The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 418
INTRODUCER:	Senator Simpson
SUBJECT:	Essential Health Benefits under Health Insurance Policies and Contracts
DATE:	March 22, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			HP	
3.			RC	

I. Summary:

SB 418 provides options for health insurers or health maintenance organizations issuing or delivering individual policies or contracts in Florida to comply with the federally, mandated essential health benefit (EHB) requirement. These options include:

- Selecting one or more services or categories from the list of essential health benefits required by any single state or multiple states;
- Selecting one or more services or categories from any one or more of the required categories of EHBs from one state or multiple states; or
- Selecting any combination of services or coverages required by any one or a combination of states to provide the ten required categories of EHBs.

Starting in plan year 2020, the federal Centers for Medicaid and Medicare Services is providing states with greater flexibility in the selection of its EHB-benchmark plan. This flexibility may foster innovation in plan design and greater access to affordable coverage.
The options include:

- Selecting the EHB-benchmark plan that another state used for the 2017 plan year.
- Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another state used for the 2017 plan year.
- Selecting a set of benefits that would become the state's EHB-benchmark plan.[1]

[1] The Center for Consumer Information and Insurance Oversight, Information on Essential Health Benefits (EHB) Benchmark Plans https://www.cms.gov/cciio/resources/data-resources/ehb.html (last viewed February 11, 2019).

II. Present Situation:

Regulation of Insurance in Florida

The Florida Office of Insurance Regulation (OIR) is responsible for the regulation of all activities of insurers and other risk-bearing entities.[2]

2019 Individual and Small Group Markets

Nine health insurance companies writing individual policies or contracts submitted rate filings to the OIR in June 2018. In August 2018, the OIR announced that premiums for the individual PPACA compliant plans would increase an average of 5.2 percent effective January 1, 2019.[3] The average approved rate changes on the exchange plans ranged from -1.5 percent to a +9.8 percent. Only one insurer, Blue Cross Blue Shield offers individual coverage in all 67 counties.[4] During the 2019 open enrollment period, 1,786,679 individuals enrolled in Florida plans through the federally administered exchange.[5]

The OIR approved the 2019 rates for 14 small group insurers.[6] The weighted average change in approved rates from 2018 was 6.0 percent. The percentage change in approved rates from 2018 ranged from -11.8 percent to +14.5 percent. Florida Blue and United Healthcare (and affiliates) offer small group plans in every county.

Patient Protection and Affordable Care Act (PPACA)

The federal PPACA was signed into law on March 23, 2010.[7] Among its significant changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements including 10 categories of mandated essential health benefits, rating and underwriting standards, mandatory review of rate increases, reporting of medical loss ratios and payment of rebates, internal and external appeals of adverse benefit determinations, and other requirements.[8] The PPACA preempts any state law that prevents the application of a provision of PPACA.

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[2] The OIR is under the Financial Services Commission, which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, which serves as the agency head of the commission. Section 20.121(3), F.S.

[3] Office of Insurance Regulation, Individual PPACA Market Monthly Premiums for Plan Year 2019, available at https://floir.com/siteDocuments/IndividualMarketPremiumSummary.pdf (last viewed February 11, 2019). See also OIR Press Release, OIR Announces 2019 PPACA Individual Market Health Insurance Plan Rates, available at https://www.floir.com/PressReleases/viewmediarelease.aspx?id=2234 (last viewed February 11, 2019).

[4] OIR, Individual Market County Offerings, available at https://www.floir.com/sitedocuments/IndividualMarketCountyOfferings.pdf, (last viewed February 11, 2019).

[5] CMS.gov, *Final Weekly Enrollment Snapshot for the 2019 Enrollment Period,* January 3, 2019, at https://edit.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period (last viewed February 14, 2019).

[6] OIR, Small Group PPACA Market Monthly Premiums for Plan Year 2019, dated August 22, 2018, available at OIR https://www.floir.com/siteDocuments/SGMarketPremiumSummary.pdf (last viewed February 14, 2019).

[7] P.L. 111-148. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.

[8] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), (42 U.S.C. 300gg et seq.).

