# FLORIDA HEALTH INSURANCE ADVISORY BOARD MEETING

Thursday, November 4, 2021, 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 12, 2021 – Attachment

VI. Executive Director Selection Committee Status Report

VII. State of the Market Annual Report Approval – Attachment

VIII. Discussion/Approval of Legislative Proposals for 2022 - Attachment

IX. Other Business

X. Public Comment

XI. Adjourn

# FLORIDA HEALTH INSURANCE ADVISORY BOARD

*September 21, 2021*

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# FLORIDA HEALTH INSURANCE ADVISORY BOARD
# BOARD MEETING

**November 4, 2021**

## 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, October 12, 2021, 2:00 PM**
**Via Teleconference**
**Tallahassee, FL**

**Board Members Present:**

| | | |
|---|---|---|
| Mike Yaworsky, Chair Designee | Ken Stevenson, Vice Chair | Cody Farrill |
| Louisa McQueeney | Christina Lake | William "Bill" Herrle |
| Eric Johnson, PhD, ASA | Richard B. Weiss, CPA | John J. Matthews |
| Seth M. Phelps | Rick Wallace | Robert Muszynski |
| Nathan Landsbaum | | |

**Others Present:**

- Amy Hardee, Administrative Assistant II to the Deputy Commissioner – Life & Health, Office of Insurance Regulation (OIR)
- Monica Ross, Chief Legal Counsel, 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

Monica Ross was recognized and reviewed the antitrust statement.

## IV. Chair's Opening Remarks

The Chair thanked the members for their attendance.

The Chair also noted that Liz Miller, one of our carrier representatives who joined the Board in October 2020, has left her role as President and CEO of Sunshine Health so Nathan Landsbaum (the new President and CEO of Sunshine Health) has been appointed to serve in her stead.

## V. Approval of Minutes, August 24, 2021

The Chair presented the minutes from the August 24, 2021, meeting for adoption, noting that members had been provided with advance copies. Seth Phelps 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 Status Report

The Chair recapped the Board's approved motion from its last meeting and turned the time over to Seth Phelps (Chair, Executive Director Selection Committee) for a status report.

Mr. Phelps reported that the Board's LinkedIn account is up and available. The Committee is now seeking approval for the draft job posting, which was included in the Board Packet, that reflects the job duties previously approved. Rick Wallace moved to adopt the Committee's recommended job posting, with a second by John Matthews, and the job posting was approved without objection.

The Chair thanked Mr. Phelps for the report and the Committee's work so far.

## VII. 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.

The Chair proposed that the Board accept the current Plan of Operation with no changes at this time and move forward with any recommendations or updates once an Executive Director is appointed. Cody Farrill moved to accept the recommendation, with a second by Christina Lake, and the recommendation was adopted without objection.

## VIII. Discussion of Legislative Proposals for 2022

The Chair noted that the purpose of today's call was to discuss possible legislative proposals for 2022 and reminded members that only those proposals reaching a full consensus by the members would be submitted for consideration to the 2022 Florida Legislature on behalf of the entire Florida Health Insurance Advisory Board.

The Chair reported that eight 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.

**Recommendation #2: Expand statute 627.666 to include individual on- and off-exchange policyholders a Deductible Health Credit Transfer to a new policy equal to the deductible paid by the policyholder 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.**
Ms. McQueeney reviewed her proposal, *Deductible Health Credit Transfer*, as submitted, noting that this was approved by the Board previously as a legislative recommendation.

Seth Phelps noted that currently the way the group carryover credit works is that up to the prior 90 days could carry over from the previous calendar year if the group moves. He asked if the intention here is only for the current calendar year or allowing up to the prior 90 days to carry over from the previous year for individuals also. Ms. McQueeney replied that said she thinks we should do both.

**<u>Recommendation #3:</u> 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.**
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.

Cody Farrill noted that the use of electronic health records has made medical records more accessible and that many consumers are now able to now access their medical records via electronic health records through their physician or provider. Ms. McQueeney agreed that electronic health records are wonderful; however, providers do not always provide testing results, so she wants it tied to billing. Also, there are many elderly people who do not know how to use computers.

