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 Health Policy

BILL:	CS/SB 418
INTRODUCER:	Banking and Insurance Committee and Senator Simpson
SUBJECT:	Essential Health Benefits Under Health Plans
DATE:	March 29, 2019
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 418 requires the Office of Insurance Regulation to conduct a study to evaluate Florida's essential health benefits (EHB) benchmark plan and submit a report 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.

Starting in plan year 2020, the federal government is providing each state with greater flexibility in the selection of its EHB-benchmark plan. This flexibility may foster innovation in plan design and greater access to affordable coverage in the states. The 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.[1]

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. Such coverage options must be substantially equivalent to the state EHB-benchmark plan and could be submitted to the OIR for review and approval.

[1] CMS.gov, *The Center for Consumer Information and Insurance Oversight, Information on Essential Health Benefits (EHB) Benchmark Plans* https://www.cms.gov/cciio/resources/data-resources/ehb.html (last viewed February 11, 2019).

The bill takes effect upon becoming a law.

II. Present Situation:

Regulation of Insurance in Florida

The Florida Office of Insurance Regulation (OIR) is responsible for the regulation of all activities of insurers and other risk-bearing entities that do business in the state.[2]

2019 Individual and Small Group Markets

Nine health insurance companies writing individual policies or contracts submitted rate filings to the OIR in June 2018, which were compliant with the federal Patient Protection and Affordable Care Act (PPACA).[3] 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.[4] 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.[5] During the 2019 open enrollment period, 1,786,679 individuals enrolled in Florida plans through the federally administered exchange.[6] The 2020 open enrollment period will occur from November 1, 2019, through December 15, 2019, and plans sold during this span will start January 1, 2020.[7]

The OIR approved the 2019 rates for 14 small group insurers.[8] 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.

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[2] 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.

[3] The federal Patient Protection and Affordable Care Act was enacted on March 23, 2010, which created or expanded a number of health care protections and guarantees, provided states with a Medicaid eligibility expansion option, and made available individual health insurance subsidies, and tax credits based on income.

[4] Office of Insurance Regulation, *Individual PPACA Market Monthly Premiums for Plan Year 2019*, (August 22, 2018) *available at* https://floir.com/siteDocuments/IndividualMarketPremiumSummary.pdf (last viewed February 11, 2019). See also Press Release, Office of Insurance Regulation, *OIR Announces 2019 PPACA Individual Market Health Insurance Plan Rates*, (August 28, 2019) *available at* https://www.floir.com/PressReleases/viewmediarelease.aspx?id=2234 (last viewed February 11, 2019).

[5] OIR, *Individual Market County Offerings*, (August 22, 2019) *available at* https://www.floir.com/sitedocuments/IndividualMarketCountyOfferings.pdf, (last viewed February 11, 2019).

[6] 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 February 14, 2019).

[7] Centers for Medicare and Medicaid Services, *Dates and deadlines for 2019 health insurance, Healthcare.gov,* https://www.healthcare.gov/quick-guide/dates-and-deadlines/ (last viewed March 28, 2019).

[8] 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 February 14, 2019).

The initial deadline for the submission of 2020 rates by health insurance issuers is July 24, 2019, with certification of rates expected to be completed by early October, 2019.[9]

Patient Protection and Affordable Care Act (PPACA)

The federal PPACA was signed into law on March 23, 2010.[10] Among its significant 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 conditions and without basing premiums on any health-related factors. Further, PPACA requires 10 categories of essential health 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.[11] The PPACA preempts any state law that prevents the application of a provision of PPACA. [12]

Essential Health Benefits

The PPACA requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in the following 10 benefit categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Pregnancy, maternity, and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.[13]

State EHB-Benchmark Plans, Generally

Rules adopted by the U.S. Department of Health and Human Services (HHS)[14] define EHB based on state-specific EHB benchmark plans. In plan year 2017, 2018, and 2019, the EHB-benchmark plan is defined as a plan that was sold in 2014. The HHS codified regulations to

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[9] Centers for Medicare and Medicaid Services, *Proposed Key Dates for Calendar Year 2019, Qualified Health Plan (QHP) Certification in the Federally Facilitated Exchanges (FFEs); Rate Review; and Risk Adjustment*, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Key-Dates-Table-for-CY2019.pdf (last viewed March 28, 2019).

[10] Pub. Law No. 111-148. On March 30, 2010, PPACA was amended by Pub. Law No. 111-152, the Health Care and Education Reconciliation Act of 2010.

