FLORIDA HEALTH INSURANCE ADVISORY BOARD MEETING

Wednesday, November 30, 2022, 3:00 PM
Conference Call
Call-In Number: 866-299-7949
Code: 1433866#

AGENDA

I. **Call to Order**

II. **Roll Call - Attachment**

III. **Antitrust Statement - Attachment**

IV. **Approval of Minutes, September 15, 2022 - Attachment**

V. **State of the Market Annual Report Approval - Attachment**

VI. **Executive Director's Report – Attachments**

VII. **Discussion/Approval of Legislative Proposals for 2023 - Attachment**

VIII. **Other Business**

IX. **Public Comment**

X. **Adjourn**

Florida Health Insurance Advisory Board Meeting

November 30, 2022

Table of Contents

Attachment A

FLORIDA HEALTH INSURANCE ADVISORY BOARD

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Vacant
Agent

Attachment B

FLORIDA HEALTH INSURANCE ADVISORY BOARD

BOARD MEETING

November 2022

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.

Attachment C

Florida Health Insurance Advisory Board
Board of Directors Meeting Minutes
Thursday, September 15, 2022, 9:00 AM
Via Teleconference
Tallahassee, FL

Board Members Present:

Alexis Bakofsky, Chair	John J. Matthews	Rick Wallace
Ken Stevenson, Vice Chair	Louisa McQueeney	Richard B. Weiss, CPA
Eric Johnson, PhD, ASA	Robert Muszynski	
Nathan Landsbaum	Seth M. Phelps	

Others Present:

- Jack McDermott, FHIAB Executive Director
- Anoush Brangaccio, General Counsel, Office of Insurance Regulation (OIR)

I. Call to Order

Alexis Bakofsky (Chief of Staff, Office of Insurance Regulation) as the Chair called the meeting to order at 9:00 am indicating the meeting was properly noticed to the public in accordance with Florida Law.

II. Roll Call

Jack McDermott conducted a roll call of members, noting the presence of a quorum.

III. Antitrust Statement

Anoush Brangaccio was recognized to review the antitrust statement.

IV. Chair's Opening Remarks

The Chair thanked the members for their attendance and appreciated the diverse expertise of Board members. She also noted the Board's unique perspectives will be valuable during the Board's review of legislative proposals later in the meeting. The Chair also welcomed the new executive director, Jack McDermott, to his first official Board meeting.

V. Approval of Minutes

The Chair presented the minutes from the Board's April 13, 2022, meeting and asked for questions or comments. The Chair accepted a motion from Seth Phelps to approve the minutes, seconded by Nathan Landsbaum. The minutes were approved without changes.

VI. Approval of 2020 Audits & 2021 Audit Engagement Letter

The Chair recognized Seth Phelps, Chair of the audit committee, for the audit committee's recommendation for the 2020 audits and 2021 audit engagement letter. Mr. Phelps asked for a motion to approve the 2020 audit reports and summary of audit findings, and accept the 2021 Purvis Gray engagement letter, and further instruct the executive director to execute the finalization of the 2020 audits and initiate the 2021 audit engagement. Ken Stevenson made a motion for approval that was seconded by Richard Weiss. The motion was approved.

VII. Executive Director's Report

The Chair recognized Jack McDermott to present the executive director's report. Mr. McDermott presented several administrative items including: 1) the financial statements as of December 31, 2021 and August 31, 2022, 2) a discussion of FHIAB documents from 1993-2006 in a storage facility and obtaining a legal review to create a retention schedule that may allow for the disposal of these documents, 3) research about obtaining a P.O. Box for FHIAB prior to the corporate assessments, 4) research about migrating the FHIAB website from OIR to a third-party host, and 5) a discussion/review of the FHIAB's Plan of Operations; additionally the executive director requested the Board review the current Plan of Operations and consider volunteering for an FHIAB Plan of Operations Re-Write Committee that will be formed after the next Board meeting.

VIII. Discussion of Legislative Proposals for 2023

The Chair moved to the next agenda item which included a presentation of eight legislative proposals. All eight proposals were submitted by board member Louisa McQueeney and she asked Louisa to present each item. Louisa presented the following eight proposals:

Proposal # 1: Deductible Health Credit Transfer

Proposal # 2: Provide Health Care Consumers with One Free Copy of their Own Medical Records

Proposal # 3: Protect Consumers from Prescription Drug Formulary Changes During a Policy Year

Proposal # 4: Cap the Cost of Insulin at $35 a Month

Proposal # 5: Prohibit Balance Billing for Ground Emergency Medical Transportation

Proposal # 6: Include Applied Behavioral Analysis as a Covered Benefit in all Insurance Plans

Proposal # 7: Add Fetal Alcohol Spectrum Disorder (FASD) to Include to the Definition of the Term Developmental Disabilities

Proposal # 8: Apply Payments by, or on Behalf of, a Beneficiary to Count Toward the Out-of-Pocket Cost Sharing Calculations

There was a discussion for Proposal # 2. Board member Eric Johnson asked about who would pay the cost for these medical records. Ms. McQueeney replied that it would be paid by the provider.

