

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 Commerce and Tourism

BILL: SB 1422

INTRODUCER: Senator Gruters

SUBJECT: Health Plans

DATE: March 22, 2019

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Johnson</u>	<u>Knudson</u>	<u>BI</u>	Favorable
2.	<u>Harmsen</u>	<u>McKay</u>	<u>CM</u>	Favorable
3.	_____	_____	<u>RC</u>	_____

I. Summary:

SB 1422 revises regulatory provisions relating to alternative coverage arrangements, such as short-term limited duration insurance policies and association health plans (AHPs). The bill codifies 2018 federal regulations to provide consumers and employers with more affordable coverage options and choices for health insurance coverage.

An AHP is a type of multiple employer welfare association, which constitutes a legal arrangement that allows business associations or unrelated employer groups to jointly offer health insurance and other fringe benefits to their members or employees. 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 AHP that would be treated as a large group rather than a small group for insurance purposes. This will 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 also 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.

II. Present Situation:

Health care spending in the United States is expected to grow an average of 5.5 percent annually from 2018 through 2027, reaching nearly \$6.0 trillion by 2027.¹ Consumers are becoming responsible for a growing proportion of this spending, as demonstrated in the increased use of high deductible health plans and other forms of cost sharing. Since 2012, the percentage of workers covered by a plan with a deductible of \$1,000 or greater has grown from 34 to 51 percent.²

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations (HMOs), and other risk-bearing entities.³ The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S., and before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.⁴

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 federal Patient Protection and Affordable Care Act (PPACA)⁵ compliant plans would increase an average of 5.2 percent effective January 1, 2019.⁶ The average approved rate changes to the plans on the exchange ranged from -1.5 percent to +9.8 percent. Only one insurer, Blue Cross Blue Shield, offers individual coverage in all 67 counties.⁷ During the 2019 open enrollment period, 1,786,679 individuals enrolled in Florida plans through the federally administered exchange.⁸

The OIR approved the 2019 rates for 14 small group insurers.⁹ The weighted average change in approved rates from 2018 was 6 percent. The percentage change in approved rates from 2018

¹ Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), *National Health Expenditure Projections 2018-2027*, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf> (last viewed Mar. 22, 2019).

² Brendan Riley, *Can Consumers be Smarter Health Care Shoppers in the Quest for Cost Containment?*, 79 N.C. Med. J., 34 (Jan.-Feb. 2018).

³ Section 20.121(3)(a), F.S.

⁴ Section 641.21(1), F.S.

⁵ The Patient Protection and Affordable Care Act (Pub. L. No. 111-148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), which amended and revised several provisions of the PPACA, was enacted on March 30, 2010.

⁶ Office of Insurance Regulation, *Individual PPACA Market Monthly Premiums for Plan Year 2019*, <https://floir.com/siteDocuments/IndividualMarketPremiumSummary.pdf> (last viewed February 11, 2019). See also Office of Insurance Regulation, *OIR Announces 2019 PPACA Individual Market Health Insurance Plan Rates*, <https://www.floir.com/PressReleases/viewmediarelease.aspx?id=2234> (last viewed Mar. 22, 2019).

⁷ Office of Insurance Regulation, *Individual Market County Offerings*, <https://www.floir.com/sitedocuments/IndividualMarketCountyOfferings.pdf>, (last viewed Mar. 22, 2019).

⁸ CMS, *Final Weekly Enrollment Snapshot for the 2019 Enrollment Period* (Jan. 3, 2019), <https://edit.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period> (last viewed Mar. 22, 2019).

⁹ Office of Insurance Regulation, *Small Group PPACA Market Monthly Premiums for Plan Year 2019* (Aug. 22, 2018), available at <https://www.floir.com/siteDocuments/SGMarketPremiumSummary.pdf> (last viewed Mar. 22, 2019).

ranged from -11.8 percent to +14.5 percent. Florida Blue and UnitedHealthCare (and affiliates) offer small group plans in every county.

State Regulation of Short-term Limited Duration Insurance Policies

In Florida, short-term limited duration insurance (STLDI) is an individual health insurance coverage with an issuer or insurer that has specified in the contract an expiration date that is within 12 months of the contract's effective date.¹⁰ An STLDI policy that is renewable or is for a term longer than 6 months cannot exclude preexisting conditions for more than 24 months.¹¹

Currently in Florida there are two licensed insurers (Blue Cross Blue Shield and Integon Indemnity Corporation) offering short term limited duration individual policies that provide coverage for an estimated 10,000 members.