Mr. Farrill also noted that this seems to be the role of the physician/provider rather than the insurer. John Matthews noted that the intent of this recommendation is noble; however, he agrees it is not within the scope of the Board. Mr. Matthews also noted that insurers do not always have every slip of paper that providers have. Rich Weiss agreed and noted that insurers do have the authority to request medical records; however, there may be a cost associated with such requests, depending on the contract negotiated between the provider and insurer. Eric Johnson concurred with the previous statements regarding the incompleteness of insurer's records.

Mr. Johnson also pointed out that there has been pretty significant activity at the federal level around transparency of information so it may be worthwhile to consider the effectiveness of that and let that develop a little bit before continuing down the path of doing something at the state level.

**<u>Recommendation #4:</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 year*, as submitted. She noted that we've discussed this before and it's been said that it's the drug companies, but her point remains that it's the insurance companies (not the consumers) that enter into contracts with the pharmaceutical companies.

**<u>Recommendation #5:</u> 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 Florida Legislature did previously include air ambulance in its surprise billing legislation (HB 747 in 2020), which is in ongoing litigation. He also noted that the Federal No Surprises Act does wrap in air ambulance coverage, which is set to go live on January 1, 2022. Therefore, the "air" aspect of this recommendation is mute. As a result, the Chair asked Ms. McQueeney if she would have any interest in striking the word "air" from her recommendation and she agreed. This recommendation now reads as follows:

### 5. Prohibit balance billing for emergency medical transportation

Consumers in a life-threatening accident or major medical emergency in need of emergency transportation by road or water 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.*

**<u>Recommendation #6:</u> 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 all insurance plans*, as submitted.

**<u>Recommendation #7:</u> Include Fetal Alcohol Spectrum Disorder to the definition of the term developmental disabilities in statute 627.6686.**
Ms. McQueeney reviewed her proposal, *Include Fetal Alcohol Spectrum Disorder (FASD) to the definition of the term developmental disabilities*, as submitted.

**<u>Recommendation #8:</u> 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 apply any amount paid by the insured or paid on his or her behalf through a third-party, for which there is no generic drug available, shall be applied toward the policyholder's total contribution to any cost-sharing requirement. Include disclosure in policy documents and on websites, that these payments will be applied to the policyholder's out-of-pocket maximum, deductible, or copayment responsibility.**
Ms. McQueeney reviewed her proposal, *Apply payments by, or on behalf of, a beneficiary to count toward the out-of-pocket cost sharing calculations*, as submitted.

The Chair thanked everyone for their participation and input into the discussion. He then noted that these recommendations will be voted on at the Board's next meeting.

**IX. Other Business**

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.

**X. 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.

**XI. Adjourn**

The Chair thanked everyone for participating. Having no further business, the meeting was adjourned at 2:49 pm.

_____ _____

Mike Yaworsky, Chair Designee Date

# 2021 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, 2020. Previous reports are available on the FHIAB section of the Office's website at: http://www.floir.com/Sections/LandH/FHIAB.aspx.