Mr. Johnson questioned the appropriateness of the FHIAB making a recommendation that could amend statutes relating to providers rather than amending the health insurance code. He asked that Ms. McQueeney provide more details as to how the adoption of this proposal would be incorporated into Florida Statutes. Ms. McQueeney agreed to provide additional information prior to the next meeting.

The Chair reemphasized that no votes on these items will be taken today and asked that additional information on any of these items be forwarded to the executive director prior to the next meeting. The Chair said the FHIAB will have another meeting in a month or two to finalize the Board's legislative recommendations.

IX. Other Business

The Chair asked if any Board member had "other business" or other items to be presented to the Board. Hearing none, she moved to the next agenda item.

X. Public Comment

The Chair asked if anyone from the public had comments about any of the items discussed during the Board meeting. There were 6 members of the public that provided comment:

Doreen Glenn (mother of son with expensive medication) – spoke in favor of Proposal # 8

Jeff Jones (insurance agent) – spoke to show appreciation of the FHIAB meeting

Stephanie Hanks (Manager for Policy & Research, AIDS Institute) – spoke in favor of Proposal # 8

Donna Sabatino, RN (State Policy & Advocacy Director, AIDS Institute) -- spoke in favor of Proposal # 8

Jennifer Werden (FASD Parent Advocate, The Florida Center for Early Childhood) - spoke in favor of Proposal #7

Christa Stephens (State Government Affairs Director, Autism Speaks) - spoke in favor of Proposal # 6

XI. Adjourn

The Chair thanked everyone who participated and provided public comment. Having completed the agenda, the Chair adjourned the meeting.

_____ _____

Alexis Bakofsky, Chair Date

Attachment D

2022 FLORIDA HEALTH INSURANCE MARKET REPORT

BY THE

FLORIDA HEALTH INSURANCE ADVISORY BOARD

Adopted November ***, 2022

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, 2021. Previous reports are available on the FHIAB section of the Office's website at: http://www.floir.com/Sections/LandH/FHIAB.aspx.