[11] 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.).

[12] PPACA, s. 1321(d)

[13] HealthCare.gov, *What Marketplace health insurance plans cover*, available at: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ (last viewed February 11, 2019).

[14] 45 CFR s. 156.100.

allow each state to select a benchmark plan that serves as a reference plan. According to the HHS, this approach seeks to balance coverage of essential health benefits (EHB) categories and affordability and provide flexibility for states as primary regulators of health insurance. States can choose a benchmark plan from among the following health insurance plans:

- The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
- Any of the largest three state employee plans by enrollment;
- Any of the largest three national federal employer health benefit plans (FEHBP) plan options by enrollment; or
- The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

All 10 essential health benefit categories must be included as a part of EHB; therefore, if the selected or default benchmark plan does not initially cover a category, the benchmark must be supplemented.[15] If one or more categories of benefits is missing in the benchmark plan, the insurer or HMO must supplement it.[16] States are required to supplement pediatric dental and vision with the benefits which are equivalent to the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan[17] with the largest national enrollment or the benefits in the Children's Health Insurance Program.[18]

In Florida, the state did not select a plan; therefore, the default benchmark plan is the largest small group plan, which is supplemented to include pediatric dental. The small group plan also includes all of the mandated coverage required under Florida law.

EHB-Benchmark Plans in 2020 and Thereafter

For plan year 2020 and after, the HHS provides states with greater flexibility to update their EHB benchmark plans, if they so choose.[19] Such modifications are subject to HHS review and approval to become effective. States that opt not to exercise this flexibility continue to use the same benchmark plan applicable for the prior year.[20]

Under the new regulations, a state may modify its EHB-benchmark plan by:

- Selecting the EHB-benchmark plan that another state used for the 2017 plan year;
- Replacing one or more EHB categories of benefits in its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or

[15] 45 CFR s. 156.110(b).
[16] 45 CFR s. 156.110(b)-(c).
[17] Federal Employees Dental and Vision Insurance Program, *available at* https://www.benefeds.com/Portal/EducationSupport?EnsSubmit=EducationSupportMainCnt&ctoken=WyGpd9Pk (last viewed March 20, 2019).
[18] The program, established pursuant to Title XXI of the U.S. Social Security Act, is a program jointly administered by the states and the United States Department of Health and Human Services that provides matching funds to states for health insurance for children from families with low to moderate household incomes. In Florida, the program is known as Florida KidCare.
[19] CMS.gov, *The Center for Consumer Information and Insurance Oversight, Information on Essential Health Benefits (EHB) Benchmark Plans*, available at https://www.cms.gov/cciio/resources/data-resources/ehb.html (last viewed February 11, 2019). For plan year 2020, no state has opted to permit insurers or HMOs to substitute benefits between benefit categories.
[20] 45 CFR s. 156.111(c).

- Selecting a set of benefits that would become the state's EHB-benchmark plan.[21]

The regulation allows an issuer of a plan offering EHB to substitute benefits for those provided in the EHB-benchmark plan under the following conditions:

- The substituted benefit is not a prescription drug benefit.[22]
- An issuer may substitute a benefit within the same category, unless prohibited by state law.
- For plan years beginning on or after January 1, 2020, an issuer may substitute benefits between categories if the state in which the plan will be offered has notified HHS that substitution between EHB categories is permitted.

If a state selects a new EHB benchmark plan for submission to the HHS, the plan will be required to include coverage for all 10 EHB categories of benefits, and the state will be required to confirm its plan to include coverage for each EHB category.[23] Further, a state is required to confirm that its new EHB-benchmark plan meets the applicable requirements[24] on scope of benefits, including that the state's EHB-benchmark plan provide a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category, the scope of benefits provided under a typical employer plan.[25] Because of these requirements, HHS concludes that the options at 45 CFR s. 156.111(a), do not allow a state to reduce substantially the level of coverage, and instead allow a state the option to adjust its EHB-benchmark plan.[26]

In the proposed rule published on January 24, 2019, the suggested deadline for the states to submit any revisions to its EHB benchmark selection for the 2021 plan year is May 6, 2019, and the suggested deadline for the 2022 plan year is May 8, 2020.[27]

Issuer Options

If an issuer (health insurer or HMO) offers a policy or contract that includes substituted benefits, the issuer must:

- Provide benefits that are substantially equivalent to the EHB-benchmark plan;
- Provide an appropriate balance among the EHB categories such that benefits are not unduly weighted toward any category; and
- Provide benefits for diverse segments of the population.[28]

The issuer is required to submit to the state insurance regulator evidence of actuarial equivalence certified by a member of the American Academy of Actuaries and evidence that the plan meets other specified requirements.

