HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 805 CS Health Care Insurers and ID Cards
SPONSOR(S): Benson
TIED BILLS: **IDEN./SIM. BILLS:** SB 1274

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee	18 Y, 0 N, w/CS	Tinney	Cooper
2) Health Care Regulation Committee	9 Y, 0 N, w/CS	Bell	Mitchell
3) Commerce Council			
4)			
5)			

SUMMARY ANALYSIS

HB 805 w/ CS requires individual and group health insurers and HMOs to provide an identification card to policyholders and subscribers. Although the bill amends various sections of law, the requirements for the information to be contained on the health insurance identification card is the same, whether the requirements specify an identification card for an individual or group health policy or an HMO. Under the bill, a health insurance ID card is required to include the following information:

1. Name of organization issuing or administering the health policy;
2. Name of person or family covered by the policy;
3. Type of health care plan or network;
4. Member ID number, contract number, or policy or group number;
5. Telephone number or electronic address for use in receiving insurer authorization;
6. Telephone number or electronic address for use in determining estimated co-payments, deductibles, co-insurance, or maximum out-of-pocket expenses for the insured and covered dependents; and
7. National identification code for insurer, if available.

All insurers are required to present the required ID card information in an easy-to-read manner. The bill also authorizes an insurer to encode the information on a magnetic strip or a smart card, or through other electronic technology.

The requirements of the bill may necessitate the redesign of current insurance cards in order to include the information required by the bill. However, given that the effective date of the bill is not until July 1, 2007 and only applies to new cards issued by insurers and HMOs the fiscal impact should be minimal.

The bill also amends several other sections of law to correct cross-references.

State agencies report they will not incur costs to implement the bill.

The bill expands health flex plan eligibility from 200 percent to 250 of the federal poverty level. The current federal poverty level is $37,000 for a family of four.

The portion of the bill relating to ID cards has an effective date of July 1, 2007 and the portion of the bill pertaining to health flex plans has an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government; Empower Families; and Promote Personal Responsibility—Under the bill, health insurers and HMOs are required to provide an insurance ID card containing specified information to policyholders and subscribers and their respective covered dependents.

B. EFFECT OF PROPOSED CHANGES:

Health Insurance Policies: Changes Proposed by the Bill

The bill requires individual and group health insurers and HMOs to provide an identification card to policyholders and subscribers. Although the bill amends various sections of law, the requirements for the information to be contained on the health insurance identification card are the same, whether the requirements specify an identification card for an individual or group health policy or an HMO. For example, under the bill, a health insurance ID card is required to include the following information:

1. Name of organization issuing or administering the health policy;
2. Name of person or family covered by the policy (contract holder, certificate holder, or subscriber);
3. Type of health care plan or network;
4. Member ID number, contract number, or policy or group number;
5. Telephone number or electronic address for use in receiving insurer authorization;
6. Telephone number or electronic address for use in determining estimated co-payments, deductibles, co-insurance, or maximum out-of-pocket expenses for the insured and covered dependents; and
7. National identification code for insurer, if available.

Part VI of ch. 627, F.S., specifies the requirements for health insurance policies sold to individuals in Florida. Section 627.642, F.S., regarding the outline of coverage for individual policies, is amended to require insurers offering individual major medical health insurance policies to issue an insurance ID card to their policyholders.

The bill also amends s. 627.657, F.S., regarding group health insurance policies to require group insurers to issue an ID card to their policyholders. Similarly, the bill amends s. 641.31, F.S., relating to HMO contracts, to require HMOs to issue an ID card to their respective members.

All insurers are required to present the required ID card information in an easy-to-read manner. The bill also authorizes an insurer to encode the information on a magnetic strip or a smart card, or through other electronic technology. Several other sections of law are amended by the bill to correct cross-references.

Health Flex Plans: Changes Proposed by the Bill

The bill expands the financial eligibility requirements to qualify for health flex plans. In order to meet the financial eligibility requirements to qualify for health flex plans family income must be equal or less than 250 percent of the federal poverty level. The current federal poverty level is $37,000 for a family of four. The bill provides that employment-based group eligibility is expanded to 75 percent of the employees have a family income of 250 percent of the federal poverty level.