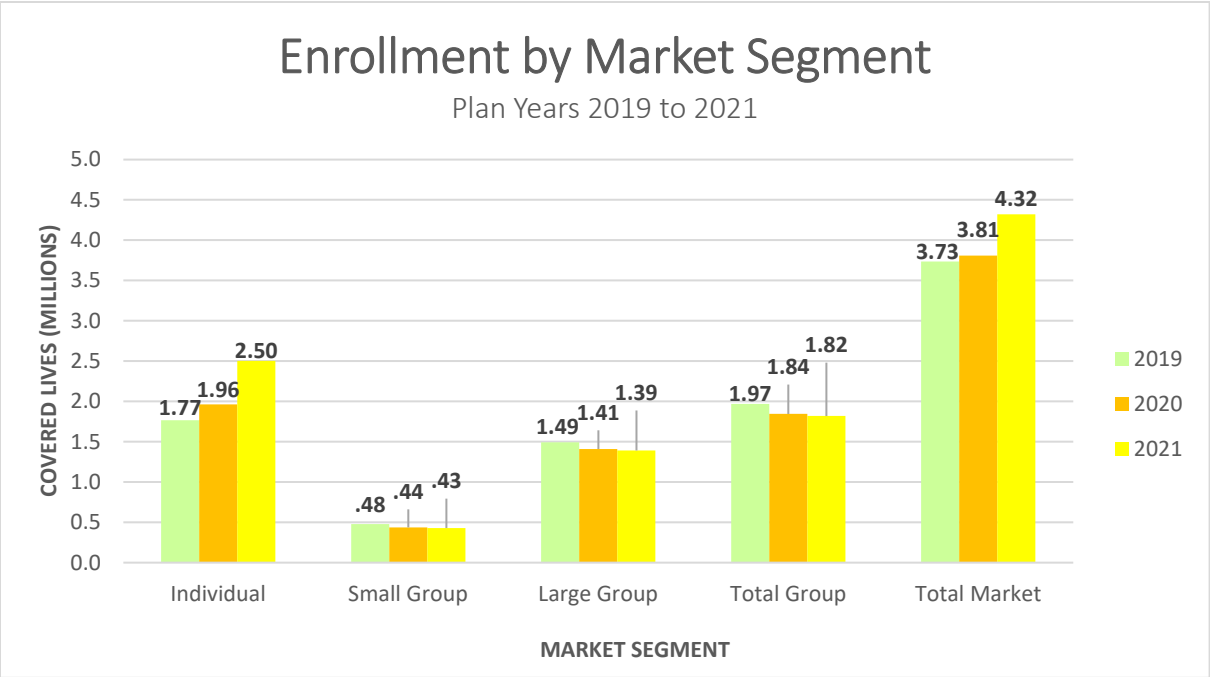
Executive Summary

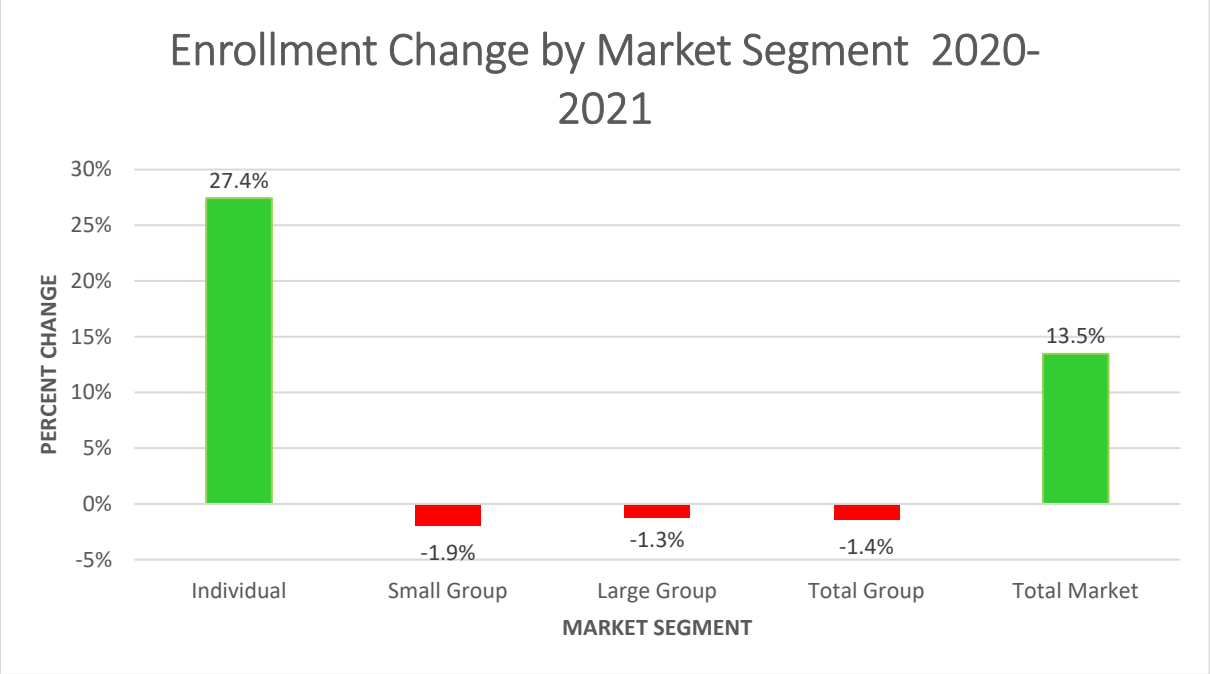
Overall enrollment continued to grow, and potentially accelerated, in certain segments of the market due to the effects of COVID-19 on employment and personal income. Rates have largely stabilized leading to smaller changes, and the long-term trend of increasing individual enrollment and decreasing group enrollment is not only consistent – the gap is widening.

Today, in the State of Florida, people covered under individual policies exceed those covered under a group policy. Under the Affordable Care Act (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 were extended indefinitely on March 23, 2022, by a bulletin issued by the Centers for Medicare & Medicaid Services (CMS). 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.

Both the small group and large group markets continue to contract, and this trend is not expected to change. The percentage decline from 2020 to 2021 was smaller than in prior years and may have been related to COVID-19 as well as a restructuring of the workforce. In addition, carriers have been 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 significant increase in 2021 of 512,565 covered lives or 13.5%. This follows an increase from the previous year of 72,894 covered lives or 2.0%. While the overall market remains significantly larger than before the ACA and had remained stable over the last several years – 2021 potentially indicates an anomaly – a significant year-over-year increase relative to prior years.

As of year-end 2021, coverage by market segment consisted of:

- **Individual Coverage –** 2,501,234, an increase of 538,548 covered lives or 27.4%
- **Small Group** (1-50 members) **–** 427,906, a decrease of 8,335 covered lives or 1.9%
- **Large Group** (51+ members) **–** 1,390,999, a decrease of 17,648 covered lives or 1.3%
- **Total Market –** 4,320,139 an increase of 512,565 covered lives or 13.5%

