the higher enrollment in the individual market and higher premiums in the group market. As enrollment growth exceeded premium growth in the individual market, average premium per enrollee decreased by approximately 1%.

Table 2
Commercial Insurance Premium 2017-2019

Market Segments	2017	2018	2019
Individual Guaranteed Issue			
Grandfathered (In-State and Out-of-State)	$1,482,351	$1,303,471	$1,106,010
Transitional (In-State and Out-of-State)	$988,739	$821,365	$724,462
ACA On-Exchange	$7,113,254,073	$8,872,098,668	$9,455,661,811
ACA Off-Exchange	$1,123,749,202	$1,220,961,890	$1,157,720,398
Total Guaranteed Issue	$8,239,474,365	$10,095,185,394	$10,615,212,681
Individually Underwritten			
Grandfathered (In-State and Out-of-State)	$293,757,097	$261,971,038	$230,156,312
Transitional (In-State and Out-of-State)	$568,521,050	$537,363,981	$478,854,011
Total Individually Underwritten	$862,278,147	$799,335,019	$709,010,323
Conversion			
Total Conversion	$1,713,525	$2,043,382	$1,071,231
Small Groups (1 – 50)			
Self-Employed or Sole Proprietor	$27,296,586	$15,869,872	$855,637
2 – 50 Member Groups	$2,990,108,758	$2,837,618,918	$2,996,318,490
Total Small Groups	$3,017,405,344	$2,853,488,790	$2,997,174,127
Large Groups (51+)			
Total Large Groups	$7,857,654,557	$8,098,489,292	$8,213,793,248
Market Totals			
Total Individual Market	$9,103,466,037	$10,896,563,795	$11,325,294,235
Total Group Market	$10,875,059,901	$10,951,978,082	$11,210,967,375
Total Commercial Market	$19,978,525,938	$21,848,541,877	$22,536,261,610

Loss Ratios



The loss ratios provided above are calculated by dividing the losses associated with various market segments by the amount of premiums collected. As expected, each market demonstrates a different loss ratio profile. However, each market segment produced a higher loss ratio in 2019 than in 2018.

In the individual market, the overall loss ratio increased from 72.24% in 2018 to 73.77% in 2019 while the small group overall loss ratio increased from 76.73% in 2018 to 77.76% in 2019.

The large group market experienced an overall loss ratio of 85.56% in 2019 which is higher than the 83.16% ratio reported in 2018. This market segment has a higher volume and lower administrative cost environment; consequently, higher loss ratios are generally expected in this market segment relative to other markets.

Table 3
Direct Premium/Losses & Loss Ratios 2018-2019

Market Segments	2018			2019		
Individual Guaranteed Issue	Direct Premium Earned	Direct Losses Incurred	Loss Ratio	Direct Premium Earned	Direct Losses Incurred	Loss Ratio
Grandfathered (In-State and Out-of-State)	$1,303,471	$2,027,463	155.54%	$1,106,010	$1,684,453	152.30%
Transitional (In-State and Out-of-State)	$821,365	$1,052,367	128.12%	$724,462	$695,391	95.99%
ACA On-Exchange	$8,872,098,668	$6,311,181,891	71.14%	$9,455,661,811	$6,896,407,809	72.93%
ACA Off-Exchange	$1,220,961,890	$880,665,026	72.13%	$1,151,934,109	$833,733,582	72.38%
Total Guaranteed Issue	$10,095,185,394	$7,194,926,746	71.27%	$10,615,212,681	$7,736,810,174	72.88%
Individually Underwritten						
Grandfathered (In-State and Out-of-State)	$261,971,038	$212,937,733	81.28%	$230,156,312	$176,180,006	76.55%
Transitional (In-State and Out-of-State)	$537,363,981	$457,203,929	85.08%	$478,854,011	$439,154,143	91.71%
Total Individually Underwritten	$799,335,019	$670,141,662	83.84%	$709,010,323	$615,334,149	86.79%
Conversion						
Total Conversion	$2,043,382	$6,156,213	301.28%	$1,071,231	$1,996,518	186.38%
Small Groups (1 – 50)						
Self-Employed or Sole Proprietor	$15,869,872	$15,104,430	95.18%	$855,637	$1,719,042	200.91%
2 – 50 Member Groups	$2,837,618,918	$2,174,285,002	76.62%	$2,996,318,490	$2,329,014,037	77.73%
Total Small Groups	$2,853,488,790	$2,189,389,432	76.73%	$2,997,174,127	$2,330,733,079	77.76%
Large Groups (51+)						
Total Large Groups	$8,098,489,292	$6,918,565,139	85.43%	$8,213,793,248	$7,028,085,883	85.56%
Market Totals						
Total Individual Market	$10,896,563,795	$7,871,224,621	72.24%	$11,325,294,235	$8,354,140,842	73.77%
Total Group Market	$10,951,978,082	$9,107,954,571	83.16%	$11,210,967,375	$9,358,818,962	83.48%
Total Commercial Market	$21,848,541,877	$16,979,179,192	77.71%	$22,536,261,610	$17,712,959,804	78.60%