[21] 45 CFR s. 156.111(a).
[22] 45 CFR s. 156.115
[23] 45 CFR s. 156.111(e)(1).
[24] 45 CFR s. 156.111(b)
[25] 45 CFR s. 156.111(e)(2).
[26] 83 FR at 17011.
[27] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020; 84 Fed. Reg. 227, 283-284 (Jan. 24, 2019) (to be codified at 45 CFR s. 156.115).
[28] 45 CFR s. 156.111(e).

III. Effect of Proposed Changes:

For purposes of Sections 1 and 2, the term, EHB-benchmark plans has the same meaning as provided in 45 CFR s. 156.20. This regulation provides that an EHB-benchmark plan is the standardized set of essential health benefits that must be met by a qualified health plan, as defined in 45 CFR s. 155.20, or other issuer as required by 45 CFR s. 147.150.

Section 1 creates an undesignated section that requires the OIR to conduct a study to evaluate the state's current EHB-benchmark plan for non-grandfathered individual and group plans and options for changing the EHB-benchmark plan pursuant to 45 CFR s. 156.111 for future years.

- Consider EHB-benchmark plans and benefits under the 10 essential health benefits categories established under 45 CFR s. 156.110(a), which are used by the other 49 states;
- Compare the costs of benefits within such categories and overall costs of EHB-benchmark plans used by other states with the costs of benefits within the categories and overall costs of the current EHB-benchmark plan of this state; and
- Solicit and consider proposed individual and group health plans from health insurers and health maintenance organizations in developing recommendations for changes to the current EHB-benchmark plan.

The OIR is required to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives that includes recommendations for changing the current EHB-benchmark plan. The report is due by October 30, 2019. The OIR must also include an analysis as to whether proposed plans submitted by health insurers and HMOs pursuant to Section 2 of the bill meet the requirements for EHB-benchmark plans under 45 CFR s. 156.111(b).

Section 2 creates s. 627.443, F.S., to authorize an insurer or HMO, which issues or delivers individual or group policies or individual or group contracts in Florida, options for providing the 10 categories of essential health benefits mandated by PPACA. The insurer or HMO may provide essential health benefits by:

- Selecting one or more services or coverages for each of the required 10 essential health benefits categories from the list of essential health benefits required by any single state or multiple states;
- Selecting one or more services or categories from any one or more of the required categories of EHBs from one state or multiple states; or
- Selecting any combination of services or coverages required by any one or a combination of states to provide the required categories of EHBs.

An insurer or HMO is authorized to include any combination of services or coverages required by any one or a combination of states to provide the 10 categories of EHB required under PPACA in a policy or contract issued in this state.

Further, the section authorizes health insurers and HMOs to submit the policies or contracts authorized under this section to the OIR for consideration as part of the OIR's study of the state's EHBs, required under section 1 of the bill. A health insurer or HMO may also submit to the OIR for evaluation a policy or contract as equivalent to the current state EHB-benchmark plan or to any EHB-benchmark plan created in the future.

Section 3 provides the bill takes effect upon becoming law.

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:

Once the state submits a new EHB-benchmark plan and the federal government approves, it is anticipated that insurers and HMOs will be able to offer consumers more innovative coverage options at affordable prices for coverage that is substantially equivalent to the new state EHB-benchmark plan.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Section 1, lines 67-73, reference health plans created by health insurers and HMOs "under this section." Section 1 of the bill requires an OIR study of the essential health benefits benchmark plan; plans would not be created pursuant to the study. Submission by health insurers and HMOs of plans for consideration in the study is addressed in lines 54-57.

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VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 627.6054 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on March 25, 2019:
The CS:

- Requires the OIR to study options for revising the EHB-benchmark plan and to present recommendations to the Legislature and Governor.
- Allows insurers or HMOs to propose policies or contracts using alternate EHB-benchmark plans and to submit them to OIR for consideration as equivalent to the current EHB-benchmark plan or to any EHB-benchmark plan created in the future.
- Revises the effective date of the bill from July 1, 2019, to upon becoming a law.

B. Amendments:

None.