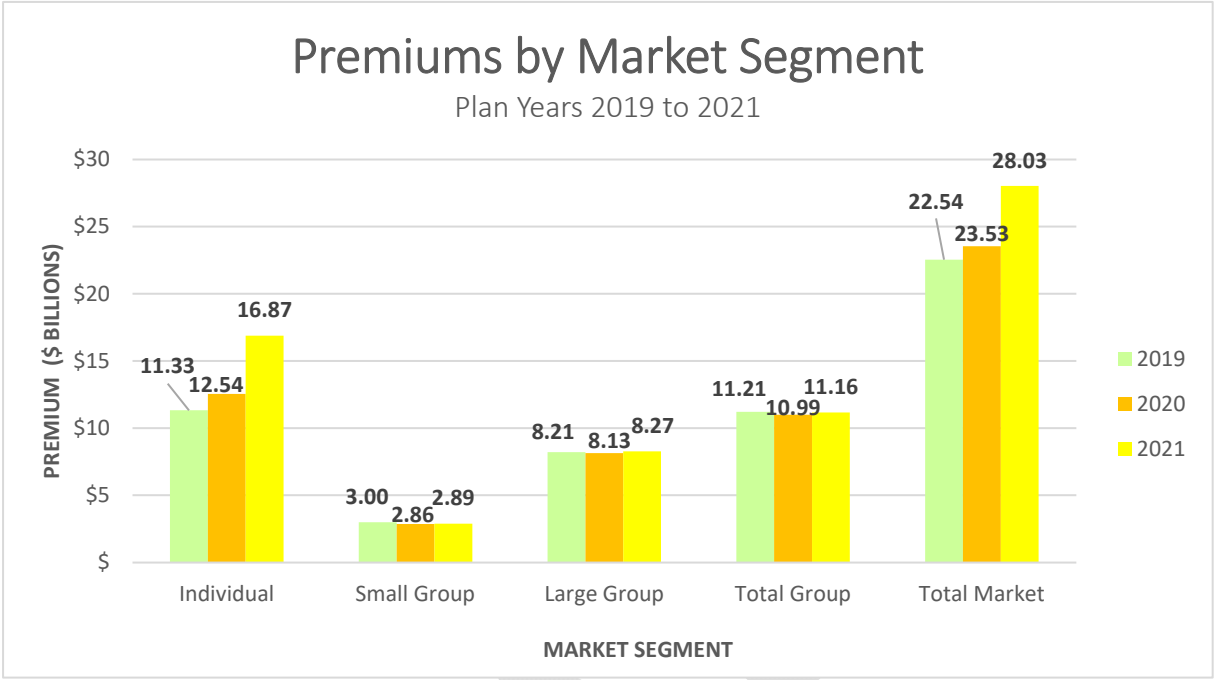
The individual market enrollment continues to grow despite the implied tax penalty (individual mandate) being set to $0 and changes to federal and state law that encourage growth of alternative products such as short-term limited duration policies (up to 364 days) and health care sharing ministries. 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. In 2020, the individual market overtook the group market in terms of enrollment – which accelerated dramatically in 2021 as the individual market grew 27.4%, while the small group market declined 1.9%, creating an even larger gap.

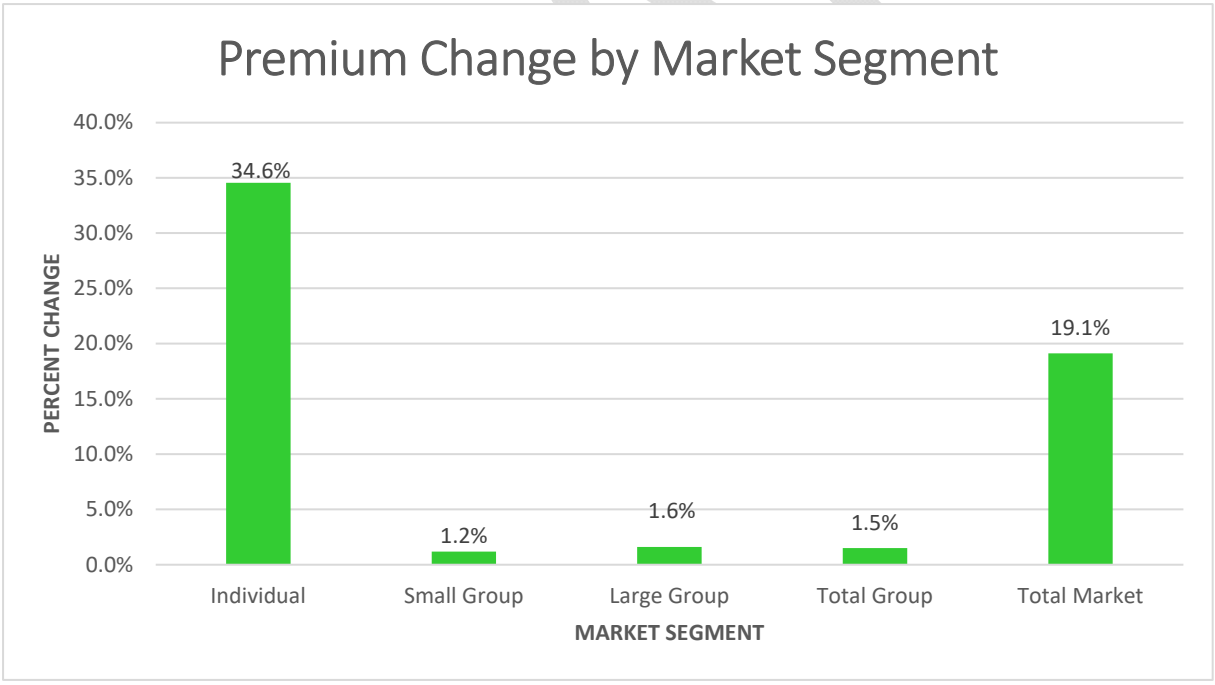
In contrast to the individual market, enrollment in the total group market continues to decline. The declining trend in group coverage was in effect prior to the implementation of the ACA as small group enrollment was 1,073,683 in 2005 but had dropped to 598,361 in 2014 and large group enrollment declined from 2,468,056 in 2005 to 1,628,198 in 2014. The declining trends in group enrollment have generally slowed down (but continued), possibly due to COVID-19 and its effects on employment. Other contributing factors may be that carriers have been active in developing products that help employers reduce costs by self-insuring. In addition, some small employers have chosen to stop 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.

