HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 177 Health Insurance
SPONSOR(S): Jobs & Entrepreneurship Council and 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	14 Y, 0 N, As CS	Davis	Thorn
3)			
4)			
5)			

SUMMARY ANALYSIS

Under current law, insurers cannot exclude bone marrow transplant procedures from a policy that covers cancer treatment.

The bill expands the definition of bone marrow transplant to include "non-ablative" therapy, which prepares a patient for a bone marrow transplant but does so without destroying all of the bone marrow. The bill also adds that the therapy is done with "life-prolonging" intent.

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.

In order to conform identification cards to the bill's requirements and re-issue cards to members, DMS will incur an estimated $113,500 fiscal impact.

This bill will become effective on January 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government: The bill expands coverage for bone marrow transplants to include non-ablative therapy and therapy done with life-prolonging intent. The bill also 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.

Empower families: Increases family stability by providing for coverage of a bone marrow transplant therapy that is less harmful to patients. The bill also expands the intent of therapy from that which is done to cure to that which is intended to prolong life.

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

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

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]

Bone Marrow Transplant Coverage

Bone marrow, which develops and stores about 95 percent of the body's blood cells, is a soft, spongy tissue found inside the bones.[4] When a disease results in damage to or destruction of a person's bone marrow, a bone marrow transplant may be needed. Florida law defines a "bone marrow transplant" as "human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy with curative intent."[5]

Ablative therapy takes the form of high doses of radiation or chemotherapy, and it makes room in the bone marrow for new, healthy blood cells; it accomplishes this by completely destroying the patient's bone marrow.[6] Because of the destructive impact of ablative therapy, a form of therapy known as non-ablative therapy has been developed and is currently in use. Non-ablative therapy does not destroy the entire bone marrow. It may be accomplished via lower doses of chemotherapy or radiation, or drugs that suppress the immune system.[7] The Agency for Health Care Adminstration (AHCA) Bone Marrow Transplant panel has recommended, and the bill provides for the addition of "non-ablative" therapy and "life-prolonging" intent to the statutory language.

Under current law, an insurer or a health maintenance organization (HMO) may not exclude coverage for bone marrow transplant procedures when those procedures are recommended by the referring physician and the treating physician if the procedure is found to be accepted within the appropriate oncological specialty and not experimental.[8] The AHCA is required to adopt rules for making that determination; the rules are based on the recommendations of the advisory panel that consists of experts in the field, as well as specified consumer and insurance industry representatives.[9]

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, the type of information provided in such a card is currently at the discretion of each issuer.

PROPOSED CHANGES

The bill amends four section of the Florida Insurance Code: sections 627.4236, 627.642, 627.657, and 641.31, Florida Statutes. Each section covers a different type of health care coverage. The amendment to section 627.4236 provides for coverage of "non-ablative" therapy for bone marrow transplants. The amendments to the remaining sections are similar in nature to each other; each set of amendments requires that an insurance identification card be provided to each policyholder/subscriber and sets out a uniform list of information to be provided on each card.

[3] Section 641.31, F.S.
[4] University of Chicago Hospitals, Bone Marrow Transplant page, http://www.uchospitals.edu/online-library/content=P00086.
[5] Section 627.4236(1), F.S.
[6] University of Chicago Hospitals, Bone Marrow Transplant page, http://www.uchospitals.edu/online-library/content=P00086.
[7] Id.
[8] Section 627.4236(2), F.S.
[9] Section 627.4236(3), F.S.

Bone Marrow Transplant Coverage

The bill amends section 627.4236, Florida Statutes. The bill provides for coverage of non-ablative therapy for bone marrow transplants, which is therapy that does not destroy the entire bone marrow to allow for the growth of new blood cells.[10] The bill also provides that therapy is done with "life-prolonging" intent, in addition to the current "curative" intent. The inclusion of non-ablative therapies conforms the statute to current bone marrow transplant practice. Moreover, the addition of life-prolonging intent reflects the fact that a number of bone marrow transplants do not ultimately cure the afflicting diseases, but do prolong a patient's survival and add to the patient's quality of life.

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,[11] 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.

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

[10] No report was submitted as required by section 624.215, Florida Statutes, assessing the social and financial impacts of the proposed coverage.

[11] Section 627.642, F.S.

providing policyholders with the required medical policy,[12] 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,[13] 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 it 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.

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.

[12] Section 627.657, F.S.

[13] 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 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 627.4236, Florida Statutes, to include non-ablative therapy for bone marrow transplants; amendment also provides that the therapy is done with life-prolonging intent.

Section 2: 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 3: 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 4: 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 5: States effective date of January 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Department of Management Services (DMS) states that the requirement to re-issue PPO Plan Pharmacy Benefit ID cards will cost $113,500 based on an approximate PPO Plan enrollment of 227,000 members at $0.50 per card. The re-issuance is required in order to indicate the national plan identifier. Any additional cost to the fully insured HMOs would be imbedded in Plan Year 2008 renewal rates.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The express requirement of non-ablative therapy in the bone marrow provision does not appear to have an impact on the private sector, as it is currently the accepted form of bone marrow treatment, and insurance companies and HMOs are already covering it for their policyholders and subscribers.

The bill creates 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:

AHCA has reviewed the bone marrow amendment language and has concluded that the addition of nonablative therapy and life-prolonging intent to the definition of bone marrow transplant clarifies further the purpose of bone marrow transplant, and it has no effect on Medicaid policy or reimbursement.

DMS states that it will not incur any fiscal impact from the required coverage of non-ablative bone marrow transplant therapy or therapy done with life-prolonging intent because the medical guidelines utilized for the State Group Health Insurance Plan already provide for them.

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:

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 22, 2007, the Jobs and Entrepreneurship Council adopted one amendment to the bill. The amendment added to the bill the provisions concerning insurance coverage for bone marrow transplant procedures.