HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 951 Health Plan Regulatory Administration
SPONSOR(S): Health & Human Services Committee; Insurance & Banking Subcommittee; Cummings
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1170

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	12 Y, 0 N, As CS	Peterson	Luczynski
2) Health & Human Services Committee	17 Y, 0 N, As CS	Tuszynski	Calamas

SUMMARY ANALYSIS

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code.

The federal Patient Protection and Affordable Care Act (PPACA) has made significant changes to the U.S. health care system. PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, establishing and reporting of medical loss ratios and payment of rebates, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements on individual and group coverage. In adopting PPACA Congress expressed that the federal law preempts state law only to the extent that it 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 preempts any state law that does. Thus, provisions in Florida law that are in conflict with PPACA are preempted; whereas provisions that merely duplicate PPACA continue to be viable and enforceable by the OIR.

The adoption of PPACA has resulted in regulatory requirements that are sometimes conflicting or duplicative of Florida law. CS/CS/HB 951 makes numerous changes throughout the statutes repealing and, in some cases, revising state law requirements to reflect current federal law. Specifically, the bill repeals: the medical loss ratio standard for major medical health insurance policies; the requirement for insurers to issue a certificate of creditable coverage; and the requirement for certain insurers to provide an outline of coverage. In addition, the bill contains numerous sections that revise cross-references and transfer language that is required to continue implementation of requirements unrelated to those that have been repealed.

The bill also exempts local government associations acting as third party administrators of local government self-insurance programs from licensing requirements under part VII of ch. 626, F.S.

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:

Background

State Regulation of Insurance

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code.[1]

Federal Patient Protection and Affordable Care Act (PPACA)

The federal Patient Protection and Affordable Care Act was signed into law on March 23, 2010.[2] The federal law made significant changes to the U.S. health care system, such as providing 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. PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, establishing and reporting of medical loss ratios and payment of rebates, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements on individual and group coverage.[3]

Many of the changes outlined in PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[4] For example, PPACA requires coverage offered in the individual and small group markets to provide the following categories of services (essential health benefits package):[5]

- 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

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

[1] s. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[2] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148. On March 30, 2010, PPACA was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. .No. 111-152.
[3] 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.
[4] 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. Grandfathered health plan coverage is tied to the individual or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010. The conditions for maintaining grandfathered status are specified in the rule. *See* PPACA s§ 1251*;* 42 U.S.C. § 18011.
[5] PPACA § 1302; 42 U.S.C. § 300gg-6.
[6] U.S. Const. art. VI, cl. 2.

same subject.[7] In adopting 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] Specifically, PPACA states:

> *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 preempts any state law that does.[10] Thus, provisions in Florida law that are in conflict with PPACA are preempted; whereas provisions that merely duplicate PPACA continue to be viable and enforceable by the OIR.

Effect of the Proposed Changes

The adoption of PPACA resulted in regulatory requirements that sometimes conflict or duplicate Florida law. Some state law provisions were originally enacted in the 1990s to conform Florida law to Health Insurance Portability and Accountability Act of 1996 (HIPAA)[11] and have not been updated to reflect changes resulting from the adoption of PPACA. The bill makes numerous changes throughout the statutes repealing and, in some cases, revising state law requirements to reflect current federal law.

Preexisting Conditions and Certificates of Coverage

HIPAA was enacted to provide guaranteed availability of coverage for certain employees and individuals, and to increase portability through the limitation of preexisting condition exclusions. Generally, group plans were allowed to impose a preexisting condition exclusion for up to 18 months after the enrollment date. The exclusion period could be reduced by the aggregate periods of creditable coverage applicable to the individual as of the enrollment date. Creditable coverage included group health plan and other specified coverage. Creditable coverage did not include excepted benefits.[12] In 1997, Florida adopted many of the requirements of HIPAA,[13] which are codified, in part, in s. 627.6561, F.S., relating to preexisting conditions.

Insurers were required to issue certificates of creditable coverage to individuals switching from one health insurance plan to another health insurance plan which would allow the individual to mitigate or avoid preexisting condition exclusions. As a result of the enactment of PPACA, health insurers no longer can deny coverage or impose higher costs for individuals who have a preexisting condition and insurers are no longer required to provide certificates of creditable coverage.[14] Sections 627.6561 and 641.31071, F.S., currently govern how preexisting conditions may be used by health insurers in determining how to write coverage and establishes the methodology for calculating creditable coverage for purposes of preexisting conditions.