Table 1
Commercial Insurance Enrollment 2019-2021

Market Segments	2019	2020	2021
Individual Guaranteed Issue			
ACA On-Exchange	1,480,060	1,676,923	2,199,609
ACA Off-Exchange	128,162	145,030	200,346
Grandfathered (In-State and Out-of-State)	339	301	284
Transitional (In-State and Out-of-State)	75	26	25
Total Guaranteed Issue	1,608,636	1,822,286	2,400,264
Individually Underwritten			
Grandfathered (In-State and Out-of-State)	41,278	36,473	32,356
Transitional (In-State and Out-of-State)	115,703	103,789	68,444
Total Individually Underwritten	156,981	140,262	100,800
Conversion			
Total Conversion	190	138	170
Small Groups (1-50)			
Self-Employed or Sole Proprietor	110	100	80
2 – 50 Member Groups	476,080	436,141	427,826
Total Small Groups	477,190	436,241	427,906
Large Groups (51+)			
Total Large Groups	1,491,683	1,408,647	1,390,999
Market Totals			
Total Individual Market	1,765,807	1,962,686	2,501,234
Total Group Market	1,968,873	1,844,888	1,818,905
Total Commercial Market	3,734,680	3,807,574	4,320,139

Commercial Premium



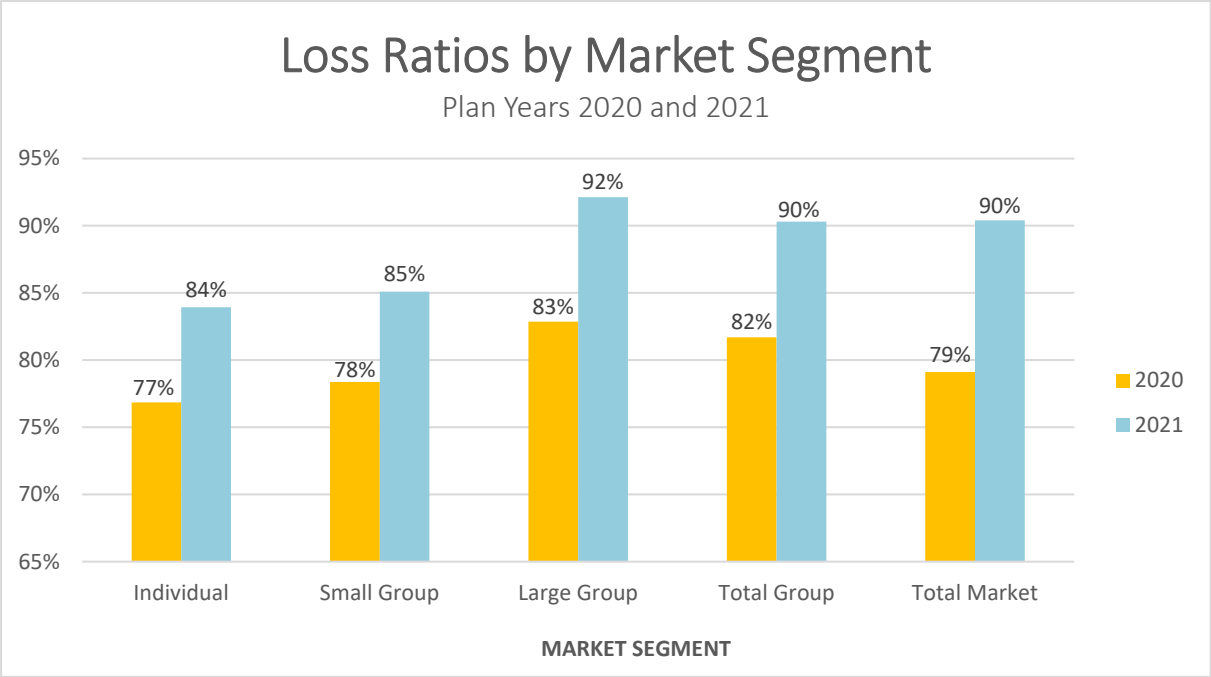


As illustrated above and shown in Table 2 below, the overall commercial market generated $28,027,667,408 in premiums in 2021, a 19.11% increase from 2020. This follows a 4.41% increase the prior year. The increase is largely the result of the higher enrollment in the individual market and higher premiums per member in all markets.

Table 2
Commercial Insurance Premium 2019-2021

Market Segments	2019	2020	2021
Individual Guaranteed Issue			
Grandfathered (In-State and Out-of-State)	$1,106,010	$808,697	$611,513
Transitional (In-State and Out-of-State)	$724,462	$476,295	$348,047
ACA On-Exchange	$9,455,661,811	$10,698,864,079	$15,093,892,765
ACA Off-Exchange	$1,157,720,398	$1,114,074,761	$1,223,834,541
Total Guaranteed Issue	$10,615,212,681	$11,819,087,384	$16,318,686,866
Individually Underwritten			
Grandfathered (In-State and Out-of-State)	$230,156,312	$231,442,132	$203,547,896
Transitional (In-State and Out-of-State)	$478,854,011	$487,977,024	$349,056,939
Total Individually Underwritten	$709,010,323	$719,419,156	$552,604,835
Conversion			
Total Conversion	$1,071,231	$932,725	$637,218
Small Groups (1 – 50)			
Self-Employed or Sole Proprietor	$855,637	$873,161	$699,306
2 – 50 Member Groups	$2,996,318,490	$2,855,835,726	$2,889,626,140
Total Small Groups	$2,997,174,127	$2,856,708,887	$2,890,325,446
Large Groups (51+)			
Total Large Groups	$8,213,793,248	$8,134,888,794	$8,265,413,042
Market Totals			
Total Individual Market	$11,325,294,235	$12,539,439,266	$16,871,928,920
Total Group Market	$11,210,967,375	$10,991,597,681	$11,155,738,488
Total Commercial Market	$22,536,261,610	$23,531,036,547	$28,027,667,408

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.

