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: Health Care Committee

BILL:	CS/CS/SB 1274
INTRODUCER:	Health Care Committee, Banking and Insurance Committee, and Senator Atwater
SUBJECT:	Plans, policies, contracts, and programs for the provision of health care services
DATE:	April 20, 2006 REVISED:

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

I. Summary:

The bill revises eligibility requirements for enrollment in a health flex plan, 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 extends eligibility for a health flex plan to persons who are part of an employer group in which at least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level and the employer has not offered health insurance during the past 6 months.

The bill requires health insurance companies and health maintenance organizations to provide identification cards to policyholders and subscribers, which 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 of 1996, and contact information for the insurer or health maintenance organization. This information will assist hospitals and other providers in determining coverage and the financial responsibility of the covered person.

This bill amends the current regulation of discount medical plan organizations (DMPOs). The bill removes the requirement that DMPOs file audited financial statements, and instead, requires DMPOs to certify that minimum capitalization requirements are satisfied. The bill authorizes a market investigation by the Office of Insurance Regulation (OIR) of a DMPO only "for cause." It authorizes DMPOs to require a waiting period for accessing hospital services and allows DMPOs to charge up to $60 dollars per month for a plan that covers physician or hospital services without prior approval from OIR. The bill requires a DMPO to file forms for informational purposes with OIR before it can market the form.

This bill substantially amends the following sections of the Florida Statutes: 383.145, 408.909, 627.642, 627.657, 636.204, 636.206, 636.210, 636.216, 636.218, 636.220, 641.185, 641.2018, 641.31, 641.3107, 641.3922, and 641.513.

II. Present Situation:

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 the federal Department 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*."[1] "Individually identifiable health information" is information, including demographic data, that relates to the:

- Individual's past, present or future physical or mental health or condition,
- Provision of health care to the individual, or
- 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.[2]

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

[1] 45 C.F.R. s. 160.103.
[2] 45 C.F.R. s. 164.502(a).

required for access or accounting of disclosures); (2) treatment, payment, and health care operations; (3) opportunity to agree or object; (4) incidental to an otherwise permitted use and disclosure; (5) public interest and benefit activities; and (6) limited data sets 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.

Florida Health Flex Plan Program

In 2002, the Legislature created the Florida Health Flex Plan Program (program) as a pilot program offering basic, affordable health care services to low-income uninsured residents of Florida. Initially, the program was established as a pilot program in northern,[3] central[4] and southern[5] regions of the state that exhibited the highest levels of uninsured residents.

As originally established, the pilot was scheduled to expire on July 1, 2004; however, the Legislature extended the program through July 8, 2008. The Legislature also expanded the program to all 67 counties in Florida and changed eligibility requirements for the program 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 enrollment in a health flex plan are:[6]

- 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 ($40,000 for a family of four in 2006);
- Have been uninsured for at least 6 months prior to enrollment; and
- 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 (AHCA) and OIR. Health flex plans are not subject to the mandated benefits specified in part IV, of ch. 627, F.S.; instead, plans 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.

[3] Baker, Bay, Bradford, Calhoun, Citrus, Clay, Columbia, Dixie, Duval, Escambia, Franklin, Gadsden, Gulf, Hamilton, Holmes, Jackson, Jefferson, Lafayette, Leon, Levy, Liberty, Madison, Okaloosa, Putnam, Santa Rosa, Sumter, Suwannee, Taylor, Union, Wakulla, Walton, and Washington Counties.
[4] Hillsborough County
[5] Miami-Dade and Broward Counties, and Indian River County.
[6] s. 408.909(5), F.S.

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.[7]

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.[8] 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.

Discount Medical Plan Organizations

Within the past 10-12 years, business entities known as discount medical plan organizations have begun offering discounts for specified health care services. These organizations are popularly referred to as DMPOs (pronounced "dimpos"). Once a consumer joins a DMPO, the consumer typically receives an ID card, literature outlining the services discounted by the DMPO, a list of participating providers, telephone numbers, and other similar information.

The DMPOs offer a variety of health care services to consumers at a discounted rate. These plans are not health insurance and therefore do not pay for services on behalf of members; instead, the plans offer members access to specific health care products and services at a discounted fee. These health products and services may include, but are not limited to, dental services, emergency services, mental health services, vision care, chiropractic services, and hearing care. Generally, a DMPO has a contract with a provider network under which the individual providers render the medical services at a discount and a marketer sells the plan to members.

These discount plans can perform a useful role in the health care delivery system by providing consumers with savings on necessary medical services; however, some unscrupulous discount medical plans may require undisclosed fees, not provide any services, or fraudulently market such discount plans as insurance products to members for those fees.

---

[7] *Health Flex Plan Program Annual Report January 2006*, the Agency for Healthcare Administration and the Office of Insurance Regulation. Found at: http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/Health_Flex/ANNUAL_REPORT-FINAL_2006.pdf (last visited on April 7, 2006)

[8] 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., outlining the requirements for HMO plans to provide the conditions of their respective plans either on the policy or in a member handbook.