Essential Health Benefits

The PPACA requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in the following ten benefit categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Pregnancy, maternity, and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.[9]

State EHB-Benchmark Plans

Rules adopted by the U.S. Department of Health and Human Services (HHS)[10] define EHB based on state-specific EHB benchmark plans. In plan year 2017, 2018, and 2019, the EHB-benchmark plan is a plan that was sold in 2014. The HHS codified regulations to allow each state to select a benchmark plan that serves as a reference plan. According to the HHS, this approach seeks to balance coverage of EHB categories and affordability and provide flexibility for states as primary regulators of health insurance. States can choose a benchmark plan from among the following health insurance plans:

- The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
- Any of the largest three state employee plans by enrollment;
- Any of the largest three national FEHBP plan options by enrollment; or
- The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

All ten essential health benefit categories must be included as a part of EHB; therefore, if the selected or default benchmark plan does not initially cover a category, the benchmark must be supplemented.[11] If one or more categories of benefits is missing in the benchmark plan, the insurer or HMO must supplement it.[12] States are required to supplement pediatric dental and

[9] What Marketplace health insurance plans cover, available at: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ (last viewed February 11, 2019).
[10] 45 CFR 156.100.
[11] 45 CFR 156.110(b).
[12] 45 CFR 156.110(b)-(c).

vision with the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan[13] with the largest national enrollment or the benefits in the Children's Health Insurance Program.[14]

In Florida, no plan was selected by the state; therefore, the default benchmark plan is the largest small group plan, which is supplemented to include pediatric dental. The small group plan includes all of the mandated coverage required under Florida law.

For plan year 2020 and after, the HHS provides states with greater flexibility for states to update their EHB benchmark plans, if they so choose.[15] A state may modify its EHB-benchmark plan by:

- Selecting the EHB-benchmark plan that another state used for the 2017 plan year;
- Replacing one or more EHB categories of benefits in its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or
- Otherwise selecting a set of benefits that would become the state's EHB-benchmark plan.[16]

Such modifications are subject to HHS review and approval to become effective. States that opted not to exercise this flexibility continue to use the same benchmark plan from plan years 2017-2019. For plan year 2020, no state opted to permit insurers or HMOs to substitute benefits between benefit categories.[17]

III. Effect of Proposed Changes:

Section 1 creates s. 627.6054, F.S., to authorize an insurer or HMO, which issues or delivers individual or group policies or contracts in Florida, options for providing the ten categories of essential health benefits mandated by PPACA. The insurer or HMO may provide essential health benefits by:

- Selecting one or more services or coverages for each of the required ten essential health benefits categories from the list of essential health benefits required by any single state or multiple states;
- Selecting one or more services or categories from any one or more of the required categories of EHBs from one state or multiple states; or
- Selecting any combination of services or coverages required by any one or a combination of states to provide the required categories of EHBs.

Section 2 provides the bill takes effects July 1, 2019.

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[13] Federal Employees Dental and Vision Insurance Program, available at https://www.benefeds.com/Portal/EducationSupport?EnsSubmit=EducationSupportMainCnt&ctoken=WyGpd9Pk (last viewed March 20, 2019).

[14] The program, established pursuant to Title XXI of the U.S. Social Security Act, is a program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children.

[15] The Center for Consumer Information and Insurance Oversight, Information on Essential Health Benefits (EHB) Benchmark Plans, available at https://www.cms.gov/cciio/resources/data-resources/ehb.html (last viewed February 11, 2019).

[16] 45 CFR 156.111.

[17] 45 CFR 156.115(b)(2)(ii).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Currently, the PPACA requires each state to adopt an EHB benchmark plan, or if not, a default plan will be used, which includes the ten categories of EHBs as well as state specific statutorily-mandated benefits. States may submit a request to HHS for the implementation of a revised benchmark-plan. Currently, insurers and HMOs do not appear to have the authority to select the EHBs.

Under the U.S. Constitution's Supremacy Clause, a federal law may preempt state law.[18] Preemption occurs when Congress intentionally enacts legislation that is intended to supersede state law on the same subject.[19] In PPACA, Congress expressed that the federal law preempts state law only to the extent that it prevents the application of a provision of PPACA. Title I of PPACA, which includes the requirements relating to health insurance regulation, contains the following provision:

> No Interference With State Regulatory Authority – Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title. [20]

Though expressed in the negative, PPACA preempts any state law that prevents the application of a provision of PPACA. PPACA effectively allows states to adopt and enforce laws that provide greater consumer protections than PPACA, but any state law that does not meet the federal minimum standards will be preempted.[21]

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[18] U.S. Const. art. VI, cl. 2
[19] See, *West Florida Regional Medical Center v. See*, 79 So.3rd 1, at 15 (Fla. 2012).
[20] PPACA s. 1321(d)
[21] "Preemption and State Flexibility in PPACA" at: http://www.naic.org/documents/index_health_reform_general_preemption_and_state_flex_ppaca.pdf (last viewed February 14, 2019).

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 1 provides that the provisions apply to individual and group policies and contracts. However, the bill amends part VI of ch. 627, F.S., which applies to individual insurance policies and does not apply to individual contracts or group policies or contracts. Part I of ch. 641, F.S., generally applies to individual or group contracts.

VIII. Statutes Affected:

This bill creates section 627.6054 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.