The loss ratios increased "across-the-board" in all categories.

In the individual market, the overall loss ratio increased from 76.84% in 2020 to 83.93% in 2021 while the small group overall loss ratio increased from 78.37% to 85.09% in 2021.

The large group market experienced an overall loss ratio increase from 82.86% in 2020 to 92.12% in 2021. 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 2020-2021

Market Segments	2020			2021		
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)	$808,697	$1,417,087	175.23%	$611,513	$979,754	160.22%
Transitional (In-State and Out-of-State)	$476,295	$467,635	98.18%	$348,047	$313,100	89.96%
ACA On-Exchange	$10,698,864,079	$8,191,567,157	76.56%	$15,093,892,765	$12,719,380,598	84.27%
ACA Off-Exchange	$1,118,938,313	$868,261,559	77.60%	$1,223,834,541	$945,637,323	77.27%
Total Guaranteed Issue	$11,819,087,384	$9,061,713,438	76.67%	$16,318,686,866	$13,666,319,775	83.75%
Individually Underwritten						
Grandfathered (In-State and Out-of-State)	$231,442,132	$157,741,096	68.16%	$203,547,896	$164,396,999	80.77%
Transitional (In-State and Out-of-State)	$487,977,024	$413,439,265	84.73%	$349,056,939	$327,335,487	93.78%
Total Individually Underwritten	$719,419,156	$571,180,361	79.39%	$552,604,835	$491,732,486	88.98%
Conversion						
Total Conversion	$932,725	$2,790,397	299.17%	$637,218	$2,857,136	448.38%
Small Groups (1 – 50)						
Self-Employed or Sole Proprietor	$873,161	$2,660,169	304.66%	$699,306	$1,337,535	191.27%
2 – 50 Member Groups	$2,855,835,726	$2,236,234,187	78.30%	$2,889,626,140	$2,458,037,765	85.06%
Total Small Groups	$2,856,708,887	$2,238,894,356	78.37%	$2,890,325,446	$2,459,415,300	85.09%
Large Groups (51+)						
Total Large Groups	$8,134,888,794	$6,740,291,193	82.86%	$8,265,413,042	$7,614,456,891	92.12%
Market Totals						
Total Individual Market	$12,539,439,266	$9,635,684,195	76.84%	$16,871,928,920	$14,160,900,397	83.93%
Total Group Market	$10,991,597,681	$8,979,185,549	81.69%	$11,155,738,488	$10,073,872,191	90.30%
Total Commercial Market	$23,531,036,947	$18,614,869,744	79.11%	$28,027,667,408	$24,234,772,588	86.47%

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 as of November 2022 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

Pamela Hull
Chief of Medicaid Plan Mg. Ops.
Florida Agency for Health Care Admin
2727 Mahan Drive, Mailstop #50
Tallahassee, FL 32308

Louisa McQueeney
Communications Director Florida Voices for Health
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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 Term Ending: 12/31/2022

Eric Johnson, Ph.D.,
ASA Chief Actuary & VP of Analytics & Business Intelligence
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Term Ending: 12/31/2022

Richard B. Weiss, CPA
President, Florida Market
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Term Ending: 12/31/2024

John J. Matthews
Vice President of Legal, Regulatory and Government Affairs
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Term Ending: 12/31/2022

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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
Director of Finance and Administration
WMFE (NPR) Radio
11510 E. Colonial Drive
Orlando, FL 32817
Term Ending: 12/31/2024

Nathan Landsbaum
President and CEO, Florida Sunshine Health
1700 N. University Drive
Plantation, FL 33322
Term Ending: 12/31/2023

A Director position for an agent representative is vacant.

Attachment E

Balance Sheet
October 31, 2022
FHIAB

	Small Employer Plan	Individual Plan	Eliminating Entry	Combined Total
Assets				
Cash Operating	13,729.69	33,991.40		47,721.09
Cash Depository	11,476.39			11,476.39
Cash Special Purpose	679.89			679.89
Prepaid Expenses	45.19	16.38		61.57
Due from Indiv Pool	30,652.54		(31,886.28)	-
Total Assets	57,817.44	34,007.78	(31,886.28)	59,938.94
Liabilities				
Federal Income Tax Payable				-
Due to Small Employer Plan		31,886.28	(31,886.28)	-
Accrued Audit Fees	11,916.67	5,958.33		17,875.00
Total Liabilities	11,916.67	37,844.61	(31,886.28)	17,875.00
Net Assets	45,900.77	(3,836.83)	-	42,063.94
Total Liabilities and Net Assets	57,817.44	34,007.78	(31,886.28)	59,938.94