CURRENT SITUATION

Insurance Regulation and General Provisions

In Florida, regulation of the insurance industry is shared by the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR). The state's Chief Financial Officer (CFO) heads DFS while the head of OIR is the Governor and Cabinet members sitting as the Financial Services Commission. Generally, OIR is responsible for granting a certificate of authority or license to an insurer; a domestic insurer, i.e., an insurer based in Florida, must possess a certificate of authority in order to conduct business in Florida.

Similarly, many insurers are required by law to seek OIR approval for their rates, or the prices they charge for coverage, and approval of the insurance forms they use for issuing policies. The Office of Insurance Regulation investigates allegations of fraud against insurers and administers state laws governing the financial reserve requirements imposed on insurers. The regulation and licensure of insurance agents and agencies is the purview of DFS. Staff of DFS also provides consumer information and assistance through the Division of Consumer Services.

Florida's Current Health Insurance Market

Various federal and state laws regulate Florida's health insurance market. The result of the various laws is that Florida's health insurance market is segmented into various groups, including self-insured groups or health plans, large groups of 51 or more participants, small groups ranging in size from 1 to 50 members, individual health policies, health maintenance organizations (HMOs), and out-of-state groups. Each segment of the market may be further divided into sub-groups, both in Florida, and in most other states, however, the Florida Insurance Code governs the activities, policies, and premiums of health insurance within the market segments serving policyholders in Florida.

Chapter 627, F.S., governs rates and contracts for all types of insurance available in Florida, including life, health, property, automobile, credit life and disability, workers' compensation, and title, among other types of policies. For example, part VI, chapter 627, F.S., governs health insurance policies for individuals, while part VII of ch. 627, F.S., governs group, blanket, and franchise health insurance policies. Part II of ch. 627, F.S., outlines the requirements insurers must include in their policies, i.e., contracts.

Chapter 641, F.S., governs health care service programs. This includes HMOs, prepaid health clinics, and other health care services.

Currently, laws governing health insurers and their policies (i.e., contracts) do not require insurers to provide an insurance card to policyholders and subscribers. The laws generally require health insurers to provide policyholders either with an outline of benefits and coverage or a member/policyholder handbook, however.[1] Many health insurers currently issue insurance cards to their policyholders, however, each insurer 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

[1] *See* s. 627.642, F.S., (2005) relating to the outline of coverage for individual health insurance policies. Similarly, *see* s. 627.657, F.S., (2005) 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] *See*, e.g., ss. 320.02 and 627.936(9)(a), F.S., (2005) regarding 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.

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 (VIN). The back of the proof of auto insurance also may contain information and phone numbers for use in reporting an accident to the insurer.

Under Florida law, the owner of a motor vehicle is required to register his or her vehicle annually.[3] As part of the registration process, a vehicle owner is required to show proof of insurance coverage with minimum benefits for personal injury protection (PIP) and property damage.[4]

Health Flex Plans

In 2002 the Legislature established the Health Flex Plan Program recognizing that a significant portion of Florida residents are unable to afford health insurance coverage. The Health Flex Plan Program was established as a pilot program in an effort to offer basic affordable health care services to low-income uninsured state residents, "by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations to develop alternative approaches to traditional health insurance, which emphasize coverage for basic and preventative care services."[5] In 2004 the Legislature expanded Health Flex plans to all 67 counties.

Health Flex Plans can be offered by licensed insurers, HMOs, 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. Currently eligibility to enroll in the Health Flex Plan is limited to individuals who:

- 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. The current federal poverty level is $37,000 for a family of four;
- Have been uninsured for at least six 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.

C. SECTION DIRECTORY:

Section 1. – Amends s. 408.909, F.S., relating to enrollment in health flex plans.

Section 2. – Amends s. 627.642, F.S., relating to health coverage provided under individual health insurance policies.

Section 3. – Amends s. 627.657, F.S., relating to health coverage provided by group, blanket, and franchise health insurance policies.

Section 4. – Amends s. 641.31, F.S., relating to health maintenance (i.e., HMOs) contracts and coverage.

