SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Banking and Insurance Committee

BILL:	CS/SB 1274
INTRODUCER:	Banking and Insurance Committee and Senator Atwater
SUBJECT:	Health Care Services/I.D. Cards
DATE:	March 29, 2006 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	**Fav/CS**
2.			HE	
3.				
4.				
5.				
6.				

I. Summary:

The bill requires health insurance companies and health maintenance organizations to provide identification cards to policyholders and subscribers that contain specified information that can be used to estimate the financial responsibility of the covered person, in compliance with the federal Health Insurance Portability and Accountability Act, and contact information for the insurer or health maintenance organization. This information will assist hospital and other providers in determining coverage and the financial responsibility of the covered person.

The bill also revises eligibility requirements for the Health Flex Plan Program, which is a program designed to offer basic, affordable health care services to low-income, uninsured state residents. The pool of potential eligible persons is expanded by allowing family income to be equal to or less than 250 percent of the federal poverty level, rather than equal to or less than 200 percent of the federal poverty level, for a family of four. The bill also requires that as a condition of eligibility, the person is part of an employer group where at least 75 percent of the employees The bill also revises eligibility requirements for the Health Flex Plan Program, which is a program designed to offer basic, affordable health care services to low-income, uninsured state residents. The pool of potential eligible persons is expanded by allowing family income to be equal to or less than 250 percent of the federal poverty level, rather than equal to or less than 200 percent of the federal poverty level, for a family of four. The bill also requires that as a condition of eligibility, the person is part of an employer group where at least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level.

This bill substantially amends the following sections of the Florida Statutes: 408.909, 627.642, 627.657, 641.31, 383.145, 641.185, 641.2018, 641.3107, 641.3922, and 641.513
This bill substantially amends, creates, or repeals the following sections of the Florida Statutes:

II. Present Situation:

Insurance Regulation
The Office of Insurance Regulation (OIR) is responsible for the regulation and oversight of insurance companies. Under the provisions of part I of ch. 627, F.S., the OIR is responsible for approval of rates and forms. Individual, small group (50 or fewer employees), and large group health insurance policies are regulated under the provisions of ch. 627, F.S. Part II of ch. 641, F.S., generally governs the regulation of health maintenance organizations.

Currently, laws governing health insurers do not require insurers to provide an insurance card to policyholders or subscribers. The laws generally require health insurers to provide policyholders either with an outline of benefits and coverage or a handbook.[1] Many health insurers and health maintenance organizations currently issue cards to their policyholders or subscribers; however, each insurer or health maintenance organization determines the type of information to be printed on the card.

Auto Insurance: Proof of Coverage
Laws governing auto insurance in Florida require insurers to provide policyholders with proof of insurance.[2] Such proof generally is provided through an insurance card. Proof of auto insurance typically contains both the policyholder's and insurer's name; a telephone number for the insurer; the policy number; a brief description of the covered auto(s), including manufacturer, model, and vehicle identification number. The back of the proof of auto insurance card also may contain information and phone numbers for use in reporting an accident to the insurer.

Federal Health Insurance Portability and Accountability Act of 1996
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information. Collectively these sections are known as the Administrative Simplification provisions. The HHS adopted privacy regulations governing individually identifiable health information, known as the Privacy Rule, on December 28, 2000. Subsequently, modifications were adopted on August 14, 2003.

The Privacy Rule, as well as the Administrative Simplification rules, applies to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities"). The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information, "*protected health information*."[3] "Individually identifiable health information" is information, including demographic data, that relates to:

[1] See s. 627.642, F.S., relating to the outline of coverage for individual health insurance policies. Similarly, see s. 627.657, F.S., prescribing the provisions and form of group health insurance policies. See also ss. 627.64725 and 641.185, F.S., (2005) outlining the requirements for HMO plans to provide the conditions of their respective plans either on the policy or in a member handbook.
[2] Sections 320.02 and 627.936(9)(a), F.S., requirements for proof of insurance coverage for motor vehicles and the requirement for auto insurers to provide notice to the Department of Highway Safety and Motor Vehicles regarding issuance, non-renewal, and cancellation of auto coverage.
[3] 45 C.F.R. s. 160.103.

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.[4]

A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action. A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) to the individual (unless required for access or accounting of disclosures); (2) treatment, payment, and health care operations; (3) opportunity to agree or object; (4) incident to an otherwise permitted use and disclosure; (5) public interest and benefit activities; and (6) limited data set for the purposes of research, public health or health care operations. Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

Health Flex Plan Program

In 2002, the Florida Legislature created the Health Flex Plan Program (program) was established as a pilot program in an effort to offer basic, affordable health care services to low-income uninsured residents of Florida. Initially, the program was established as a pilot program in only three areas of the state and Indian River County with an expiration date of July 2004; however, the Legislature extended the pilot program to 2008. In 2004, the Legislature expanded the Health Flex Plan Program to all 67 counties.