Florida Regulation of Association Health Plans or Multiple Employer Welfare Arrangements

In Florida, an AHP consisting of multiple employers is referred to as a multiple employer welfare arrangement (MEWAs).¹² A MEWA is an employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health insurance benefits or any other benefits described in s. 624.33, F.S., other than life insurance benefits, to the employees of two or more employers, or to their beneficiaries.¹³ Current state law requires AHPs or MEWAs to be based on a common industry. AHPs may not have less than 25 members and must have been organized and maintained in good faith for at least 1 year.¹⁴ A small group health alliance must be organized as a not-for-profit corporation under ch. 617, F.S.¹⁵

In the Florida, there are two AHPs/MEWAs licensed by the OIR: the Independent Colleges and Universities Benefits Association, which is comprised of 26 employers with approximately 15,000 members, and the Florida Bankers Association comprised of 64 employers with approximately 6,000 members.

Federal Regulation of Health Insurance Products

The PPACA requires health insurers to make major medical or comprehensive coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA also mandates required essential health benefits,¹⁶ rating and underwriting standards, and other provisions. The PPACA

¹⁰ Fla. Admin. Code R. 690-154.104 (2000). The Insurance Code does not prohibit the OIR from approving a short-term limited duration rider that offered a guaranteed renewability option for up to 36 months. However, Rule 690-154.104 prevents guaranteed renewability.

¹¹ Section 627.6045, F.S.

¹² See ss. 624.436-624.446, F.S., which may be cited as the "Florida Nonprofit Multiple Welfare Arrangement Act."

¹³ Section 627.437, F.S. This section does not apply to a multiple-employer welfare arrangement which offers or provides benefits which are fully insured by an authorized insurer, to an arrangement which is exempt from state insurance regulation in accordance with Pub. L. No. 93-406, the Employee Retirement Income Security Act, or to the state group health insurance program administered pursuant to s. 110.123, F.S.

¹⁴ Section 627.438, F.S.

¹⁵ *Id.*

¹⁶ 42 U.S.C. § 18022.

requires insurers and HMOs that offer qualified health plans to provide ten categories of essential health coverage.¹⁷ The PPACA preempts any state law that prevents the application of a provision of PPACA.¹⁸

In 2017, the federal Tax Cuts and Jobs Act¹⁹ reduced the tax penalty for individuals who fail to comply with PPACA's individual mandate to maintain minimum essential health coverage to zero beginning tax year 2019.²⁰ However, the act did not repeal the individual mandate.

Federal Regulation of Short-Term Limited Duration Plans

Federal law²¹ defines individual health insurance coverage as health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance. STLDI policies do not need to meet the essential health benefits requirements, and are not subject to the prohibitions on preexisting condition exclusions or lifetime and annual dollar limits. An STLDI policy is also not subject to requirements regarding guaranteed availability, guaranteed renewability, and rating requirements based on health status. As a result, an insurer would be able to offer short-term limited duration insurance policies to individuals who are in good health at substantially lower premium than available in the individual market.

The U.S. Department of Health and Human Services adopted final rules,²² effective for policies issued after October 1, 2019, that revised the definition of STLDI to specify that a STLDI policy is health 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, taking into account renewals or extensions, has a duration of no longer than 36 months in total.²³ Previously, the policy term of a STLDI policy was limited to 3 months.²⁴ The rule requires disclosures in the STLDI insurance contract regarding the scope of the coverage.

Federal Regulation of Association Health Plans

The federal Employee Retirement Income Security Act (ERISA) gives states regulatory authority over self-insured MEWAs and some authority over fully insured MEWAs to ensure solvency, require state licensure, and require financial reporting. An AHP is one type of MEWA. Further, ERISA authorizes the U.S. Department of Labor to require fully insured and self-insured MEWAs to register with the department.

¹⁷ See Center for Consumer Information & Insurance Oversight, *Information on Essential Health Benefits (EHB) Benchmark Plans* <https://www.cms.gov/ccio/resources/data-resources/ehb.html> (last viewed Mar. 22, 2019) for Florida's benchmark plan.

¹⁸ The PPACA preempts any state law that prevents the application of a provision of the PPACA. The PPACA effectively allows states to adopt and enforce laws that provide greater consumer protections than the PPACA, but any state law that does not meet the federal minimum standards will be preempted. Pub. L. No. 111-148, s. 1321(d).

¹⁹ Public L. No. 115-97, Stat. 2054 (2017).

²⁰ Prior to tax year 2019, the PPACA required that, for each month during the year, an individual must have minimum essential coverage or individual mandate; qualify for an exemption; or pay a penalty or shared responsibility payment when filing the federal income tax return. 26 U.S.C. § 5000A. See Internal Revenue Service, *Individual Shared Responsibility Provision*, <https://www.irs.gov/taxtopics/tc561> (last viewed Mar. 22, 2019).