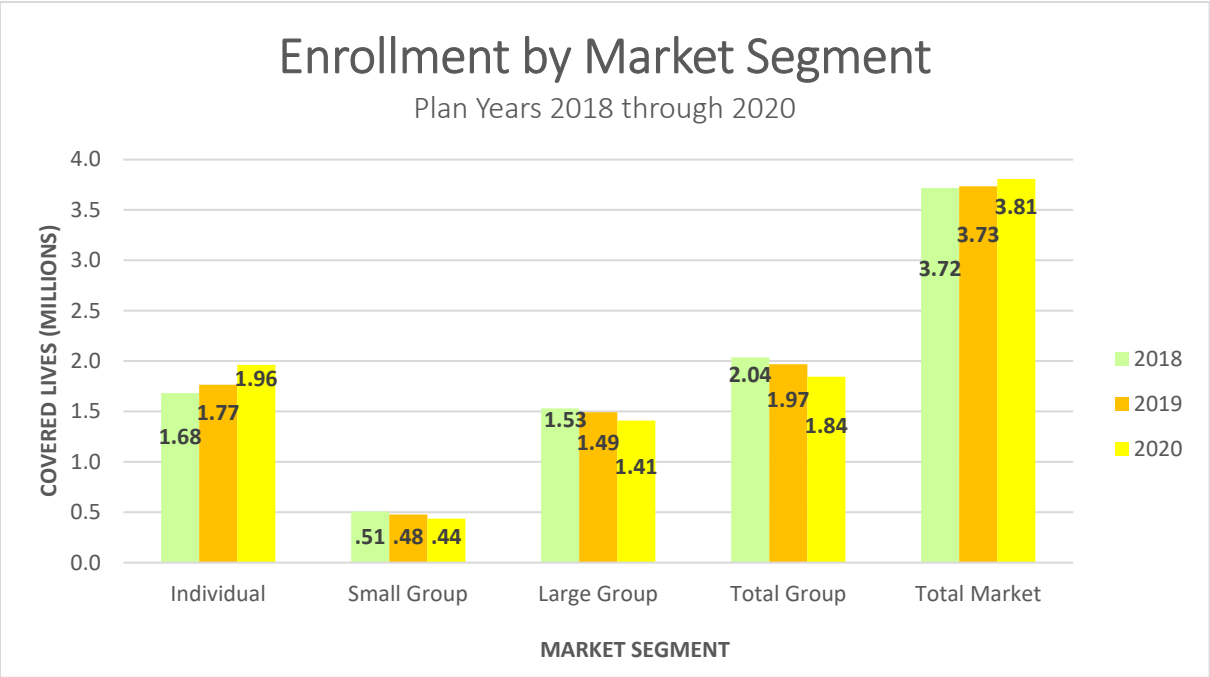
## Executive Summary

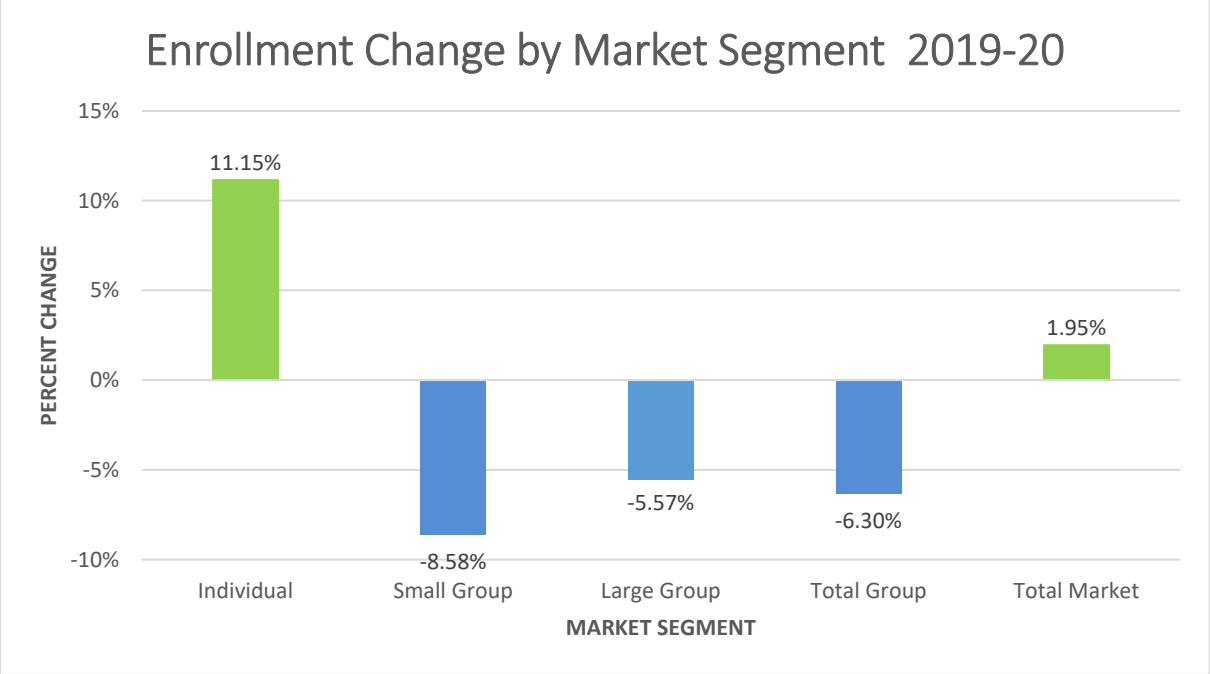
Despite the uncertainty surrounding the future of the Affordable Care Act (ACA), the health insurance market has largely stabilized. Overall enrollment continued to grow despite the effects of COVID-19 on employment and personal income. Rates have largely stabilized leading to smaller changes, although the long-term trend of increasing individual enrollment and decreasing group enrollment remains intact.