Section 5. – Amends s. 383.145, F.S., relating to hearing screening for infants and newborns to correct a cross-reference.

Section 6. – Amends s. 641.185, F.S., relating to HMO subscriber protections, to correct a cross-reference.

[3] Section 320.02, F.S., (2005).
[4] *See*, e.g., s. 627.733(3) for requirements relating to PIP coverage and s. 324.022, F.S., (2005) for the law specifying auto insurance coverage for property damage.
[5] *See* s. 408.909(1), F.S. (2005)

Section 7. – Amends s. 641.2018, F.S., relating to coverage for home health care under an HMO contract, to correct a cross-reference.

Section 8. – Amends s. 641.3107, F.S., relating to the delivery of HMO contracts to subscribers, to correct a cross-reference.

Section 9. – Amends s. 641.3922, F.S., relating to HMO conversion policies, to correct a cross-reference.

Section 10. – Amends s. 641.513, F.S., relating to emergency services provided by HMOs, to correct a cross-reference.

Section 11. – Provides effective dates.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None. The Department of Financial Services and the Department of Health, the Agency for Health Care Administration, and OIR all indicate the bill will have no financial impact on the respective departments and agencies.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Many health insurers and HMOs currently provide their policyholders and members with an insurance card. Most current health insurer cards do not contain all of the information required by the bill, however. This likely will mean the existing health insurance cards will be replaced by the respective insurer or HMO in order to include the information required by the bill. In some cases, the requirements of the bill may necessitate the redesign of current insurance cards in order to include the information required by the bill.

However, given that the effective date of the bill is not until July 1, 2007 and only applies to new cards issued by insurers and HMOs, the fiscal impact should be minimal.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Many laws imposing requirements on insurers also grant rulemaking authority to OIR and the Financial Services Commission, however this bill does not. This bill is specific in describing the information to be contained on the health insurance ID card. As a result, insurers should implement the provisions of the bill without additional direction from an administrative rule.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At its March 9, 2006 meeting, the Insurance Committee adopted five amendments to the bill to clarify the types of information health insurers must include on the health ID cards required by the bill. The amendments made the following changes to the bill:

- specifies that individual major medical health insurance policies (rather than **all** individual policies) must provide policyholders with an ID card;
- changes the information to be included by health insurers on ID cards to terminology used in most health insurance policies;
- changes the information to be included by health insurers on ID cards to terminology frequently used in health policies and recognizes federal rules adopted under the Health Insurance Portability and Accountability Act (HIPAA) govern the type of information an insurer may disclose;
- allows insurers to provide required information electronically or embedded in magnetic strips on smart cards; and
- specifies that an ID card issued by an HMO must identify the insurer as an HMO.

As its March 22, 2006 meeting, the Health Care Regulation Committee adopted 10 amendments to the bill to make technical changes and expand coverage for Health Flex Plans to 250 percent of the federal poverty level.

- **Amendment 1-3:** Ensures that a company cannot advertise as a health plan (i.e. PPO, HMO, etc.) if they are not licensed in Florida.
- **Amendment 4-5:** Provides cross references for the definition of “medical policy.”
- **Amendment 6:** Clarifies that when the federal Department of Health and Human Services establishes a “national plan identifier,” it must be included on health identification cards.
- **Amendment 7-8:** Clarifies that a phone number or web address must be listed on the health identification card so patients or facilities may verify if the plan is insured and the benefits provided.
- **Amendment 9:** Extends the effective date of the bill to July 1, 2007 and specifies that the new requirements for health identification cards only apply to cards issued after July 1, 2007.

- **Amendment 10:** Increases financial eligibility for health flex plans to 250% of the federal poverty level and provides for employment-based group health flex plan eligibility, when 75% of the employees have a family income equal or less than 250% of the federal poverty level.
- **Amendment 11:** Creates an effective date of July 1, 2006 for the new eligibility requirements for health flex plans.
- **Amendment 12-14:** Changes the terms “covered person” and “covered family” to “contract holder,” “certificate holder,” and “subscriber.” These terms are used to describe policy holders in the individual insurance market, group market, and HMO market.

The analysis is drafted to the committee substitute.