Committee on Banking and Insurance

CS/CS/SB 322 — Health Plans

by Health Policy Committee; Banking and Insurance Committee; and Senator Simpson

The bill allows insurers and health maintenance organizations (HMOs) greater flexibility in their plan design and product offerings providing options of affordable health coverage for employers, employees, and individuals. The bill also requires insurers and HMOs offering comprehensive major medical coverage to offer at least one policy or contract that does not exclude preexisting medical conditions if certain conditions are met.

Alternative Coverage Arrangements

The bill revises regulatory provisions relating to alternative coverage arrangements such as short-term limited duration insurance policies and association health plans. The bill codifies 2018 federal regulations to provide consumers and employers with more affordable coverage options and choices for health insurance coverage.

An association health plan (AHP), which is a type of multiple employer welfare association, is a legal arrangement that allows business associations or unrelated employer groups to jointly offer health insurance and other fringe benefits to their members or employers. Changes in federal rules allow small employers, through associations, to gain regulatory and economic advantages that were previously only available to large employers. As a result of the federal regulatory changes, small employers, including working owners without employees, can form an association health plan that would be treated as a large group rather than a small group for insurance purposes, which would lower insurance costs and regulatory burdens. In addition, the federal rule allows an AHP to form, based on a geographic test, such as a common state, city, county, or a metropolitan area across state lines. Working owners without employees, including sole proprietors, can join.

The bill also provides that short-term limited duration insurance is an individual or group health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and has a duration of no longer than 36 months in total. Short-term limited duration insurance was designed primarily to fill temporary gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another plan or coverage. Currently, a short-term limited duration insurance policy must expire within 12 months of the date of the contract, taking into account any extensions. The bill requires disclosure in the short-term limited duration insurance contract regarding the scope of the coverage.

Essential Health Benefits

The bill requires the Office of Insurance Regulation (OIR) to conduct a study to evaluate Florida's essential health benefits (EHB) benchmark plan and submit a report by October 30, 2019 to the Governor, the President of the Senate, and the Speaker of the House. The study must

include recommendations for changing the current EHB-benchmark plan to provide comprehensive care at a lower cost.

The Patient Protection and Affordable Care Act (PPACA) requires comprehensive major medical policies or contracts to include coverage for the 10 essential health benefits delineated in the act. Starting in plan year 2020, the federal government is providing states with greater flexibility in the selection of its EHB-benchmark plan. These options include:

- Selecting an 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; or
- Selecting a set of benefits that would become the state's EHB-benchmark plan.

The bill also provides insurers and HMOs issuing or delivering individual or group policies or contracts in Florida that provide EHBs additional flexibility in developing affordable coverage options, which are substantially equivalent to the state EHB-benchmark plan, that could be submitted to the OIR for review and approval.

Coverage for Preexisting Conditions

The bill requires each insurer or HMO issuing 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. The operative date for such mandated offer is the enactment of a federal law that expressly repeals PPACA or the invalidation of the PPACA by the United States Supreme Court. If approved by the Governor, these provisions take effect upon becoming law.

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Vote: Senate 23-13; House 70-42