For the first time, people covered under individual policies exceeded those covered under a group policy. 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, 2022. However, the Centers 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.

Both the small group and large group markets continued to contract. It is expected that the overall group market will continue to contract as it has for several years. The percentage decline from 2019 to 2020 was larger than in prior years and may have been related to COVID-19 as many businesses reduced their 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 modest increase in 2020 of 72,894 covered lives or 1.95%. This follows an increase from the previous year of 16,471 covered lives or 0.44%. 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.

As of year-end 2020, coverage by market segment consisted of:

- **Individual Coverage –** 1,962,686, an increase of 196,879 covered lives or 11.15%
- **Small Group** (1-50 members) **–** 436,241, a decrease of 40,949 covered lives or 8.58%
- **Large Group** (51+ members) **–** 1,408,647, a decrease of 83,036 covered lives or 5.57%
- **Total Market –** 3,807,574, an increase of 72,894 covered lives or 1.95%

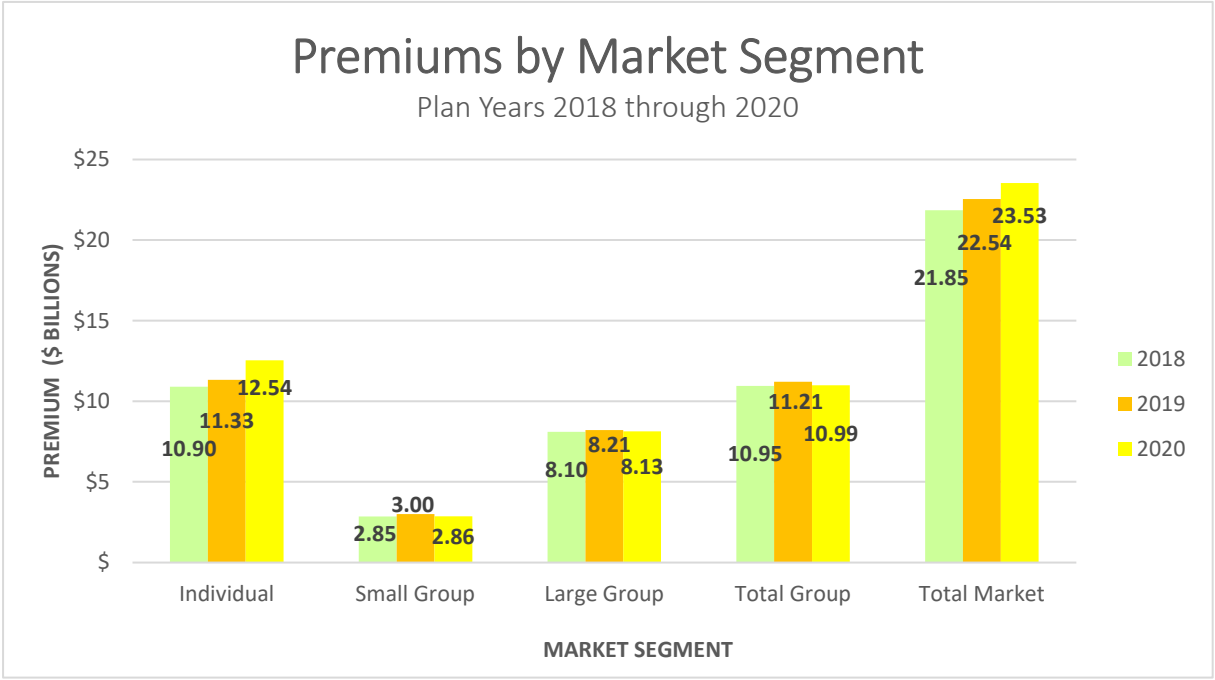
The individual market enrollment continues to grow despite the tax penalty (individual mandate) being set to $0 and recent changes to federal and state law that encourage the growth of other products such as short-term limited duration policies and health care sharing ministries. In general, the individual 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. In 2020, the individual market overtook the group market in terms of enrollment.