²¹ Section 2791(b)(5) of the PHS Act.

²² 45 CFR § 144, 146, and 148.

²³ 83 FR 38212.

²⁴ 81 FR 75316.

Under current federal law and regulations, health insurance coverage offered or provided through an employer trade association, chamber of commerce, or similar organization, to individuals and small employers, is generally regulated under the same federal standards that apply to insurance coverage sold by health insurance issuers²⁵ directly to these individuals and small employers, unless the coverage sponsored by the group or association constitutes a single ERISA covered plan.

Generally, unless the arrangement sponsored by the group or association constitutes a single ERISA covered plan, the current regulatory framework disregards the group or association in determining whether the coverage obtained by any particular participating individual or employer is individual, small group, or large group market coverage. Instead, the test for determining the type of coverage focuses on whether the coverage is offered to individuals or employers. If the coverage is offered to employers, whether the group coverage is large group or small group coverage depends on the number of employees of the particular employer obtaining the coverage. As a result, associations that want to form AHPs and existing AHPs currently face a complex and costly compliance environment, insofar as the various employer members of the association and the association's health insurance coverage arrangement may simultaneously be subject to large group, small group, and individual market regulation, which undermines one of the core purposes and advantages of an association forming and its employer members joining an AHP.

In June 2018, the U.S. Department of Labor issued its final rule on the regulation of AHPs.²⁶ The final rule maintained the existing regulatory framework but also created a second option for both new and existing AHPs/MEWAs that may elect to follow the new regulations. The second option contains the following key differences with the previous federal regulations:

- Allows for AHPs/MEWAs to be based on a common geography area or a common industry.
- Allows small employers to join together to form an AHP/MEWA and be treated as a large employer for the purposes of buying insurance. Current federal law has a look-through provision that treats small employers that are part of an AHP/MEWA as part of the small employer market, and are subject to coverage requirements of the PPACA. Insurance purchased by large employers is not subject to essential health benefit requirements (such as providing mental health, maternity benefits, etc.).
- The rules provide non-discrimination protections that prohibit associations from conditioning membership based on a health factor but does not prohibit other factors such as gender, age, geography, and industry. The association may not charge higher premiums or deny coverage to people because of preexisting conditions, or cancel coverage because an employee becomes ill.
- Self-funded MEWAs that are recognized as bona fide associations or groups under previously issued guidance from the U.S. Department of Labor remain eligible under federal law in accordance with parts 2510.3-5(a) of the Federal Labor Code.

²⁵A “health insurance issuer” or “issuer” is an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan. 29 CFR § 2590.701–2. The terms “health insurance issuer” and “issuer” are used interchangeably in this preamble.

²⁶29 CFR § 2510, available at <https://www.govinfo.gov/content/pkg/FR-2018-06-21/pdf/2018-12992.pdf> (last viewed Mar. 22, 2019).

- Self-employed individuals with no other employees can also join an AHP, along with their families. Self-employed individuals who employ other individuals have always been eligible to join an AHP.
- The new rule eliminates a provision that required a group or association acting as an employer to exist for purposes other than providing health benefits. The rule requires that a group or association of employers have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees, even if the primary purpose of the group or association is to offer such coverage to its members
- States will continue to have regulatory oversight of AHPs and share enforcement authority with the federal government.

The new rule does not affect previously existing AHPs, which were authorized under prior guidance. Such plans can continue to operate as before, or elect to follow the new requirements if they want to expand within a geographic area, regardless of industry, or to cover the self-employed. New plans can also form and elect to follow either the old guidance or the new rules. New and existing plans may use experience rating by underwriting premiums for individual employer members based on health status. However, the AHPs that wish to do so must continue to meet the prior federal regulations, which are more stringent standards in areas such as commonality of interest; and they could not enroll working owners in an AHP coverage.

Many experts are evaluating the impact of the new federal rules. Four million Americans, including 400,000 who otherwise would lack insurance, are expected to join an AHP by 2023 according to a Congressional Budget Office report.²⁷ Some large employers could be a part of an AHP; however, it is anticipated that many AHPs will draw the majority of their membership primarily from the small-group market and, to a lesser extent, the individual market. Both markets have shown a high degree of price sensitivity, particularly in the unsubsidized segment of the individual market (i.e. those individuals with income above 400 percent of the federal poverty level) who pay full costs with no employer contribution or government subsidy.²⁸ Low price will still be a key consideration and AHPs will need to have comprehensive strategies that produce the best chance of being competitive with the small-group PPACA market as well as with other alternative offerings, such as small group level-funded (self-insured) products. Price will be a significant consideration for employers, but features unrelated to price, such as payment reform, benefits, value-added features, and branding may be significant factors in the choice between AHP coverage and other options.

