HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 543 Small Group Health Insurance
SPONSOR(S): Stark
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	13 Y, 0 N	Tuszynski	Poche
2) Insurance & Banking Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, reporting of medical loss ratios and payment of rebates, covering adult dependents, internal and external appeals of adverse benefit determinations, and other requirements.

The Florida Employee Health Care Access Act (EHCAA) was enacted in 1992 to promote the availability of health insurance coverage to small employers with fifty or less employees, regardless of claims experience or employee health status. The EHCAA requires small employer health insurers (carriers) in the small group market to offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer.

A small employer carrier that offers coverage to a small employer must offer to all of the employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees. While the EHCAA requires a *small employer carrier* to offer both employee and dependent coverage to small employers, no federal or state laws require a *small employer* to provide insurance to its employees or dependents.

Under PPACA, if the cost of an employee-sponsored plan would cover an employee for 9.66% or less of household income, the employee and his or her dependents are not eligible for premium tax credits to purchase a health insurance plan on the Health Insurance Marketplace, nor are they eligible for cost-sharing reductions to lower their out-of-pocket payments for health services. This may make the cost of coverage unaffordable.

HB 543 amends s. 627.6699(5)(e)5., F.S., to provide a small employer with the option to offer employee-only coverage to all eligible employees. The bill clarifies that a small employer may offer coverage to the spouse and dependents of an eligible employee, but is not required to offer such coverage.

By clarifying that a small employer is not required to offer dependent coverage, dependents would not have an offer of affordable employer-based coverage, which should allow them to qualify for premium tax credits or other cost-sharing reductions to offset the cost of an insurance plan through the Marketplace. Such coverage through the Marketplace may be cheaper than the cost of the family coverage through employer-sponsored insurance.

This bill does not appear to have a fiscal impact on state or local government.

The bill provides for an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Patient Protection and Affordable Care Act

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.[1] PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, reporting of medical loss ratios and payment of rebates, covering adult dependents, internal and external appeals of adverse benefit determinations, and other requirements.[2]

Many of the changes outlined in PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[3] For example, PPACA requires coverage offered in the individual and small group markets to provide the following categories of services (essential health benefits package):[4]

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

PPACA prohibits an insurer from establishing rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or any other health-status related factor deemed appropriate by the U.S. Department of Health and Human Services.[5]

PPACA – Limited Preemption of State Law

Under the U.S. Constitution's Supremacy Clause, a federal law may preempt state law.[6] Preemption occurs when Congress intentionally enacts legislation that is intended to supersede state law on the same subject.[7] 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.[8]

Title I of PPACA, which includes the requirements related to health insurance regulation, contains the following provision:

[1] 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.
[2] 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.).
[3] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. See 42 U.S.C. s. 18011.
[4] 42 U.S.C. 300gg-6.
[5] 42 U.S.C. s. 300gg-4.
[6] U.S. Const. art. VI, cl. 2.
[7] See *West Florida Regional Medical Center v. See*, 79 So.3rd 1, at 15 (Fla. 2012).
[8] PPACA s. 1321(d).

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.[9]

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 do not directly conflict with PPACA, but any state law that does conflict will be preempted.[10]

Health Insurance Marketplaces

The Health Insurance Marketplace (Marketplace) is an online shopping platform for people to purchase insurance if they do not have insurance through employment, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or another source that provides qualifying coverage.[11] An individual may purchase insurance through the Marketplace even if they have access to employer-sponsored insurance. However, an individual with access to employer-sponsored insurance will not be eligible for premium tax credits unless the employer's insurance option does not meet certain standards.[12]

Health Insurance Premium Tax Credits in the Marketplace

Under PPACA, individuals and families with incomes between 100% and 400% of the Federal Poverty Level ($11,700 for an individual and $24,500 for a family of 4)[13] who purchase coverage through the Marketplace are eligible for a tax credit to reduce the cost of coverage. The amount of the tax credit varies based on income such that the premium a person would have to pay for the second cheapest silver plan[14] on the Marketplace would not exceed a percentage of their income, as follows:[15]

Income Level	Premium as a Percent of Income
Up to 133% FPL	2.03% of income
133 – 150% FPL	3.05 – 4.07% of income
150 – 200% FPL	4.07 – 6.41% of income
200 – 250% FPL	6.41 – 8.18% of income
250 – 300% FPL	8.18 – 9.66% of income
300 – 400% FPL	9.66% of income

[9] Id.
[10] National Association of Insurance Commisioners, "Preemption and State Flexibility in PPACA" available at: http://www.naic.org/documents/index_health_reform_general_preemption_and_state_flex_ppaca.pdf (last viewed January 23, 2016).
[11] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *A quick guide to the Health Insurance Marketplace*, available at: https://www.healthcare.gov/quick-guide/ (last viewed January 23, 2016).
[12] Id.
[13] U.S. Department of Health & Human Services, Office of the Assistant Secretary For Planning and Evaluation, *2015 Poverty Guidelines*, available at: https://aspe.hhs.gov/2015-poverty-guidelines (last viewed January 23, 2016).
[14] PPACA designates required coverage levels as bronze, silver, gold, or platinum. Each of these tiers corresponds to an actuarial value of the qualified health plans within that tier. The actuarial value corresponds to the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, an individual would be responsible for 30% of the costs of all covered benefits through co-pays and other cost-sharing mechanisms. The corresponding actuarial values to the PPACA tiers are: Bronze – 60%; Silver – 70%; Gold – 80%; and Platinum – 90%.
[15] Internal Revenue Service, *Internal Revenue Bulletin: 2014-50*, December 8, 2014, available at: https://www.irs.gov/irb/2014-50_IRB/ar11.html (last viewed January 23, 2016).

