FLORIDA HEALTH INSURANCE ADVISORY BOARD MEETING

October 8, 2024
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 11, 2024 - Attachment**

V. **Executive Director's Report – Attachment**

VI. **Legislative Proposals for 2025 - Attachment**

VII. **Other Business**

VIII. **Public Comment**

IX. **Adjourn**

Attachment A

FLORIDA HEALTH INSURANCE ADVISORY BOARD

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Vacant
Agent

As of September 30, 2024

Attachment B

FLORIDA HEALTH INSURANCE ADVISORY BOARD

BOARD MEETING

October 2024

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

DRAFT

Florida Health Insurance Advisory Board
Board of Directors Meeting Minutes
Wednesday, September 11, 2024, 9:00 AM
Via Teleconference
Tallahassee, FL

Board Members Present:

Alexis Bakofsky, Chair	Rick Wallace	Richard B. Weiss, CPA
Stefan Grow	Louisa McQueeney	Nathan Landsbaum
Eric Johnson, PhD, ASA	Christina Lake	Seth M. Phelps
Robert Muszynski	Vickie Whaley	

Others Present:

- Jack McDermott, FHIAB Executive Director
- Stephanie Roman Caban, Senior Attorney, Legal Services, Office of Insurance Regulation

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. The Chair noted a change in the Board composition -- Vickie Whaley has been appointed as an agent representative to the Board. The Chair welcomed Ms. Whaley to her first Board meeting.

II. Roll Call

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

III. Antitrust Statement

Stephanie Roman Caban was recognized to review the antitrust statement.

IV. Approval of Minutes, December 15, 2023

The Chair presented the minutes from the Board's December 15, 2023, meeting and asked for questions or comments. The Chair accepted a motion from Rick Wallace to approve the minutes, seconded by Seth Phelps. The minutes were approved without changes.

V. Executive Director's Report

The Chair recognized Executive Director Jack McDermott for this report. Mr. McDermott reported that all of the prior year's assessments totaling $34,992 from the small group market and $14,992 from the individual market had been collected and deposited. As to the financial statements, the Board had roughly $88,000 in total assets across both programs as of August 31, 2024, which was more than sufficient to cover expenses through the remainder of the year. The Chair asked if any Board members had questions; there were none.

VI. Approval of 2022 Audits & 2023 Audit Engagement Letter

The Chair recognized Seth Phelps, Chair of the Audit Committee, to discuss the 2022 Audits and 2023 Audit Engagement Letter. Mr. Phelps stated the committee recommended the approval of the 2022 audit report, and the 2023 engagement letter. Mr. Phelps reported the 2022 audit referenced findings consistent with past audits that were in the process of being addressed by the Executive Director.

Moreover, he stated the 2023 Audit Engagement was approved with the understanding this audit would be completed prior to the end of the year, which will help with addressing the findings. In addition, Purvis Gray, the auditor, gave assurances this second audit could be completed within the requested timeframe. Mr. Phelps asked if any Board members had questions; there were none. The Chair accepted a motion from Rick Wallace to approve the committee's recommendation, seconded by Christina Lake.

VII. Other Business

The Chair mentioned one item for the next meeting will be the 2025 Legislative recommendations. She said the next meeting will be scheduled shortly, with a deadline of September 25th or by the end of the month, to have the legislative proposals to the executive director for compilation prior to the meeting. She reminded Board members this meeting will involve a presentation of the legislative proposal, and questions about these proposals, but no vote will be taken at the next meeting.

The Chair asked if any Board member had any other business before the Board. Louisa McQueeney asked about the status of her re-appointment to the Board; the Chair stated she is still on the Board, and the Chair would look into the re-appointment, and we should have this resolved prior to the next meeting.

VIII. Public Comment

The Chair asked for public comment. Nobody from the public commented.

IX. Adjourn

The Chair thanked the Board members for their participation and the public for listening to the discussion. Having completed the agenda, the Chair adjourned the meeting around 9:15 am.