With the implementation of the new federal rule, all associations (new or existing) may establish a fully-insured AHP on September 1, 2018. Existing associations that sponsored an AHP on or before the date the Final Rule was published may establish a self-funded AHP on January 1, 2019. All other associations (new or existing) may establish a self-funded AHP on April 1, 2019.

²⁷ U.S. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), available at <https://www.cbo.gov/system/files?file=2018-06/53826-healthinsurancecoverage.pdf> (last viewed Mar. 22, 2019).

²⁸ Milliman, Inc., *Association health plans after the final rule*, (Aug. 22, 2018), <http://www.milliman.com/insight/2018/Association-health-plans-after-the-final-rule/> (last viewed Mar. 22, 2019).

III. Effect of Proposed Changes:

Section 1 amends s. 624.438, F.S., to revise the eligibility requirements for a MEWA to codify the new, expanded eligibility requirements contained in federal rule. The section removes provisions relating to eligibility requirements that were in effect prior to the adoption of the new federal rules, including the requirement that a MEWA have been organized and maintained in good faith for a continuous period of 1 year for purposes other than obtaining or providing insurance, and commonality of trades or profession.

Section 2 amends s. 624.6045, F.S., to provide that short-term health insurance policies are not required to cover preexisting conditions. Currently, short-term policies that are renewable for a term longer than 6 months cannot exclude preexisting conditions for more than 24 months.

Section 3 amends s. 627.6425, F.S., to require that individual short-term policies be guaranteed renewable at the option of the individual by including such policies in the definition of health insurance.

Sections 4 and 5 amend ss. 627.6426 and 627.654, F.S., to define “short term health insurance” to mean health insurance coverage provided by an issuer with an expiration date that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration not to exceed 36 months. Section 4 applies the new definition of short-term health insurance to the individual market; Section 5 applies it to group, blanket, or franchise policies of health insurance. Sections 4 and 5 each codify the federal disclosure notice requirement for short-term policies for individual and group policies into state law, which would allow the OIR to enforce this provision.

Section 6 amends s. 627.654, F.S., to codify the federal rule that allows an association to be insured under a group policy purchased from a licensed insurer. The section also removes the requirements that an association may not have less than 25 members and have been organized and maintained in good faith for a period of 1 year. Lastly, it removes the requirement that a small group health alliance be organized as a not-for-profit corporation under ch. 617, F.S., and meet other requirements.

Section 7 provides that the bill takes effect July 1, 2019.

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:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Consumers and employers will have a greater choice of health insurance options with lower costs. Many consumers unable to afford major medical insurance coverage may be able to afford other coverage options now available.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Self-funded MEWAs that were recognized to be bona fide associations or groups under previously issued guidance from the United States Department of Labor remain eligible under federal law in accordance with sections 2510.3-5(a) of the Federal Labor Code. However, this provision is not included in Section 1 of the bill. It may be beneficial to include such groups under Section 1 as the two currently licensed MEWAs are organized under this prior federal guidance and new MEWAs have the option under federal law to follow this guidance rather than the recently expanded federal definition of bona fide group or association.

There is an apparent conflict between sections 3 and 4 of the bill. In particular, Section 3 requires guaranteed renewability for short-term plans at the option of the individual whereas Section 4 limits short-term plans to 36 months as required by federal law. It is unclear what would happen if a consumer has had a short-term plan for 36 months and wants to renew as Section 3 would require an insurer to renew the same policy but would be prohibited from renewing the same policy by Section 5 and federal law.

It appears that the primary purpose of adding a bona fide group or association of employers as defined in 2510.3-5(a) of the Federal Labor Code to Section 6 is to allow health insurers to sell comprehensive, major medical policies to these types of groups. However, as written, the bill would allow health insurers to offer other types of health insurance products to these newly included groups such as accident policies, hospital indemnity policies, and specified disease policies.

Under federal law, employee leasing companies, also known as professional employer organizations or PEOs, are considered a type of MEWA. Employee leasing companies are licensed under s. 468.529, F.S. Section 468.529(1), F.S., states in part that “no licensed employee leasing company shall sponsor a plan of self-insurance for health benefits, except as may be permitted by the provisions of the Florida Insurance Code.” Employee leasing companies are typically comprised of employers from disparate trades or industries. Since the bill would allow MEWAs that consist of employers from disparate trades or industries, it would be beneficial to clarify the OIR’s role in the regulation of health plans of self-insured employee leasing organizations.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 624.438, 627.6045, 627.6425, and 627.654.

This bill creates the following sections of the Florida Statutes: 627.6426 and 627.6525.

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.