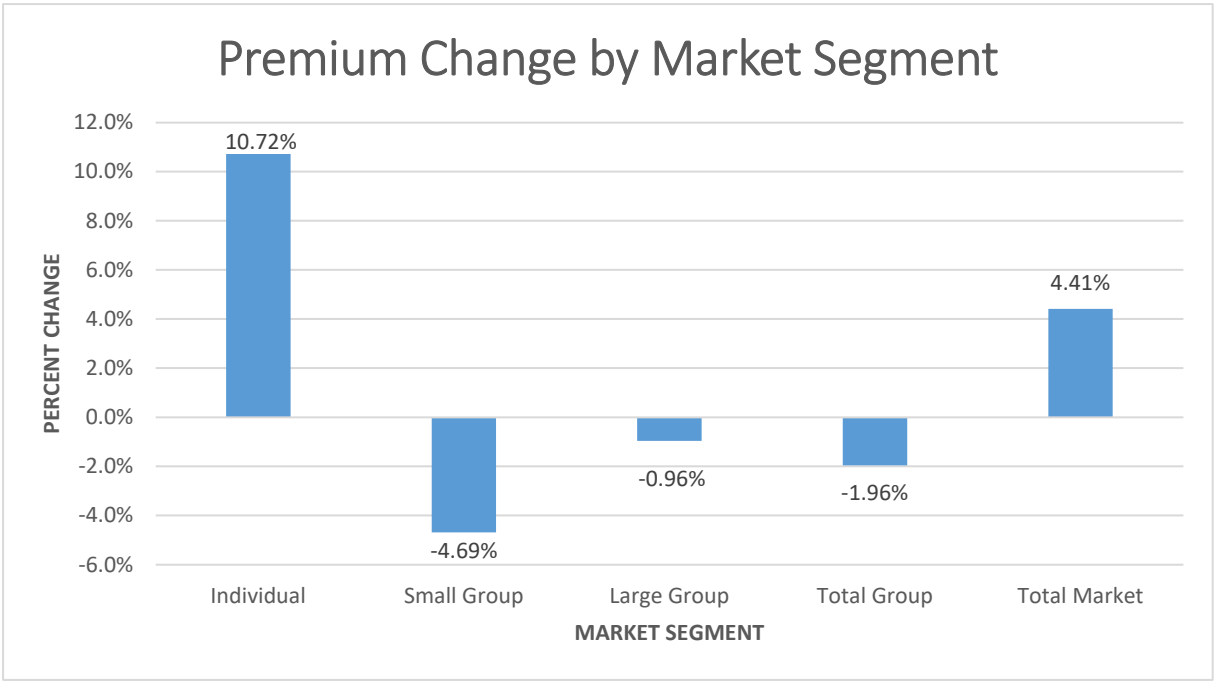
In contrast to the individual market, enrollment in the group market continues to decline. The declining trend in group coverage was in effect prior to the implementation of the ACA as small group enrollment was 1,073,683 in 2005 but had dropped to 598,361 in 2014 and large group enrollment declined from 2,468,056 in 2005 to 1,628,198 in 2014. The declining trends in group enrollment have generally slowed down since the advent of the ACA but were higher in 2020 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 2018-2020