DMPO Regulation in Florida

Currently, at least one million Florida households (more than two million citizens) are members of a DMPO. A discount plan does not fit the traditional definition of an insurance product and thus, was not subject to regulation under the Florida Insurance Code until the 2004 Legislature authorized OIR to regulate DMPOs, effective January 1, 2005.[9] A DMPO that provides access for plan members to providers of medical services at a discounted fee in exchange for fees, dues, charges, or other consideration is subject to licensure and regulation by OIR. The law provides a licensure exemption for individual providers who offer discounts to their own patients.

During the 2004 Special Session, the Legislature enacted ch. 2004-479, L.O.F., which delayed the effective date of the laws regulating DMPOs from January 1, 2005, until March 31, 2005. This extension was necessary because all rules governing the licensure of DMPO activities had not been approved by the Financial Services Commission. Rules governing the DMPO forms were adopted by the Financial Services Commission on February 16, 2005, and the final application package was approved at the April 5, 2005, Cabinet meeting.

In 2005, the Legislature again modified the DMPO statutes related to the licensure and regulation of these entities.[10] The law:

- Authorizes OIR to impose an administrative penalty and cease and desist orders in lieu of suspending or revoking the license of a DMPO;
- Provides that any charge or form is deemed approved on the 60th day after filing unless OIR has previously disapproved it;
- Authorizes OIR to disapprove any form that does not comply with pt. II of ch. 636, F.S., or that is unreasonable, discriminatory, misleading, or unfair;
- Authorizes a DMPO to retain up to a $30 one-time processing fee if a membership is canceled within 30 days of joining the plan;
- Revises the DMPO's liability for the actions of its marketer;
- Eliminates audited financial statement requirements for licensure, if the applicant is a subsidiary of a parent company and certain conditions are met by the parent company;
- Eliminates the filing of annual, audited financial statements for a subsidiary of a parent company if certain conditions are met, and instead, requires a DMPO to file a sworn affidavit certifying compliance with net worth requirements; and
- Repeals the civil remedies provision.

Auto Insurance: Proof of Coverage

Laws governing auto insurance in Florida require insurers to provide policyholders with proof of insurance.[11] Such proof generally is provided through an insurance card. Proof of auto insurance typically contains:

[9] Ch. 2004-297, L.O.F.
[10] Ch. 2005-232, L.O.F.
[11] Sections 320.02 and 627.733(3)(a), F.S., respectively, require insurance coverage for motor vehicles and require auto insurers to provide notice to the Department of Highway Safety and Motor Vehicles regarding issuance, non-renewal, and cancellation of auto coverage.

- Both the policyholder's and insurer's name;
- A telephone number for the insurer;
- The policy number; and,
- 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.

III. Effect of Proposed Changes:

Section 1. Amends s. 408.909, F.S., expanding the potential pool of persons eligible to enroll in an approved health flex plan. 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 $40,000.[12] In 2006, 250 percent of the federal poverty level for a family of four is $50,000. The bill also extends eligibility for a health flex plan to persons who are part of an employer group in which at least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level and the employer has not offered health insurance during the past 6 months.

Section 2. Amends s. 627.642, F.S., requiring 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 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 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 federal HIPAA.
- The national plan identifier, in accordance with the compliance date set forth by HHS.

The identification card 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.

[12] Department of Health and Human Services, HHS Poverty Guidelines, published in Vol. 71, No. 15, pp. 3848-3849, of the Federal Register, January 24, 2006.

Section 3. Amends s. 627.657, F.S., requiring group health insurers to issue identification cards to policyholders that must accompany 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 to obtain information necessary to verify benefits and to estimate patient financial responsibility, in compliance with privacy rules under the federal HIPAA.
- The national plan identifier, in accordance with the compliance date set forth by HHS.

The identification card 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 4. Amends s. 636.204, F.S., to remove the requirement that DMPOs file audited financial statements to become licensed.

Section 5. Amends 636.206, F.S., authorizing a market investigation by OIR of a DMPO only "for cause."

Section 6. Amends 636.210, F.S., allowing DMPOs to require a waiting period for accessing hospital services.

Section 7. Amends 636.216, F.S., allowing DMPOs to charge up to $60 dollars per month without prior approval from OIR for plans containing a physician or hospital benefit, and removes the requirement for prior approval of forms, instead, requiring an organization to file forms for informational purposes only with OIR before they can market the form.

Section 8. Amends 636.218, F.S., removing the requirement that an audited financial statement prepared in accordance with generally accepted accounting principles be included in the annual report each DMPO must file with OIR.

Section 9. Amends 636.220, F.S., requiring each DMPO to certify in writing and under oath at the time of licensure and annually thereafter that minimum capitalization requirements required by law are satisfied.

Section 10. Amends s. 641.31. F.S., requiring 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 to obtain information necessary to verify benefits and to estimate patient financial responsibility, in compliance with privacy rules under the federal HIPAA.
- The national plan identifier, in accordance with the compliance date set forth by HHS.

The identification card 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.

Sections 11-16. Amend ss. 383.145, 641.185, 641.2018, 641.3107, 641.3922, and 641.513, F.S., to provide conforming cross-references.

Section 17. 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:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

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 persons eligible for enrollment in a health flex plan 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 $50,000, rather than $40,000, would be eligible for the program.

Discount medical plan organizations will have lower administrative costs associated with complying with state regulations.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.