Background

The FHIAB evolved from small group health insurance reform in Florida. Originally established in 1992 as the Florida Small Employer Health Reinsurance Program, it was expanded in 1997 to include the Florida Individual Health Reinsurance Program. Both Programs were governed by the same Board of Directors and operated as the Florida Health Reinsurance Program.

Florida law changes in 2005 directed the Program to advise the Office of Insurance Regulation, the Agency for Health Care Administration, the Department of Financial Services, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:

1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.
2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.
3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.
4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.
5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.

In light of these developments, the Board voted to change its name to the Florida Health Insurance Advisory Board, which better reflected its new responsibilities.

The composition of the board of directors was also changed to decrease the number of insurance company representatives and to add representatives of the business community and other stakeholders. There are 14 members of the Board as prescribed by statute. A current listing of the FHIAB directors follows.

FLORIDA HEALTH INSURANCE ADVISORY BOARD
BOARD OF DIRECTORS

David Altmaier, Chair
Commissioner
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399

Ken Stevenson, Vice Chair
Vice President, Employee Benefits
Earl Bacon Agency
3131 Lonnbladh Road
Tallahassee, FL 32308
Term Ending: 12/31/2022

Molly McKinstry
Deputy Secretary
Division of Health Quality Assurance
Florida Agency for Health Care Admin.
2727 Mahan Drive, Mailstop #2
Tallahassee, FL 32308

Louisa McQueeney
Communications Director
Florida Voices for Health
9653 El Clair Ranch Road
Boynton Beach, FL 33437
Term Ending: 12/31/2023

Christina Lake
Executive Vice President
Datamaxx Group, Inc.
2001 Drayton Drive
Tallahassee, FL 32311
Term Ending: 12/31/2023

William "Bill" Herrle
Executive Director
NFIB
110 East Jefferson Street
Tallahassee, FL 32301
850-681-0416
Term Ending: 12/31/2022

Eric Johnson, PhD, ASA
Chief Actuary & VP of Analytics & Business Intelligence
AvMed Health Plans
4300 NW 89th Blvd.
Gainesville, FL 32606
Term Ending: 12/31/2022

Richard B. Weiss, CPA
President, Florida Market
Aetna
261 N University Drive
Plantation, FL 33324
Term Ending: 12/31/2024

John J. Matthews
Regional General Counsel, Southeast
UnitedHealthcare
4560 Grove Park Drive
Tallahassee, FL 32311
Term Ending: 12/31/2022

Seth M. Phelps
Assistant General Counsel
Blue Cross and Blue Shield of Florida, Inc.
4800 Deerwood Campus Parkway
DCC1-7th Floor
Jacksonville, FL 32246
Term Ending: 12/31/2022

Rick Wallace
President/CEO
FAMOS, LLC
d/b/a American Academy of Cosmetology
1330 Blanding Blvd, Suite 125
Orange Park, FL 32065
Term Ending: 12/31/2024

Robert Muszynski
Vice President – Finance
Orlando Regional Realtor Association
1330 Lee Road
Orlando, FL 32810
Term Ending: 12/31/2024

Liz Miller
President and CEO, Florida
Sunshine Health and WellCare
107 N Burlingame Avenue
Temple Terrace, FL 33617
Term Ending: 12/31/2023

A Director position designated for an agent representative is vacant.