- CS/CS/HB 951 amends ss. 627.6561 and 641.31071, F.S., relating to preexisting conditions, to remove the requirements for insurers and HMOs to provide certificates of creditable coverage, and amends various other provisions of law to remove cross-references related to their use.

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[7] *West Florida Regional Medical Center v. See*, 79 So.3d 1, 15 (Fla. 2012).
[8] PPACA § 1321(d); 42 U.S.C. § 18041(d).
[9] *Id.*
[10] National Association of Insurance Commissioners, *"Preemption and State Flexibility in PPACA" available at* http://www.naic.org/documents/index_health_reform_general_preemption_and_state_flex_ppaca.pdf (last visited Jan. 26, 2016).
[11] Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
[12] Generally, health insurance is divided into two types of coverage: major medical coverage and excepted benefits. PPACA regulates major medical, or comprehensive health insurance. Health insurance that provides benefits on a limited or ancillary basis have been referred to as excepted benefits. The Florida Insurance Code delineates the excepted benefits in s. 627.6561(5)(b), F.S. Excepted benefits include coverage like limited scope dental, hospital indemnity, specified disease, and others.
[13] Ch. 97-179, Laws of Fla.
[14] 45 C.F.R. 148.124. "The rules for providing certificates of creditable overage and demonstrating creditable coverage have been superseded by the prohibition on preexisting condition exclusions."

Medical Loss Ratio; Payment of Rebates

Effective for plan years beginning January 1, 2011, PPACA requires health insurers to report to the federal Department of Health and Human Services information concerning the percent of premium revenue spent on claims for clinical services and activities (medical loss ratio or MLR). Insurers must provide a rebate to consumers if the MLR is less than 85 percent in the large group market and 80 percent in the small group and individual markets.[15] Grandfathered health plans are not exempt from this requirement. Florida law requires, as a condition of prior approval of rates by the OIR, that the projected minimum loss ratio for small group and individual policies is 65 percent.[16] Rebates are not required if the MLR is not met. The calculation of Florida's MLR is not consistent with federal regulations.

- The bill repeals s. 627.411(3), F. S., which sets forth the MLR standard for major medical health insurance policies, thereby eliminating the conflict with PPACA.

Outline of Coverage

Effective September 23, 2012, rules implementing PPACA required small group health plans and health insurers to provide each participant or enrollee with a written summary that accurately describes the plan's benefits and coverage and that complies with the detailed requirements stated in the regulations.[17] The agencies' guidance includes a template, sample language, and a glossary of terms commonly used in connection with health insurance coverage. Section 627.642, F.S., requires an outline of coverage be provided to all individual policyholders and specifies requirements for its contents. While the intent of both requirements is to assist policyholders in understanding their contracts, it has been reported that the duplication instead has resulted in confusion.

- The bill amends s. 627.642, F.S., which establishes the requirement for an outline of coverage, to limit its application to excepted benefit and large group policies, only, which are not currently covered by the PPACA requirement to provide a summary of benefits.

Health Insurance Administrators

Section 626.88(1), F.S., defines an administrator of insurance as any person who directly or indirectly solicits or effects coverage of, collects charges or premiums from, or adjusts or settles claims of insurance funds or programs, or provides billing and collection services to health insurers and health maintenance organizations on behalf of health care providers. The statute exempts 19 entities from the definition of administrator, including unions, tax-exempt trusts, and workers' compensation plans. Such entities can operate as administrators without adhering to all filing and reporting requirements.

- The bill amends s. 626.88(1), F.S., to add corporate not-for-profits whose memberships consist entirely of local government units authorized to enter into risk management consortiums to the list of exempted entities.

B. SECTION DIRECTORY:

Section 1: Amends s. 112.08, F.S., related to group insurance for public officers, employees, and certain volunteers and physical examinations.
Section 2: Amends s. 408.909, F.S., relating to flex plans, to conform a cross-reference.
Section 3: Amends s. 409.817, F.S., relating to approval of health benefits coverage, to eliminate an exception to the prohibition on preexisting condition exclusions.

