FLORIDA HEALTH INSURANCE ADVISORY BOARD MEETING

Tuesday, November 17, 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, October 14, 2020 – Attachment

VI. Discussion of Legislative Proposals for 2021 – Attachment

VII. Other Business

VIII. Public Comment

IX. Adjourn

FLORIDA HEALTH INSURANCE ADVISORY BOARD

October 9, 2020

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FLORIDA HEALTH INSURANCE ADVISORY BOARD
BOARD MEETING

November 17, 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
Wednesday, October 14, 2020, 11:00 AM
Via Teleconference
Tallahassee, FL

Board Members Present:

David Altmaier, Chair	Ken Stevenson, Vice Chair	Molly McKinstry
Louisa McQueeney	William "Bill" Herrle	Eric Johnson
Richard B. Weiss	Seth M. Phelps	Rick Wallace
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

I. Call to Order

Commissioner and Chair David Altmaier called the meeting to order at 11:00 am 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 and their service to the people of Florida, especially during these unprecedented times.

The Chair also noted that Chris Coffey, one of our carrier representatives who joined the Board in January 2019, is no longer with Sunshine Health/Centene so Liz Miller (President and CEO, Florida, Sunshine Health and WellCare) has been appointed to serve as a carrier representative in Chris Coffey's stead.

V. Approval of Minutes, December 3, 2019

The Chair presented the minutes from the December 3, 2019, meeting for adoption, noting that members had been provided with advance copies. Eric Johnson moved to adopt the minutes as written, with a second by Rick Wallace, and the minutes were adopted without objection.

VI. Executive Director Selection Committee Report/Recommendation

The Chair advised that he re-convened the Executive Director Selection Committee from last year with the goal of finding a replacement for our former Executive Director. Seth Phelps has agreed to continue as Chair, with Louisa McQueeney continuing as a member of the Committee, and Vice Chair Ken Stevenson replacing Adam Clatsoff as the third member of the Committee. He then turned the time over to Seth Phelps for a report from the Executive Director Selection Committee.

Seth Phelps reported that the Committee met on Monday (October 12, 2020) via teleconference. He noted that the Committee reviewed the Executive Director Duties list from last year and found them to still be appropriate. The Committee discussed its options: (1) pursue the runner-up from the last selection process or (2) go through a full selection process. The Committee unanimously recommends going through a full selection process due to the length of time it has been since the Committee last met and noting that Ken Stevenson was not part of the Committee last year.

Molly McKinstry moved to proceed as recommended by the Committee, with a second by Richard Weiss, and the recommendation was adopted without objection.

VII. Executive Director's Report

A. Annual Audits

The Chair presented the 2017 and 2018 Audit Reports for the Individual and Small Employer Health Reinsurance Programs, which were prepared by Purvis Gray, noting that members had been provided with advance copies. These reports have been reviewed and approved by the Audit Committee. Rick Wallace moved to adopt, with a second by Ken Stevenson, and the reports were adopted without objection.

The Chair presented the draft Audit Engagement Letter for the 2019 Audit by Purvis Gray, noting that members had been provided with advance copies. The Chair noted that the fees are the same as past years, and that the letter has been reviewed and approved by the Audit Committee. Richard Weiss moved to adopt, with a second by Seth Phelps, and the recommendation was adopted without objection.

B. Review of Plan of Operation

The Chair reported that the Plan of Operation requires that the Board review this plan and submit proposed amendments, if any, to the Commissioner for approval. During our last meeting last December, Michelle Robleto (Executive Director at the time) recommended no amendments to the Plan of Operation at that time as she was preparing for an overall assessment and external legal review of the Plan in 2020. Michelle resigned shortly after that and the Executive Director position has not yet been filled.

Therefore, the Chair proposed that the current Plan of Operation be accepted with no changes, noting that once an Executive Director is appointed, an overall assessment and external legal review of the Plan should be a priority. Rick Wallace moved to accept the recommendation, with a second by Bill Herrle, and the recommendation was adopted without objection.

VIII. Other Business

The Chair reported the need to elect a Chairman for the Audit Committee. Seth Phelps, Assistant General Counsel at Blue Cross and Blue Shield of Florida, has indicated his willingness to serve in this role. The Chair asked if there was a motion from a Board Member to accept this appointment or if there were other nominations. Ken Stevenson moved to accept the recommendation, with a second by Richard Weiss, and the recommendation was adopted without objection.

The Chair noted that Robert Muszynski and Bill Herrle are the other two Audit Committee members and he thanked everyone for their service on this Committee.

The Chair reported that we have three board members whose terms expire at the end of 2020: (1) Richard Weiss (President - FL Market, Aetna), (2) Rick Wallace (President/CEO, FAMOS, LLC), and (3) Robert Muszynski (Vice President - Finance, Orlando Regional Realtor Association). All three have graciously agreed to serve another term on the board and we are grateful for their participation and service.

The Chair noted that the Board will be receiving an email soon asking for legislative proposals for 2021. These proposals will be discussed at the next meeting with voting taking place at a follow-up meeting.

The Chair asked if there was any other business to be brought before the Board. There being none, the Chair moved to the next agenda item.

IX. 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.

X. Adjourn

The Chair thanked everyone for participating. Having no further business, the meeting was adjourned at 11:23 am.

_____ _____

David Altmaier, Chair Date

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.*