2021 LEGISLATIVE PROPOSALS

RECEIVED FROM

FLORIDA HEALTH INSURANCE ADVISORY BOARD

(FHIAB) BOARD MEMBERS

FOR DISCUSSION

Louisa McQueeney, Florida Voices for Health

1. Employee/Dependent Option Coverage in Small Group Plans

In the small group market, under most employer-sponsored group health plans, employers subsidize the employee's premium cost, but spouse/dependent coverage are offered under the plan completely at the employee's expense, with no employer contribution.

Covering a spouse is not mandated by federal law and in the ACA environment, it would be advantageous to have the option to not offer spousal coverage, so that the spouse could qualify for Premium Tax Credits (PTC's). However, in the group market, carriers do not give small groups the option of not offering spousal coverage.

- ***Recommendation**: Provide a clear legislative directive whereby small group employers be specifically allowed the option to offer "employee/dependent(s)" coverage in the open market, where dependent(s) are dependent children only.*

2. Direct insurance companies to itemize the cost of medical, dental and vision in plans that offer these coverages and control provider networks.

A growing number of consumers have enrolled in bundled health insurance plans that include vision and dental benefits with their medical coverage. For many Floridians in the individual market, the federal government pays a portion, through premium tax credits, of their monthly premium directly to insurers. Consumers make their decisions with the expectation that the services, benefits and networks described by the insurers will remain in place for the duration of the plan year. However, the availability of providers and meaningful access often changes without notice to the consumer. Consumers are left to pay premiums based on the inclusion of benefits they cannot access. This becomes even more clear in the bundled plans. When dental and/or vision services cannot be accessed because the providers refuse to accept the insurance, the insurance carrier should refund that portion of the premium back to the consumer and the government. Itemization of the premiums allows for greater transparency and accountability in the health insurance Marketplace.

- ***Recommendation**: Require insurance companies to itemize the cost of medical, dental and vision in bundled plans. Require insurance companies to refund consumers and, if applicable the federal government, for dental and/or vision services that cannot be used due to non-accessible provider networks.*

3. Deductible Health Credit Transfer

With the continual rise in annual health insurance deductibles to consumers, having to start a new deductible in the middle of the year creates financial hardship. The deductibles for 2021 could end up being as high as $8,550 for an individual and $17,100 for a family. Some policies require the insured to pay the entire deductible before the insurance company pays anything at all.

When consumers change health insurance plans outside of the Open Enrollment period, as a result of an employer changing plans outside of annual renewal, or a change of employer, or a change in geographic area, or loss of employer coverage and purchase individual coverage, annual deductibles start all over again even if a consumer has met part or all of the accumulators out of their own pocket. This is even more egregious when consumers stay with the same carrier with the expectation that the accumulators will be recognized.

- ***Recommendation****: Expand statute 627.666 to include individual on- and off-exchange policy holders a Deductible Health Credit Transfer to a new policy equal to the deductible paid by the policy holder to the prior insurer. The Credit Transfer should be for the entire amount paid by the consumer without limitations such as a time frame of 90 days preceding the effective date of the succeeding insurer's plan or recognition of the expenses actually incurred under the terms of the succeeding insurer's plan and subject to a similar deductible provision.*

4. Provide health care consumers with one free copy of their own medical records.

Patients have a right to their medical records under the Health Insurance Portability and Accountability Act (HIPAA). The same law allows providers to charge fees for providing the requested copies. Many requests for records are not honored in a timely fashion if honored at all and some at great expense to the consumer. Obtaining one's own medical records is especially important when disputes arise with insurance companies, resulting in denial of claims, leaving patients in precarious financial positions.