Income Statement
For the Nine Months Ended October 31, 2022
FHIAB

	Small Employer Plan	Individual Plan	Eliminating Entry	Combined Total
Revenues				
Interest Income	0.91	2.25		3.16
Expense Write-Off	165.17	33.83		199.00
Expenses				
Contract Services	24,900.00	5,100.00		30,000.00
Professional Fees	5,416.67	2,708.33		8,125.00
Meetings	688.88	141.21		829.98
Storage Fees	451.94	92.57		544.50
Income tax expense	-	-		-
Advertising expense	-	-		
Total Expenses	31,494.82	8,049.75	-	39,544.45
Change in Net Assets	(31,328.74)	(8,013.67)	-	(39,541.29)
Net Assets, January 1, 2022	77,229.50	4,176.73		81,406.23
Net Assets, August 31, 2021	45,900.76	(3,836.94)	-	41,864.94

Attachment F

Florida Health Insurance Advisory Board

Proposed Budget

November 1, 2022 – December 31, 2023

[14 Months]

Expense Category	Proposed Budget
Executive Director	$70,000
Legal Services	$5,000
Meeting Expenses	$200
Miscellaneous Expenses	$200
P.O. Box	$200
Postage/Delivery	$50
Shredding Services	$600
Storage Services	$600
Supplies/Printing	$50
Adobe Writer Subscription	$179
Travel	$0
Telephone / Conference Call [4 calls]	$1,000
Website Services	$2,500
Total Expenses to be Apportioned (prior to Audits)	**$80,579**

Small Group	
83% of Total Expenses to be Apportioned	$66,880
Small Group Audit	$6,500
Total Small Group Expenses	**$73,380**
Individual	
17% of Total Expenses to be Apportioned	$13,698
Individual Audit	$3,250
Total Individual Expenses	**$16,948**
Overall Total Expenses	**$90,328**

Attachment G

Florida Health Insurance Advisory Board
Proposed 2023 Assessment

	Small Group	Individual	Total
November 1, 2022 Balance	$45,900	($3,837)	$41,865
Proposed 2023 Assessment	$74,700	$25,300	$100,000
Proposed 2022-2023 Budget	($73,380)	($16,948)	($90,328)
Estimated January 1, 2024 Balance	$47,220	$4,515	$51,735

Attachment H

Proposal # 1: Deductible Health Credit Transfer

Louisa McQueeney – Florida Voices for Health

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 2023 could end up being as high as $9,100 for an individual and $18,200 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, because 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 the accumulators out of their own pocket. This is even more egregious when consumers stay with the same carrier with the expectation already incurred accumulators will be recognized, only to find out that they will not.

□ 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 period 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.

Proposal # 2: Provide Health Care Consumers with One Free Copy of their Own Medical Records

Louisa McQueeney – Florida Voices for Health

Patients have a right to their medical records under the Health Insurance Portability and Accountability Act (HIPAA). However, 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. Having a patient see and review their medical records and related provider charges billed to the insurer would also bring down improper billing and potential fraud. This in turn should lead to lower health insurance costs to both plan sponsors and individuals.

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

Proposal # 3: Protect Consumers from Prescription Drug Formulary Changes During a Policy Year

Louisa McQueeney – Florida Voices for Health

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 in which they are classified.

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. The consumer's input is not part of the process, but 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*

Proposal # 4: Cap the Cost of Insulin at $35 a Month

Louisa McQueeney – Florida Voices for Health

The Inflation Reduction Act, recently signed into law, will reduce the cost of insulin to no more than $35 per month for people on Medicare starting 2023. This includes insulin pumps. However, the new law doesn't extend to individual and group health plans. The cost of insulin, which has been around for 100 years, is 10 times higher in the US than any other developed country and creates an enormous financial burden on Floridians who cannot survive without.

We have all heard the heartbreaking stories. While there is no high cost of development to insulin and innovation is limited, there is also no "free" market where market forces would drive down the cost to consumers. This lack of "free" market allows for price increases at will for this lifesaving medicine. Putting a cap on the price of insulin will save money through less hospital admissions for high blood sugar emergencies and less health complications resulting in disability. Putting a cap on the cost of insulin would drive down the cost of healthcare for all Floridians

□*Recommendation: Require individual & group health insurance policies to cap insured's monthly cost-sharing obligation for covered prescription insulin drugs at $35 starting with 2023 plans; require health maintenance contracts to cap subscriber's monthly cost-sharing obligation for covered prescription insulin drugs at $35 starting with 2023 plans.*

Proposal # 5: Prohibit Balance Billing for Ground Emergency Medical Transportation

Louisa McQueeney – Florida Voices for Health

The No Surprises Act of 2019 addressed many balance billing or "surprise" billing issues for consumers. However, it didn't address the cost of ground emergency medical transportation. Consumers in a life-threatening accident or major medical emergency in need of ground emergency transportation 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 this coverage gap 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 ground emergency transportation.*

Proposal # 6: Include Applied Behavioral Analysis as a Covered Benefit in all Insurance Plans

Louisa McQueeney – Florida Voices for Health

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 twenty-one.

These services are extremely important for recipients with developmental disabilities. In the health insurance market these services are required under statute section 627.6686, and applicable to a group health insurance policy or group health benefit plan offered by an insurer which includes the state group insurance program provided under s. 110.123. However, these services are not required to be included in any health insurance plan offered in the individual market, any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer.