| Market Segments | 2018 | 2019 | 2020 |
|---|---|---|---|
| | | | |
| **Individual Guaranteed Issue** | | | |
| ACA On-Exchange | 1,366,560 | 1,480,060 | 1,676,923 |
| ACA Off-Exchange | 136,329 | 128,162 | 145,030 |
| Grandfathered (In-State and Out-of-State) | 524 | 339 | 301 |
| Transitional (In-State and Out-of-State) | 91 | 75 | 26 |
| **Total Guaranteed Issue** | 1,454,071 | 1,608,636 | 1,822,286 |
| | | | |
| **Individually Underwritten** | | | |
| Grandfathered (In-State and Out-of-State) | 47,943 | 41,278 | 36,473 |
| Transitional (In-State and Out-of-State) | 130,054 | 115,703 | 103,789 |
| **Total Individually Underwritten** | 177,997 | 156,981 | 140,262 |
| | | | |
| **Conversion** | | | |
| **Total Conversion** | 209 | 190 | 138 |
| | | | |
| **Small Groups (1-50)** | | | |
| Self-Employed or Sole Proprietor | 1,578 | 110 | 100 |
| 2 – 50 Member Groups | 504,884 | 476,080 | 436,141 |
| **Total Small Groups** | 506,462 | 477,190 | 436,241 |
| | | | |
| **Large Groups (51+)** | | | |
| **Total Large Groups** | 1,530,037 | 1,491,683 | 1,408,647 |
| | | | |
| **Market Totals** | | | |
| Total Individual Market | 1,681,710 | 1,765,807 | 1,962,686 |
| Total Group Market | 2,036,499 | 1,968,873 | 1,844,888 |
| **Total Commercial Market** | 3,718,209 | 3,734,680 | 3,807,574 |

## Commercial Premium



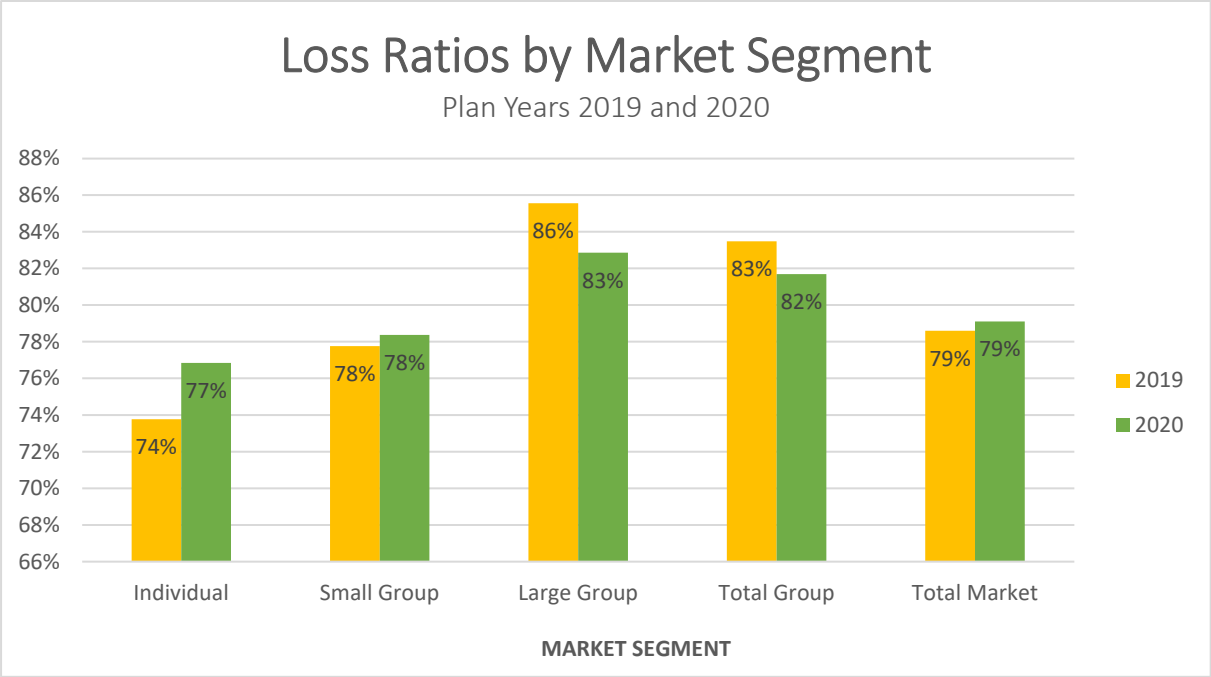




As illustrated above and shown in Table 2 below, the overall commercial market generated $23,531,036,547 in premiums in 2020, a 4.41% increase from 2019. This follows a 3.15% increase the prior year. The increase is largely the result of the higher enrollment in the individual market and higher premiums per member.