- ***Recommendation****: Provide consumer with one free copy of their medical record, to be provided to consumer by mail or electronic mail, at the time of payment request for services provided.*

5. Protect Consumers from prescription drug formulary changes during a policy year.

Drug pricing remains at the forefront of consumer complaints when accessing health coverage. Consumers often pick a health insurance plan based on the prescription drugs covered and the cost tiers they are classified in.

Consumers enter a contract with the health insurance plan for a twelve-month period and pay an agreed upon amount per month for this period based on the contract they were presented. Health insurance plans negotiate drug prices with the pharmaceutical companies on behalf of consumers, without any involvement or say of consumers. Insurance carriers then present health plans including drug formularies and premium rates to the Office of Insurance Regulation for approval. Consumer input is never part of this process; however, the consumer is expected to pick up the extra cost in the end or go without the prescription(s) they contracted for.

In recent years insurance carriers have been making changes to their drug formularies during the policy period. Insurers routinely reclassify drugs to more access restrictive drug tiers, increase the consumer's co-payment, co-insurance, or deductible, and reclassify drugs to higher cost sharing tiers. There are also instances of certain drugs being dropped from coverage altogether. Consumers are then informed by mail that they will be financially responsible for the entire cost drug in the middle of the policy year.

- ***Recommendation****: Prohibit insurance carriers from amending or removing a covered prescription drug during the policy year. This will not preclude the insurance carrier from expanding the formulary and lowering prices throughout the policy year. This would exclude the formulary for Florida Medicaid which is covered under section 409.91195, Florida Statutes)*

6. Protect Consumers from uncontrolled health insurance premium rates based on preexisting conditions.

Under the Patient Protection and Affordable Care Act an insurer may not vary rates based on one or more pre-existing conditions. Rates can vary based solely on four factors: family composition, geographic area, age, and tobacco use.

During the 2019 session, the Florida Legislature passed CS/CS/SB 322.which includes requirements for insurers in the event the federal Affordable Care Act (ACA) is repealed or invalidated by the U.S. Supreme Court. The new law specifically requires insurers who issue comprehensive major medical policies or contracts in Florida to offer 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.

However, the new law does not prohibit insurers from charging higher premium rates based on health status. Without this protection, pre-ACA history shows that plans offered to people with pre-existing conditions will be substantially more costly. Policies may be out of reach for most people with pre-existing conditions and they will be at serious risk of losing coverage.

It is estimated that over 8 million Floridians live with one or more than one pre-existing conditions. Without this protection other stakeholders are at risk, such as hospitals likely to incur more uncompensated care and employers by increasing premiums due to cost shifting.

- ***Recommendation****: Codify into state law requirements that Florida health plans may not vary rates based on one or more pre-existing conditions. Rates can vary based solely on four factors: family composition, geographic area, age, and tobacco use. Insurers are prohibited from charging an older adult in the oldest age band more than 3 times the rate of a younger person in the youngest age band and from charging tobacco users more than 1.5 times the rate of a non-tobacco-user's rate.*

7. Direct the Florida Office of Insurance Regulation to develop better and more inclusive standards of network adequacy for all group and individual health plans.

Network adequacy standards are required to ensure that health plans provide access to the services for which subscribers pay. Insurers have created narrow networks to control costs. However, every network should be minimally adequate to enable access to a multiplicity of necessary health services including, but not limited to primary care, pediatric care, hospital care, mental health care, oncology care, obstetric and newborn care, and dental care where applicable. The "reasonable access" standard identified by CMS is insufficient at ensuring timely access to consumers as well as culturally and linguistically appropriate competency among providers. These standards are even more insufficient for consumers who are members of vulnerable populations with health disparities for instance in rural areas, where travel distances are an additional problem.

When provider networks are inadequate, consumers may have no choice but to seek care outside their health plan's network. In those cases, insurers often require enrollees to pay a greater share of the cost for out- of-network care, and the insurer is not required to count those costs toward annual out-of-pocket maximums under the ACA.