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 very 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.*

Proposal # 7: Add Fetal Alcohol Spectrum Disorder (FASD) to Include to the Definition of the Term Developmental Disabilities

Louisa McQueeney – Florida Voices for Health

Harm to Florida's children from prenatal alcohol exposure (PAE) is a significant public health problem and the leading known cause of preventable developmental disabilities in the United States. Given that nearly half of pregnancies are unintended and women often don't realize they are pregnant until they are 6 weeks along or more, makes it easy to understand that women could drink alcohol while not knowing they are expecting. Many myths and misconceptions about the risk of alcohol use during pregnancy remain despite nearly 50 years of research.

Recent studies show an alarming prevalence of up to 1 in 20 first graders in the United States meeting criteria for Fetal Alcohol Spectrum Disorders (FASD) classification. PAE is especially harmful to the developing brain and could impact all facets of a child's life. Research also shows alcohol causes far greater harm to the brain than other drugs, yet recognition of the disability -- with appropriate FASD-informed supports and services -- can prevent secondary disabilities. Without these supports and services, many young adults with FASD may end up incarcerated, homeless, vulnerable to substance abuse, unemployed, and reduced access to health care.

Among medical and behavioral health professionals, inconsistent use or limited knowledge of diagnostic criteria and clinical guidelines result in many (if not most) children and adults living with FASD going undiagnosed or misdiagnosed. Families struggling with children with FASD, many of them adopted or fostered, cannot find systems of care that are familiar with or equipped to diagnose and address FASD-related disabilities. Although there is no cure for individuals impacted by FASD, research shows intervention services and supports, including social, environmental, and educational strategies can prevent subsequent trauma to the individual, their caregivers, and society.

□ *Recommendation: Include Fetal Alcohol Spectrum Disorder to the list of definitions of the term developmental disabilities in statute 627.6686.*

Proposal # 8: Apply Payments by, or on Behalf of, a Beneficiary to Count Toward the Out-of-Pocket Cost Sharing Calculations

Louisa McQueeney – Florida Voices for Health

Patients, even those with health insurance, are having difficulty affording their medications as a result of steadily rising out-of-pocket costs. To help cover the patients' copays, some drug manufacturers, charitable assistance foundations, and other third parties offer copay assistance programs to help patients afford their specialty drugs. These programs are intended to provide relief to policyholders who have trouble paying for their prescription drug copays. Most patients, who use copay assistance require highly specialized life-saving medications to treat hemophilia, MS, HIV, cancer, and other rare and chronic diseases for which, in many cases, no generics or lower-cost drugs are available.

In recent years, insurance companies and pharmacy benefit manager (PBMs) have implemented so-called "copay accumulator adjustment programs" where none of these payments made on behalf of the patient would count towards their deductible and annual maximum out of picket costs. In addition, most insurance plans make it very difficult for a patient to find out if they have an accumulator program, using very vague language, if any at all in plan policy documents.

The financial assistance that patients receive is a specified amount per year based on the cost of the prescription. Patients often discover mid plan year that the copay assistance limit has been reached and they have to pay the entire cost of the prescription drug because none of the third-party payments were counted towards their out-of-pocket costs – defeating the purpose of the copay assistance. Research has shown that many patients will abandon their medication at the pharmacy or ration doses when they have to pay more than $75 to $225 out of pocket, foregoing life-saving medication.

With copay accumulator programs, insurers and PBMs are collecting the financial assistance intended for the patient, and then requiring the patient to

pay the deductible again, making it harder for consumers get their medications and other health care.

Fourteen (14) states have passed legislation prohibiting copay accumulator policies: Arkansas, Arizona, Connecticut, Georgia, Illinois, Kentucky, Louisiana, Maine, North Carolina, Oklahoma, Tennessee, Virginia, Washington, and West Virginia.

Earlier this summer, Governor DeSantis issued an executive order (number 22-164) directing the state to implement healthcare reforms that reduce costs to consumers, promote transparency, and hold PBMs accountable. Adopting copay accumulator legislation that prohibits the harmful and deceitful practices of insurers and PBMs aligns with the Governor's commitment to protect advancing Floridians health.

□ *Recommendation: Require each health insurer, issuing, delivering, or renewing a policy in Florida, which provides prescription drug coverage, administered by the insurer or pharmacy benefit manager, to count any amount paid by the insured or paid on his or her behalf through a third party (including but not limited to manufacturer or provider cost share assistance payments such as manufacturer cost share assistance) toward the policyholder's total contribution to any deductible or out-of-pocket requirement. Insurers must include in policy documents, such as the summary of benefits, and on websites that these payments will be applied to the policyholder's out-of-pocket maximum, deductible, or copayment responsibility.*

In the absence of legislation prohibiting copay accumulator policies, each health insurer, issuing, delivering, or renewing a policy in Florida, which provides prescription drug coverage, administered by the insurer or PBM must clearly disclose the copay accumulator in the summary of benefits, in policy documents and on websites, made available to consumers prior to enrollment in a policy and that payments paid on his or her behalf will not count towards the policyholder's out-of-pocket costs maximum, deductible, or copayment responsibility. In addition, payments made on behalf of the policy holder must appear on the explanation of benefits (EOB) as a payment the insurer will not apply towards the policyholder's out-of-pocket maximum, deductible or copayment responsibility.