Florida Employee Heath Care Access Act

The Employee Health Care Access Act (EHCAA)[16] was enacted in 1992 to promote the availability of health insurance coverage to small employers with fifty or less employees, regardless of claims experience or employee health status.[17] The EHCAA requires small employer health insurers (carriers) in the small group market to offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer.[18]

A small employer carrier that offers coverage to a small employer must offer to all of the employer's eligible employees[19] and their dependents.[20] A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.[21] While the EHCAA requires a *small employer carrier* to offer both employee and dependent coverage to small employers,[22] no federal or state laws require a *small employer* to provide insurance to its employees or dependents.[23]

Employer-Sponsored Insurance Offered to Dependents

Eligibility for federal premium tax credits to purchase health insurance from the Marketplace is not solely determined by income. Whether a family has access to affordable employer-sponsored insurance is also used to determine eligibility.[24] The problem is the definition of "affordable" as for both an individual employee and a family, it is defined based on the cost of individual-only coverage and does not take into consideration the often significantly higher cost of a family plan.[25]

Under PPACA, if the cost of an employee-sponsored plan would cover an employee for less than 9.66% of household income, the employee and his or her dependents are not eligible for premium tax credits to reduce the cost of a Marketplace plan or for cost-sharing reductions to lower their out-of-pocket payments for health services, regardless of the ability to afford coverage otherwise.[26] For example, if an employee can purchase an employee-only plan and the cost is only 9.5% of his or her household income, yet the family option costs 13% of his or her household income, which is unaffordable for the family, they do not qualify for premium tax credits. This is referred to as the "family glitch" in PPACA – the family is priced out of the Marketplace because they have been offered an affordable employee-sponsored plan and are not eligible for premium tax credits, yet the employer-based family option is out of the family's budget.

Florida Health Insurance Advisory Board

The Florida Health Insurance Advisory Board (Board) was established in 1992 as the Small Employer Health Reinsurance Program.[27] Its purpose was to promote the availability of health care coverage to small employers.[28] At that time, Board members were primarily representatives of health insurers licensed under chapter 624 or 641 of the Florida Statutes.[29] In 2005, the Legislature expanded the

[16] S. 627.6699, F.S.
[17] Ch. 92-33, Laws of Fla.
[18] S. 627.6699(5)(b), F.S.
[19] S. 627.6699(3)(g), F.S., defines an "eligible employee" as an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements or other requirements of this act. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.
[20] S. 627.6699(5)(e)5., F.S.
[21] Id.
[22] Id.
[23] Office of Insurance Regulation, *Agency Analysis of 2016 House Bill* 543, p. 2, Dec. 18, 2015.
[24] Health Affairs, *Health Policy Briefs, The Family Glitch*, available at: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129 (last viewed January 23, 2016).
[25] Id.
[26] Id.
[27] Florida Office of Insurance Regulation, *Florida Health Insurance Advisory Board*, available at: http://www.floir.com/sections/landh/fhiab.aspx (last viewed January 23, 2016).
[28] Id.
[29] Id.

composition of the Board to include representatives of employers, an individual policyholder, and a representative from the Agency for Health Care Administration (AHCA).[30] The Board's responsibilities were expanded to include an advisory role on health insurance issues to the Office of Insurance Regulation (OIR), AHCA, the Department of Financial Services, other executive departments and the Legislature.[31]

In its legislative recommendations for 2014,[32] 2015,[33] and 2016[34] the Board has recommended that small group employers be specifically allowed the option to offer employee-only coverage to allow spouses and dependents to obtain coverage in the Marketplace, where they may qualify for a premium tax credit.

OIR has also stated that it has received comment that there is confusion in the insurance market as to whether a small employer has the option to offer employee-only coverage.[35]

Effect of the Proposed Changes

HB 543 amends s. 627.6699(5)(e)5., F.S., to provide a small employer with the option to offer employee-only coverage to all eligible employees. The bill clarifies that a small employer may offer coverage to the spouse and dependents of an eligible employee, but is not required to offer such coverage.

This clarification allows employers to inform small group carriers that they have made the choice to offer employee-only coverage. This, in turn, allows the small group carrier to offer such coverage and not extend an offer of coverage to dependents of an eligible employee.

By clarifying that a small employer is not required to offer dependent coverage, dependents will not have an offer of affordable employer-based coverage, which should allow them to qualify for premium tax credits to offset the cost of an insurance plan through the Marketplace, which may be cheaper than the cost of the family coverage through employer-sponsored insurance.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act.
Section 2: Provides for an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[30] Ch. 2005-231, Laws of Fla.
[31] Id.
[32] Florida Office of Insurance Regulation, Florida Health Insurance Advisory Board, *2014 Legislative Recommendations*, available at: http://www.floir.com/siteDocuments/FHIABLegRecommendations2014.pdf (last viewed January 23, 2016).
[33] Florida Office of Insurance Regulation, Florida Health Insurance Advisory Board, *2015 Legislative Recommendations*, available at: http://www.floir.com/siteDocuments/FHIABLegRecommendations2015.pdf (last viewed January 23, 2016).
[34] Florida Office of Insurance Regulation, Florida Health Insurance Advisory Board, *2016 Legislative Recommendations*, available at: http://www.floir.com/siteDocuments/FHIABLegRecommendations2016.pdf (last viewed January 23, 2016).
[35] Supra. at FN 23, pg. 4.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

For low to moderate-income families that qualify for premium tax credits to purchase health insurance through the Marketplace, dependents of employees of a small employer may have access to less expensive coverage as compared to the cost of family coverage through the employer.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES