HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 177 Health Insurance
SPONSOR(S): Cretul
TIED BILLS: **IDEN./SIM. BILLS:** SB 2094

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Insurance	9 Y, 0 N	Davis	Overton
2) Jobs & Entrepreneurship Council		Davis	Thorn
3)			
4)			
5)			

SUMMARY ANALYSIS

Health insurance companies and health maintenance organizations (HMOs) are not currently required to provide insurance identification cards to policyholders and subscribers; although, many choose to do so. The bill requires these entities to provide identification cards to their policyholders and subscribers for the purpose of creating a uniform set of information relating to each policy or contract.

The bill requires that the identification card contain specified information that can be used to identify the insured individual, identify the type of plan, obtain authorization for services, and estimate the financial responsibility of the covered person.

Health insurers and HMOs will be required to include the following information, at a minimum (the terminology varies depending on the type of health plan involved):

- The name and organization issuing the policy/contract or the name of the organization administering the policy/contract;
- The name of the contract holder/certificateholder/subscriber;
- 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 (individual and group plans only);
- 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 for determining whether the plan is insured and for obtaining a benefits verification in order to determine patient financial responsibility;
- The national plan identifier, in accordance with the compliance date set by the federal Department of Health.

Additionally, an HMO is required to include a statement that it is indeed an HMO. The bill specifies that HMOs are only those authorized under the applicable Florida law.

With respect to formatting, the bill also provides that the card must present the information in a readily identifiable manner; 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.

This bill will become effective on January 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government: The bill requires health insurance providers and health maintenance organizations to provide identification cards to their policyholders or subscribers; the bill requires the insurers to conform the information provided on the cards to meet certain criteria.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

Health Insurance Plan Basics

Health insurance plans can generally be broken into two types: traditional/indemnity plans and managed care plans. Traditional/indemnity plans are generally the most flexible in terms of the insurer's choice of doctor and do not require a referral for services. However, they tend to be more expensive than managed care plans. Managed care plans utilize networks of health care providers that have contracted with the insurer to provide services to their members. There are different types of managed care plans, primarily preferred provider organizations (PPOs), and health maintenance organizations (HMOs). A PPO allows a member to go to any provider he or she chooses; however, the member's out-of-pocket expense is less if the member chooses a provider that is in the PPO network. An HMO plan is a managed care plan that provides a more limited set of options than a PPO, but the HMO benefits its subscribers by generally having smaller co-pays and by being subject to tighter regulation.

Many employers provide group health insurance as a part of their package of employee benefits. The employee may be allowed to choose between two or more managed care plans. Other organizations such as unions may provide group health insurance benefits to their members as well. Individuals who are unable to access a group health plan may choose to obtain individual health insurance. Individual coverage may also extend to dependent spouses and children.

Coverage Descriptions

Because the features of different insurance plans vary so widely, Florida law requires health insurers and HMOs to provide members with descriptions of their coverage. The required disclosures vary depending on the insurance context: individual/family accident and health insurance (individual); group health insurance; and health coverage provided by HMOs.

Insurers of individual policies are required to provide their policy holders with an outline of coverage that sets out general information about the policy or contract, such as the type of coverage, eligibility guidelines, limitations on coverage, and coverage exclusions.[1] Group health insurance policy holders are also entitled to a certificate that sets forth the essential features of coverage.[2] HMO subscribers are entitled to a copy of the conditions of their plans, to be contained either in the HMO contract itself or in a member handbook.[3]

[1] Section 627.642, F.S.
[2] Section 627.657, F.S.
[3] Section 641.31, F.S.

Member Identification Cards

Although many insurers and HMOs do so currently, they are not required by law to provide an identification card to their policyholders or subscribers. When provided by an insurer or HMO, an identification card identifies policyholders or subscribers as members of a particular insurance program. Given that issuing an identification card is optional by law, the type of information provided in such a card is at the discretion of each issuer.

PROPOSED CHANGES

The bill amends three section of the Florida Insurance Code: sections 627.642, 627.657, and 641.31, Florida Statutes. Each section covers a different type of health care coverage. The amendments to each section are similar in nature; each set of amendments requires that an insurance identification card be provided to each policyholder/subscriber, and it sets out a uniform list of information to be provided on each card.

Family/Individual Accident and Health Policies

The bill amends section 627.642, Florida Statutes, and adds a new subsection (3). The new subsection requires that in addition to providing the required outline of coverage,[4] the insurer must provide an identification card that contains certain specific information.

The card must state either the name of the organization issuing the policy or the name of the organization administering the policy. The card must also state the name of the contract holder.

In order to help determine what type of insurance plan the policy holder has, the card must indicate any of the following: if the insurance plan is filed in the state, the name of the plan only must be listed on the card; if the plan is self-funded, the card must indicate such; or, the card must indicate the name of the network of providers that the insurer has contracted with to provide health care services to its members.

The card must also provide the member's identification number, the contract number, and, if applicable, the policy or group number.

To assist the provider with obtaining an authorization for treatment, the card must provide a contact phone number or electronic address.

Additionally, the card must provide a phone number or electronic address that will enable the covered person or hospital, physician, or other person rendering services covered by the policy to determine if the plan is insured and to obtain a benefits verification in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act (HIPAA).

The card must also provide the insurer's national plan identifier, in accordance with the compliance date set forth by the federal department of Health and Human Services.

Moreover, the required information must be easily accessed by the provider. It must be presented on the identification card 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.

[4] Section 627.642, F.S.

Group Health Insurance Policies

The bill amends section 627.657, Florida Statutes. The substantive changes are essentially the same as the changes to section 627.642, Florida Statutes. The bill renumbers existing subsection (2) as subsection (3), and creates a new subsection (2). The new subsection (2) requires that in addition to providing policyholders with the required medical policy,[5] the insurer must also provide an identification card that contains certain specific information.

The card must state either the name of the organization issuing the policy or the name of the organization administering the policy. The card must also state the name of the certificate holder.

In order to help determine what type of insurance plan the policy holder has, the card must indicate any of the following: if the insurance plan is filed in the state, the name of the plan only must be listed on the card; if the plan is self-funded,[6] the card must indicate such; or, the card must indicate the name of the network of providers that the insurer has contracted with to provide health care services to its members.

The card must also provide the member's identification number, the contract number, and, if applicable, the policy or group number.

To assist the provider with obtaining an authorization for treatment, the card must provide a contact phone number or electronic address.

Additionally, the card must also provide a phone number or electronic address that will enable the covered person or hospital, physician, or other person rendering services covered by the policy to determine if the plan is insured and to obtain a benefits verification in order to estimate patient financial responsibility, in compliance with HIPAA privacy rules.

The card must also provide the insurer's national plan identifier, in accordance with the compliance date set forth by the federal department of Health and Human Services.

Moreover, the required information must be easily accessed by the provider. It must be presented on the identification card 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.

Health Maintenance Organizations (HMOs)

The bill amends section 641.31, Florida Statutes, and adds a new subsection (41). The new subsection (41) requires that in addition to providing a subscriber with the required contract, certificate, or member handbook, the HMO must provide an identification card that satisfies the criteria listed below. These requirements differ somewhat from the requirements in sections 627.642 and 627.657, Florida Statutes, because they arise in the HMO context.

The card must state either the name of the organization issuing the contract or the name of the organization administering the contract; the card must also state the subscriber's name.

[5] Section 627.657, F.S.

[6] Although self-funded plans are regulated under federal law (ERISA), many self-funded plans contract with an insurer to regulate the plan. The insurer would be subject to the identification requirement. For instance, the State of Florida's health insurance program is self-funded. However, the State contracts with Blue Cross Blue Shield of Florida to regulate its PPO plan. Thus, Blue Cross Blue Shield would be required to comply with the identification card requirements.

The card must provide a statement that the health plan is an HMO. In order to be identified as an HMO, a health plan must have a certificate of authority issued under chapter 641, Florida Statutes.

The card must also provide the member's identification number, the contract number, and the group number, if applicable.

The card must provide a contact phone number or electronic address for providers to obtain authorizations.

Consistent with the other sections, the card must provide a phone number or electronic address that will allow the covered person or hospital, physician, or other person rendering services covered by the contract to determine if the plan is insured and to obtain a benefits verification in order to estimate patient financial responsibility, in compliance with HIPAA privacy rules.

The HMO must provide its national plan identifier, in accordance with the compliance date set forth by the federal department of Health and Human Services.

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.

C. SECTION DIRECTORY:

Section 1: Amends section 627.642, Florida Statutes, to require that individual health insurers provide policyholders with an identification card that contains certain information. Specific to individual/family health insurers.

Section 2: Amends section 627.657, Florida Statutes, to require that all group health insurers provide certificate holders with an identification card that contains certain information. Specific to group health insurers.

Section 3: Amends section 641.31, Florida Statutes, to require that all health maintenance organizations provide subscribers with an identification card that contains certain information. Specific to health maintenance organizations.

Section 4: States effective date of January 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The impact of the bill is the creation of a uniform set of information to be used by health care providers to verify their patients' health care coverage. For those that do not already provide identification cards or do not provide the required information, insurers and HMOs may incur the cost of creating and distributing identification cards that do conform to their policyholders or subscribers. This does not appear to be a recurring cost. Providers should benefit from a more standardized, efficient method of determining patients' coverage and financial responsibility.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The bill does not require counties or municipalities to spend funds or to take any action requiring the expenditure of funds; reduce the authority that municipalities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR:

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES