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 Rules

BILL: CS/CS/SB 322

INTRODUCER: Health Policy Committee; Banking and Insurance Committee and Senator Simpson

SUBJECT: Preexisting Conditions

DATE: March 12, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Lloyd	Brown	HP	**Fav/CS**
3.	Johnson	Phelps	RC	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 322 requires each insurer or health maintenance organization (HMO) issuing 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 the Patient Protection and Affordable Care Act (PPACA) or the invalidation of the PPACA by the United States Supreme Court. Preexisting conditions affect an estimated 129 million Americans.[1]

The PPACA prohibits group and individual health insurance plans from imposing preexisting condition exclusions. This requirement of the PPACA preempts state laws that allow such insurers to utilize preexisting condition exclusions. The currently preempted Florida law prohibits individual health policies from excluding preexisting conditions for more than 24 months and that may relate to conditions that manifested themselves during the 24-month period. Individual health policies may exclude coverage for named or specific conditions without any time limit. Florida law prohibits group policies from excluding preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee, and may only relate to conditions that manifested themselves during the six-month period prior to coverage.

[1] 80 FR 72192.

II. Present Situation:

PPACA

On March 23, 2010, the PPACA was signed into law.[2] Among its sweeping changes to the U.S. health insurance system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions, for preexisting medical conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements, including an individual mandate of coverage, required 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.[3] The PPACA preempts any state law that prevents the application of a provision of PPACA.[4]

Preexisting Condition Exclusions

The PPACA prohibits health insurance policies from excluding coverage for any preexisting condition.[5] A health insurer that offers individual or group health insurance coverage may not impose any preexisting condition exclusion.[6] Rules define the term, "preexisting condition exclusion" to include a denial of coverage.[7] Individual (but not group) grandfathered health plans are exempt from this requirement.[8]

Regulation of Insurance in Florida

Florida's Office of Insurance Regulation (OIR) is responsible for the regulation of all activities of insurers and other risk-bearing entities.[9]

---

[2] Pub. Law No. 111-148, 124 Stat. 119-1945 (2010). PPACA was amended by Pub. Law No. 111-152, the Health Care and Education Reconciliation Act of 2010.

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

[4] 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. PPACA s. 1321(d).

[5] PPACA s. 1201; PHSA s. 2704 (42 U.S.C. 300gg-3).

[6] 45 CFR 144.108.

[7] *Preexisting condition exclusion* means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage…whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage…such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period. *See* 45 C.F.R. s. 144.013.

[8] A grandfathered health plan can be an individual or group health insurance policy purchased on or before March 23, 2010. Such plans are not subject to the ACA prohibition on pre-existing conditions and other specified ACA requirements. A plan can lose its grandfathered status if it is significantly changed. See Healthcare.gov, Grandfathered Health Insurance Plans, available at https://www.healthcare.gov/health-care-law-protections/grandfathered-plans (last viewed Feb. 18, 2019).

[9] 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.

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.[10] 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.[11] During the 2019 open enrollment period, 1,786,679 individuals enrolled in Florida plans through the federally administered exchange.[12]

The OIR approved the 2019 rates for 14 small group insurers.[13] 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.

Preexisting Condition Exclusions

The PPACA prohibits group and individual health insurance plans from imposing preexisting condition exclusions.[14] This requirement of the PPACA preempts state laws that allow such insurers to utilize preexisting condition exclusions. The currently preempted Florida law prohibits individual health policies from excluding preexisting conditions for more than 24 months and that may relate to conditions that manifested themselves during the 24-month period.[15] Individual health policies may exclude coverage for named or specific conditions without any time limit.[16] Florida law prohibits group policies from excluding preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee and may only relate to conditions that manifested themselves during the six-month period prior to coverage.[17]

PPACA Legislation and Litigation

In recent years, major federal legislation has been filed to amend, repeal or replace the PPACA.[18] In 2017, the federal Tax Cuts and Jobs Act[19] reduced the tax penalty for individuals who fail to