The eligibility requirements for the program were expanded in 2004 to allow residents of Palm Beach or Miami Dade counties that are eligible under a federally approved Medicaid demonstration waiver to be eligible for enrollment. The other eligibility requirements for the Health Flex plan are:[5]

- Are residents of this state;
- Are 64 years of age or younger;
- Have family income equal to or less than 200 percent of the federal poverty level($37,500 for a family of four);
- Have been uninsured for at least 6 months prior to enrollment; and

[4] 45 C.F.R. s. 164.502(a).
[5] Section 408.909(5), F.S.

- Are not covered by a private insurance policy and are not eligible for coverage by a public health care program.

Health Flex Plan providers are not subject to licensure under the Florida Insurance Code. Instead, they must meet quality of care and financial guidelines jointly developed by the Agency for Health Care Administration and the OIR. Health Flex Plans are not subject to the mandated benefits specified in Part IV, of ch. 627, F.S.; instead, providers can design a flexible benefit coverage product. Health Flex Plans can be offered by insurers, health maintenance organizations, health care providers, local governments, health care districts, or other public or private organizations, and through small employers' business purchasing arrangements sponsored by local government.

As of November 1, 2005, the agency, in conjunction with the OIR, had approved four Health Flex Plan applications. As of September 30, 2005, there were a total of 1,208 enrollees in the various Health Flex Plans.[6]

III. Effect of Proposed Changes:

Section 1 amends s. 408.909, F.S., to expand the potential pool of eligible persons for the Health Flex Plan Program. Income eligibility requirements are expanded by allowing family income to be equal to or less than 250 percent of the federal poverty level, rather than equal to or less than 200 percent of the federal poverty level. Under current law, 200 percent of the federal poverty level for a family of four is $37,700, based on 2004 federal poverty level guidelines. In 2005, 250 percent of the federal poverty level for a family of four is $48,375.[7] The bill also requires that as a condition of eligibility, that the person is part of an employer group where at least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level.

Section 2 amends s. 627.642, F.S., to require an insurer to provide an identification card to a person with individual major medical health insurance coverage that contains the following applicable information, at a minimum:

- The name of the organization issuing the policy or the name of the organization administering the policy.
- The name of the contract holder.
- The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or name of network.
- The member identification number, contract number, and policy or group number.
- A contact phone number or electronic address for authorizations.
- A phone number or electronic address that can be used by the covered person or hospital, physician, or other providers that may obtain information necessary to verify benefits and to estimate patient financial responsibility, in compliance with privacy rules under the federal Health Insurance Portability and Accountability Act.

[6] *Health Flex Plan Program Annual Report January 2006*, the Agency for Healthcare Administration and the Office of Insurance Regulation.
[7] Department of Health and Human Services, HHS Poverty Guidelines, published in volume 70, number 33 of the Federal Register.

- The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification cared must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 3 amends s. 627.657, F.S., to require group health insurers to issue identification cards to policyholders that must be accompanied by the policy. The identification card must contain the following information, at a minimum:

- The name of the organization offering the contract or the name of the organization administering the contract.
- The name of the certificate holder.
- The type of plan only if the plan is filed in this state, an indication that the plan is self-funded, or the name of the network.
- The member identification number, contract number, and policy or group number, if applicable.
- A contact phone number or electronic address for authorizations.
- A telephone number or electronic address that can be used by the covered person or hospital, physician, or other providers that may obtain information necessary to verify benefits and to estimate patient financial responsibility, in compliance with privacy rules under the federal Health Insurance Portability and Accountability Act.
- The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

Section 4 amends s. 641.31. F.S., to require the contract, certificate, or member handbook of the health maintenance organization to be accompanied by an identification card that contains, at a minimum the following information:

- The name of the organization offering the contract or the name of the organization administering the contract.
- The name of the subscriber.
- A statement that the health plan is a health maintenance organization. Only a health plan with a certificate of authority issued under this chapter may be identified as a health maintenance organization.
- The member identification number, contract number, and group number, if applicable.
- A contact phone number or electronic address for authorizations.
- A telephone number or electronic address that can be used by the covered person or hospital, physician, or other providers that may obtain information necessary to verify benefits and to estimate patient financial responsibility, in compliance with privacy rules under the federal Health Insurance Portability and Accountability Act.
- The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

Sections 5-10 amends ss. 383.145, 641.185, 641.2018, 641.3107, 641.3922, and 641.513, F.S., to provide conforming cross-references.

Section 11 provides that, except as otherwise provided in this act, this act will take effect January 1, 2007, and will apply to identification cards issued for policies or certificates issued or renewed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Insurers that do not presently provide an identification card or do not currently provide all of the required information on the identification will incur indeterminate administrative costs to comply with the requirements of the bill.

The information required on the identification card will assist hospitals and other health care provides in determining the financial responsibility of the policyholder or subscriber.

The pool of potential eligible persons for the Health Flex Plan Program will be expanded by requiring family income to be equal to or less than 250 percent of the federal poverty level, rather than equal to or less than 200 percent of the federal poverty level. As a result of this change, a family of four with an income of up to $48,375 rather than $37,700 could be eligible for the program.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.