- ***Recommendation****: In inadequate narrow networks where primary care, mental health and hospital services are not within 30 miles or 30 minutes of each enrollee's place of residence or work, treat out-of-network care as in-net-work care and apply the cost of the care to the annual accumulators, such as the deductible. Improve network adequacy.*

8. Prohibit balance billing for emergency medical transportation.

Consumers in a life-threatening accident or major medical emergency in need of emergency transportation by road, water or air to receive immediate health care attention at a nearby facility, are not able to make an informed decision or negotiate at arms-length about the cost of the transport. Health insurance companies provide coverage for this event, but some coverage gaps can leave consumers with surprise high medical bills for the service.

- ***Recommendation****: Apply the balance bill rules under HB221, signed into law by Governor Scott, to include emergency transportation.*

9. Protect Consumers and Insurance Markets from short term plans.

Short term insurance plans were intended to fill gaps when consumers were in between coverage. They are now being sold as a replacement for comprehensive coverage. Short term plans with an initial term of 364 days can be renewed for up to 36 months, are not subject to the protections of the Affordable Care Act such as coverage for pre-existing conditions or no annual limit as to how much the policy would have to pay for a claim. Short term plans are not required to cover the ten essential health benefits.

Many consumers do not have the health literacy to understand the concept of short-term plans, their coverage limitations, and the cost implications to them if a claim arises. The appeal of the short-term plan is the lower cost, but consumers still expect comprehensive coverage with protections.

In addition, short term plans are likely to cause rates of ACA compliant health insurance plans to increase since younger, healthier consumers are more likely to purchase cheaper plans, thereby decreasing the ACA compliant plans risk pool.

- ***Recommendation**: Require a stronger consumer disclosure than is required by federal regulation. Ensure brokers and agents read the full disclosure to the consumer and require the consumer to sign a statement that they have read the disclosure. Institute an external appeal process where a third party will make final appeal determinations.*

10. Include Applied Behavioral Analysis as a covered benefit in select private insurance plans.

As required by federal law Florida's Medicaid program covers medically necessary Applied Behavioral Analysis (ABA) services to correct, or ameliorate a defect, a condition, or a physical or mental illness for eligible recipients under the age of 21. These services are extremely important for recipients on the autism spectrum.

Unlike 33 other states, Florida decided not to include ABA services as an essential health benefit in individual, or small and large group insurance policies. In 2018, claim costs incurred for ABA services in Missouri were about $9.1 million across 3,700 individuals and 85,000 claims. This was just 0.28 percent of total claims incurred in 2018. For each member month of autism coverage, the cost of ABA therapy amounted to 51 cents. According to the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP), "while costs associated with autism-related treatment have risen during the years since the mandate was enacted, the fact that these costs remain near three-tenths of one percent of overall claim costs means this law continues to have little appreciable impact on insurance premiums.

Once a recipient loses Medicaid eligibility, they lose coverage for these important services. Neither KidCare program policies or exchange and off exchange policies cover ABA services, placing an undue financial burden on families already dealing with difficult circumstances. Expanding some plans off and on exchange to include coverage for ABA services could provide relief for this population.

- ***Recommendation**: Require each carrier authorized to sell health insurance in Florida to include at minimum one plan in each service area to cover Applied Analysis Services as covered by Medicaid.*

11. Establish Step Therapy Protocols.

Step therapy or "fail first" policies allow health plans to control the order in which patients take certain therapies. Step therapy protocols require that patients must try one or more medications selected by their insurer before the plan will grant coverage for the drug originally prescribed by the healthcare provider. Patients and healthcare providers have voiced concern regarding the potential adverse effects of step therapy when it is not paired with protections for patients.

When patients are required to cycle through and document a "step"—or in some cases, more than one step or medication—the process may result in substantial delays in treatment deemed appropriate by their healthcare provider. The use of ineffective treatment has been associated with higher costs due to additional office visits, increased drug costs, and even the increased likelihood of needing additional treatment or hospitalization. The risk profile of the medication as well as side effects and the ability for an individual to adhere to the medication must also be considered.

- ***Recommendation****: Establish clear, meaningful, and accessible procedures for prescribers to override the process by requesting an exemption; Prohibit insurers from requiring insured patients to fail a drug more than once.*