---

[10] Office of Insurance Regulation, Individual PPACA Market Monthly Premiums for Plan Year 2019, *available at* https://floir.com/siteDocuments/IndividualMarketPremiumSummary.pdf (last viewed Feb. 28, 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 Feb. 28, 2019).
[11] OIR, Individual Market County Offerings, available at https://www.floir.com/sitedocuments/IndividualMarketCountyOfferings.pdf, (last viewed Feb. 28, 2019).
[12] CMS.gov, *Final Weekly Enrollment Snapshot for the 2019 Enrollment Period* (January 3, 2019), *available at* https://edit.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period (last viewed Feb 28, 2019).
[13] OIR, Small Group PPACA Market Monthly Premiums for Plan Year 2019 (August 22, 2018), *available at* https://www.floir.com/siteDocuments/SGMarketPremiumSummary.pdf (last viewed Feb. 14, 2019).
[14] 42 U.S.C. s. 300gg-3.
[15] Section 627.6045, F.S.
[16] Section 627.607(2), F.S.
[17] Prior creditable coverage reduces the exclusion period.
[18] Compare Proposals to Replace the Affordable Care Act, *available at* https://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/ (last viewed Feb. 28, 2019).
[19] Pub. Law No. 115-97, Stat. 2054 (2017).

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.

On December 14, 2018, the U.S. District Court for the Northern District of Texas, declared the individual mandate of the PPACA unconstitutional and the remaining provisions of the PPACA inseverable from the mandate, and thus invalid.[21] Subsequently, on December 31, 2018, the Court issued a stay that keeps the PPACA in force while the ruling is appealed.[22] In response to the ruling, the federal U.S. Department of Health and Human Services[23] stated, "The recent U.S. District Court decision regarding the Affordable Care Act is not an injunction that halts the enforcement of the law and not a final judgment. Therefore, HHS will continue administering and enforcing…"

III. Effect of Proposed Changes:

Section 1 creates s. 627.6046, F.S., to require insurers issuing or delivering individual health insurance policies in Florida to offer at least one comprehensive major medical health insurance policy that does not exclude or delay coverage under the policy or contract due to one or more preexisting medical conditions. This mandated offer is triggered by an operative date. The term, "operative date," means the date that either of the following occurs with respect to PPACA:

- A federal law is enacted that expressly repeals PPACA; or
- PPACA is invalidated by the United States Supreme Court.

Notwithstanding s. 627.6045, F.S.,[24] the bill requires every insurer to make such policy or contract available to all residents of the state within 30 days after the operative date. The comprehensive major medical health insurance policy that an insurer is required to offer under this section must be a policy that had been actively marketed in this state by the insurer as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date. An insurer may not limit or exclude benefits under such policy, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

The term, "preexisting medical condition" is defined to mean:

- A condition that was present before the effective date of coverage under a policy, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage; and

---

[20] Prior to tax year 2019, PPACA required that, for each month during the year, an individual must have minimum essential coverage (MEC) 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. s. 5000A. See https://www.irs.gov/taxtopics/tc561 (last viewed Feb. 28, 2019).

[21] *Texas v. Azar*, available at https://benefitslink.com/src/ctop/Texas-v-US_NDTex_12142018.pdf (last viewed Feb. 28, 2019). The Court noted that the 2010 Congress memorialized that the mandate was the keystone to PPACA, *see* 42 U.S.C. s. 18091.

[22] *Texas v. Azar*, Order *available at* https://static.politico.com/17/86/6721f2eb435fb2512430e54c2904/220.pdf (last viewed Feb. 28, 2019).

[23] *See* Statement from the Department of Health and Human Services on Texas v. Azar (December 17, 2018), *available at* https://www.hhs.gov/about/news/2018/12/17/statement-from-the-department-of-health-and-human-services-on-texas-v-azar.html (last viewed Feb. 28, 2019).