# Table 2
# Commercial Insurance Premium 2018-2020

| Market Segments | 2018 | 2019 | 2020 |
|---|---|---|---|
| | | | |
| **Individual Guaranteed Issue** | | | |
| Grandfathered (In-State and Out-of-State) | $1,303,471 | $1,106,010 | $808,697 |
| Transitional (In-State and Out-of-State) | $821,365 | $724,462 | $476,295 |
| ACA On-Exchange | $8,872,098,668 | $9,455,661,811 | $10,698,864,079 |
| ACA Off-Exchange | $1,220,961,890 | $1,157,720,398 | $1,114,074,761 |
| Total Guaranteed Issue | $10,095,185,394 | $10,615,212,681 | $11,819,087,384 |
| | | | |
| **Individually Underwritten** | | | |
| Grandfathered (In-State and Out-of-State) | $261,971,038 | $230,156,312 | $231,442,132 |
| Transitional (In-State and Out-of-State) | $537,363,981 | $478,854,011 | $487,977,024 |
| Total Individually Underwritten | $799,335,019 | $709,010,323 | $719,419,156 |
| | | | |
| **Conversion** | | | |
| Total Conversion | $2,043,382 | $1,071,231 | $932,725 |
| | | | |
| **Small Groups (1 – 50)** | | | |
| Self-Employed or Sole Proprietor | $15,869,872 | $855,637 | $873,161 |
| 2 – 50 Member Groups | $2,837,618,918 | $2,996,318,490 | $2,855,835,726 |
| Total Small Groups | $2,853,488,790 | $2,997,174,127 | $2,856,708,887 |
| | | | |
| **Large Groups (51+)** | | | |
| Total Large Groups | $8,098,489,292 | $8,213,793,248 | $8,134,888,794 |
| | | | |
| **Market Totals** | | | |
| Total Individual Market | $10,896,563,795 | $11,325,294,235 | $12,539,439,266 |
| Total Group Market | $10,951,978,082 | $11,210,967,375 | $10,991,597,681 |
| Total Commercial Market | $21,848,541,877 | $22,536,261,610 | $23,531,036,547 |

## 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.

In the individual market, the overall loss ratio increased from 73.77% in 2019 to 76.84% in 2020 while the small group overall loss ratio increased from 77.76% in 2019 to 78.37% in 2020.

The large group market experienced an overall loss ratio of 82.86% in 2020 which is lower than the 85.56% ratio reported in 2019. 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 2019-2020

| Market Segments | 2019 | | | 2020 | | |
|---|---|---|---|---|---|---|
| | | | | | | |
| 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) | $1,106,010 | $1,684,453 | 152.30% | $808,697 | $1,417,087 | 175.23% |
| Transitional (In-State and Out-of-State) | $724,462 | $695,391 | 95.99% | $476,295 | $467,635 | 98.18% |
| ACA On-Exchange | $9,455,661,811 | $6,896,407,809 | 72.93% | $10,698,864,079 | $8,191,567,157 | 76.56% |
| ACA Off-Exchange | $1,151,934,109 | $833,733,582 | 72.38% | $1,118,938,313 | $868,261,559 | 77.60% |
| Total Guaranteed Issue | $10,615,212,681 | $7,736,810,174 | 72.88% | $11,819,087,384 | $9,061,713,438 | 76.67% |
| | | | | | | |
| Individually Underwritten | | | | | | |
| Grandfathered (In-State and Out-of-State) | $230,156,312 | $176,180,006 | 76.55% | $231,442,132 | $157,741,096 | 68.16% |
| Transitional (In-State and Out-of-State) | $478,854,011 | $439,154,143 | 91.71% | $487,977,024 | $413,439,265 | 84.73% |
| Total Individually Underwritten | $709,010,323 | $615,334,149 | 86.79% | $719,419,156 | $571,180,361 | 79.39% |
| | | | | | | |
| Conversion | | | | | | |
| Total Conversion | $1,071,231 | $1,996,518 | 186.38% | $932,725 | $2,790,397 | 299.17% |
| | | | | | | |
| Small Groups (1 – 50) | | | | | | |
| Self-Employed or Sole Proprietor | $855,637 | $1,719,042 | 200.91% | $873,161 | $2,660,169 | 304.66% |
| 2 – 50 Member Groups | $2,996,318,490 | $2,329,014,037 | 77.73% | $2,855,835,726 | $2,236,234,187 | 78.30% |
| Total Small Groups | $2,997,174,127 | $2,330,733,079 | 77.76% | $2,856,708,887 | $2,238,894,356 | 78.37% |
| | | | | | | |
| Large Groups (51+) | | | | | | |
| Total Large Groups | $8,213,793,248 | $7,028,085,883 | 85.56% | $8,134,888,794 | $6,740,291,193 | 82.86% |
| | | | | | | |
| Market Totals | | | | | | |
| Total Individual Market | $11,325,294,235 | $8,354,140,842 | 73.77% | $12,539,439,266 | $9,635,684,195 | 76.84% |
| Total Group Market | $11,210,967,375 | $9,358,818,962 | 83.48% | $10,991,597,681 | $8,979,185,549 | 81.69% |
| Total Commercial Market | $22,536,261,610 | $17,712,959,804 | 78.60% | $23,531,036,947 | $18,614,869,744 | 79.11% |