Prepared by: Jack McDermott, Executive Director	Approved by Board

DRAFT

Attachment D

Balance Sheet
Sept. 30, 2024
FHIAB

	Small Employer Plan	Individual Plan	Eliminating Entry	Combined Total
Assets				
Cash Operating	57,065.01	14,019.95		71,084.96
Cash Depository	11,496.88			11,496.88
Cash Special Purpose	385.64			385.64
Prepaid Expenses	-	-		-
Due to Indiv Pool	(9,212.87)		9,212.87	-
Assessments Receivable				-
Total Assets	59,734.66	14,019.95	9,212.87	82,967.48
Liabilities				
Federal Income Tax Payable				
Due to Small Employer Plan		(9,212.87)	9,212.87	-
Accrued Audit Fees	14,100.00	7,250.00		21,350.00
Account Payable - Postage	-	-		-
Account Payable - Line1 Comn	-	-		-
Total Liabilities	14,100.00	(1,962.87)	9,212.87	21,350.00
Net Assets	**45,634.66**	**15,982.82**	**-**	**61,617.48**
Total Liabilities and Net Assets	59,734.66	14,019.95	9,212.87	82,967.48

Income Statement
For the Period Ended September, 2024
FHIAB

	Small Employer Plan	Individual Plan	Eliminating Entry	Combined Total
Revenues				
Interest Income	1.12	1.32		2.44
Expense Write-off	-	-		-
Assessments	34,992.00	14,992.00		49,984.00
Total Revenues	34,993.12	14,993.32	-	49,986.44
Expenses				
Contract Services	37,350.00	7,650.00		45,000.00
Professional Fees				
Meetings	94.41	19.34		113.75
Storage Fees	-	-		-
Adobe Acrobat	149.31	30.60		179.91
Quickbooks	136.95	28.05		165.00
PO Box	-	-		-
Postage	-	-		-
Document Destruction	-	-		-
Total Expenses	37,730.67	7,727.99		45,458.66

Attachment E

Proposal # 1: Deductible Health Credit Transfer

Louisa McQueeney – Florida Voices for Health

With the recent small decline in annual health insurance deductibles to consumers, having to start a new deductible in the middle of the year remains a financial hardship. The deductibles for 2025 could end up being as high as $9,200 for an individual and $18,400 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 record requests are not honored in a timely fashion if honored at all and can be at great expense to the consumer. Obtaining and keeping track of 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 just makes common sense. It would bring down improper billing and potential fraud, which in turn should lead to lower health insurance costs to both plan sponsors and individuals.

□ *Recommendation: Provide consumers with one free copy of their medical record provided to consumer by mail or electronic mail, within 90 days of discharge or at the time of provider payment request for services provided, whichever comes sooner.*

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 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 with. 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.

For many 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 of the 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 of 2022 has reduced the cost of insulin to no more than $35 per month for people on Medicare. This includes insulin pumps. However, the law doesn't extend to individual and group health plans. Although some pharmaceutical companies did lower their prices for insulin, 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 it. We have all heard 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 life saving 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. Since last year 3 more states enacted insulin price caps legislation, bringing the number to 25 States and the District of Columbia. This includes Alabama and West Virginia. 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 2025 plans; require health maintenance contracts to cap subscriber's monthly cost-sharing obligation for covered prescription insulin drugs at $35 starting with 2025 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, the most likely mode of transportation any of us will use when in an emergency. 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 arm's-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. Fourteen states have passed laws addressing the issue, including Texas, Arkansas, and Louisiana during the last year.

□ *Recommendation: Apply the balance bill rules under HB 221, 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 nor 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 support, 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 because of steadily rising out-of-pocket costs. To help cover the patients' copays and co-insurance, some drug manufacturers, charitable assistance foundations, and other third parties offer copay assistance programs to help patients with serious chronic conditions afford their specialty drugs. 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 copay assistance payments made on behalf of the patient count towards their deductible and annual maximum out of pocket 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 must 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 shows that many patients will abandon their medication at the pharmacy or ration doses when they must 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, the money, intended for the patient while requiring the patient to pay the deductible again, making it harder for consumers get their medications and other health care.

On September 29, 2023, the U.S. District Court for the District of Columbia vacated a Trump-era rule from 2021 that allowed insurers to exclude drug

manufacturer co-pay support coupons and assistance from a patient's annual cost-sharing caps. While waiting for the government's position on to enforce the ruling, so far 21 states have passed legislation prohibiting copay accumulator policies: Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Kentucky, Louisiana, Maine, New Mexico, New York, North Carolina, Oklahoma, Oregon, Tennessee, Texas, Vermont, Virginia, Washington, and West Virginia.

And while Governor DeSantis signed SB 1550 into law, requiring more transparency and accountability from PBM's, a ban on copay accumulators, the harmful and deceitful practices of insurers and PBMs towards many vulnerable Floridians, who are having to make choices between getting their medications or buying food, was once again not included.

* *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.