[24] Florida law on preexisting conditions in individual market policies that is currently preempted by the PPACA.

- A condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.[25]

This section does not apply to an insurer issuing only limited benefit, disability income, specified disease, Medicare supplement, or hospital indemnity policies in this state.

Section 2 creates s. 627.65612, F.S., to require insurers issuing or delivering group health insurance policies in Florida to offer at least one comprehensive major medical health insurance policy that does not exclude or delay coverage under the policy due to one or more preexisting medical conditions, as required for individual policies and contracts in Section 1 of the bill. The terms, "operative date" and "preexisting medical condition," have the same meaning as provided in Section 1 of the bill.

Notwithstanding s. 627.6561, F.S.,[26] an insurer is required under the bill to make such coverage available within 30 days after the operative date. The comprehensive major medical health insurance policy that an insurer is required to offer under this section must be a policy that had been actively marketed in this state by the insurer as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date. An insurer may not limit or exclude benefits under such policy, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

This section does not apply to an insurer issuing only limited benefit, disability income, specified disease, Medicare supplement, or hospital indemnity policies in this state.

Section 3 amends s. 641.31, F.S., to require health maintenance organizations (HMOs) issuing or delivering individual or group contracts in Florida to offer at least one comprehensive major medical health insurance policy or contract that does not exclude or delay coverage under the policy or contract due to one or more preexisting medical conditions, as required for individual policies and contracts in Section 1 of the bill. The terms, "operative date" and "preexisting medical condition," have the same meaning as provided in Section 1 of the bill.

Notwithstanding s. 641.31071, F.S.,[27] an HMO is required under the bill to make such coverage available within 30 days after the operative date. The comprehensive major medical HMO contract that the HMO is required to offer under this section must be a contract that had been actively marketed in this state by the HMO as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date. An HMO may not limit or exclude benefits under such contract, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of the denial.

Section 4 provides this act will take effect July 1, 2019.

---

[25] *See* 45 C.F.R. s. 144.013.
[26] Florida laws on preexisting conditions for group policies offered by insurers that are currently preempted by the PPACA.
[27] Florida laws on preexisting conditions for contracts offered by health maintenance organizations that are currently preempted by the PPACA.

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:

If the U.S. Supreme Court invalidates PPACA or a federal law expressly repeals PPACA, the bill would provide access for individuals and groups to at least one policy or contract for major medical coverage that did not exclude or delay coverage due to the applicant having one or more preexisting medical conditions. Currently, the Florida Insurance Code does not prohibit preexisting condition exclusions; however, it is preempted by PPACA.

CS/CS/SB 322 requires every insurer and HMO to offer at least one policy or contract without preexisting medical exclusions to all residents. Currently, only Florida Blue offers individual plans in every county. Florida Blue and United HealthCare (and affiliates) offer small group plans in every county.

Such coverage may be expensive for some individuals with preexisting medical conditions due to adverse selection. Many individuals purchasing such coverage would be expected to have some type of preexisting medical condition. Under Florida law, insurers would be allowed to pool policies or contracts covering preexisting conditions

separately from other policies that did not offer that benefit, as well as underwrite such policies that accounts for the losses experienced.

C. Government Sector Impact:

If implemented, the required changes to health maintenance organization contracts and group health insurance policies under contract with the state for state employee benefits would be required to comply with the mandatory eligibility and benefit changes under the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 627.6046, 627.65612, and 641.31.

IX. Additional Information:

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

CS/CS by Health Policy on March 4, 2019:
Due to a scrivener's error, a provision in Section 2 of the bill, as filed, was not included in the CS adopted by the Banking and Insurance Committee. The CS by the Health Policy Committee corrected this error by re-inserting the provision relating to the type of group policy an insurer is required to offer.

CS by Banking and Insurance on February 19, 2019:
The CS:
- Revises the definition of the term, "preexisting medical condition."
- Revises requirements relating to the offer of coverage without preexisting condition exclusions.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.