## 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

Cody Farrill
Chief of Staff
Fl. Agency for Health Care Admin.
2727 Mahan Drive, Mailstop #1
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
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
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 designated
for an agent representative is
vacant.

# 2022 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 Affordable Care Act (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 (PTCs). 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. 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 2022 could end up being as high as $8,700 for an individual and $17,400 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 policyholders a Deductible Health Credit Transfer to a new policy equal to the deductible paid by the policyholder 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.*

### 3. 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). 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 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.*

### 4. 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. 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.*

## 5. Prohibit balance billing for emergency medical transportation

Consumers in a life-threatening accident or major medical emergency in need of emergency transportation by road or water 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.*

## 6. Include Applied Behavioral Analysis as a covered benefit in all 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 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.*

**7. Include Fetal Alcohol Spectrum Disorder (FASD) to the definition of the term developmental disabilities**

Harm to Florida's children from prenatal alcohol exposure (PAE) is a significant public health problem and the most known cause of developmental disabilities in the United States. Recent research shows alarming prevalence of up to 1 in 20 first graders in the United States having the resulting disability of Fetal Alcohol Spectrum Disorders (FASD). PAE is especially harmful to the developing brain, impacting 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. 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 FASD cannot find systems of care that are familiar with or equipped to diagnose and address FASD-related disabilities.

- ***Recommendation****: Include Fetal Alcohol Spectrum Disorder to the definition of the term developmental disabilities in statute 627.6686.*

**8. Apply payments by, or on behalf of, a beneficiary to count toward the out-of-pocket cost sharing calculations**

Many drug manufacturers offer copay savings programs to help patients afford expensive brand medications as well as specialty drugs. These programs are aimed 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 are available.

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

Usually the drug companies will provide assistance up to a certain amount per year, so patients mid-year may find out that they have to pay the entire co-pay because none of the third-party payments were counted towards their out-of-pocket. Research has shown that many patients will decline their medication when they have to pay more than $75 to $225 out of pocket foregoing life-saving medication. With the copay accumulator programs, insurers are shifting the cost of prescription drugs to policyholders, making it harder for consumers to meet their deductibles.

The following example explains how the copay accumulator program affects the consumer: A medication costs $20,000 a year for John Doe. With insurance but no copay card John pays $5,000 (deductible) and the insurance company pays $15,000. With a co-pay card John pays $3,500, co-pay card pays $1,500 and the insurance $15,000. With the copay accumulator program John pays $5,000, the co-pay card pays $1,500 and the insurance company pays $13,500. The $1,500 which is supposed to help the consumer is in fact helping the insurer's bottom line.

Various states, including Georgia and West-Virginia, have passed legislation prohibiting Copay Accumulator Programs.

- ***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 apply any amount paid by the insured or paid on his or her behalf through a third-party, for which there is no generic drug available, shall be applied toward the policyholder's total contribution to any cost-sharing requirement. Include disclosure in policy documents and on websites, that these payments will be applied to the policyholder's out-of-pocket maximum, deductible, or copayment responsibility.*