[15] 45 C.F.R. part 158.
[16] s. 627.411(3)(a), F.S.
[17] 26 CFR § 54.9815-2715(a)(1).

Section 4: Amends s. 624.123, F.S., relating to certain international health insurance policies, to conform a cross-reference.
Section 5: Amends s. 626.88, F.S., relating to definitions.
Section 6: Amends s. 627.402, F.S., relating to definitions, to conform a cross-reference.
Section 7: Amends s. 627.411, F.S., relating to grounds for disapproval, to remove the MLR requirements and the definition of incurred claims.
Section 8: Amends s. 627.6011, F.S., relating to mandated coverages, to conform a cross-reference.
Section 9: Amends s. 627.602, F.S., relating to scope, format of policy, to conform a cross-reference.
Section 10: Amends s. 627.642, F.S. relating to outline of coverage, to limit the requirement to excepted benefit and large group policies.
Section 11: Amends s. 627.6425, F.S., relating to renewability of individual coverage, to conform cross-references.
Section 12: Amends s. 627.6487, F.S., relating to guaranteed availability of individual health insurance coverage to eligible individuals, to conform cross-references.
Section 13: Repeals s. 627.64871, F.S., relating to certification of coverage, to conform to the repeal of s. 627.6561(8), F.S., which requires issuance of a certificate of creditable coverage in connection with preexisting conditions.
Section 14: Amends s. 627.6512, F.S., relating to exemption of certain group health insurance policies, to conform cross-references.
Section 15: Amends s. 627.6513, F.S., relating to scope, to reinstate the list of excepted coverages, which is transferred from s. 627.6561, F.S.
Section 16: Amends s. 627.6561, F.S., relating to preexisting conditions, to delete the definition of "creditable coverage" and the requirement to provide a certificate of creditable coverage, and other provisions related to the administration of creditable coverage.
Section 17: Amends s. 627.6562, F.S., relating to dependent coverage, to reinstate the list of excepted coverages, which is transferred from s. 627.6561, F.S., for purposes of the definition of "creditable coverage" for dependent eligibility.
Section 18: Amends s. 627.65626, F.S., relating to insurance rebates for healthy lifestyles, to conform a cross-reference.
Section 19: Amends s. 627.6699, F.S., relating to Employee Health Care Access Act, to conform cross-references and to remove provisions relating to preexisting conditions.
Section 20: Amends s. 627.6741, F.S., relating to issuance, cancellation, nonrenewal, and replacement, to conform cross-references.
Section 21: Amends s. 641.31, F.S., relating to health maintenance contracts, to repeal the exemption from laws restricting subscriber cost-sharing.
Section 22: Amends s. 641.31071, F.S., relating to preexisting conditions to delete the definition of "creditable coverage" and the requirement to provide a certificate of creditable coverage, and other provisions related to the administration of creditable coverage.
Section 23: Amends s. 641.31074. F.S., relating to guaranteed renewability of coverage, to apply it to individual major medical policies. This is not a substantive change in law, but a revision necessary to conform to a cross-reference change in s. 627.6425, F.S.
Section 24: Amends s. 641.312, F.S., related to scope, to conform a cross-reference.
Section 25: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

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

On February 1, 2016, the Insurance & Banking Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Restored current law related to conversion policies and made technical and conforming changes, as needed.
- Restored current law related to the requirement for excepted benefit policies and large group certificate holders to provide policyholders an outline of coverage.
- Restored current law regarding the exemption for excepted benefits from mandatory benefits provisions and conformed a cross-reference.
- Restored the guaranteed renewability requirements for individual HMO major medical policies.
- Removed sections of the bill related to the Florida Comprehensive Health Association, which was dissolved in 2015.
- Restored a portion of the provisions in current law limiting insurer and HMO practices with respect to preexisting conditions.

On February 17, 2016, the Health and Human Services Committee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Removed the phrase “or a large group” from the outline of coverage requirement.
- Added corporate not-for-profits whose memberships consist entirely of local government units authorized to enter into risk management consortiums to the list of exempted entities.

The staff analysis is drafted to the committee substitute.