The Florida Senate

PROFESSIONAL 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 2094

INTRODUCER: Banking and Insurance Committee and Senator Peaden

SUBJECT: Health Care Services

DATE: April 10, 2007 REVISED: _____ _____ _____ _____

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

I. Summary:

This committee substitute 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. The bill also provides the following changes:

- Revises the definition of bone marrow transplant for purposes of insurance coverage to include nonablative therapy and authorizes coverage for bone marrow transplants for life-prolonging intent. These changes in the law would update coverage requirements to reflect current practice and advancements in the area of bone marrow transplants.
- Expands the Health Flex Plan program eligibility for an individual from 200 to 250 percent of the federal poverty level and permits health flex plans to access the employee group market in certain circumstances. The Health Flex Plan Program was established to offer basic affordable health care services to low-income, uninsured residents. The bill also expands the types of entities that may offer Health Flex Plans.
- Creates a small business health insurance grant program to be administered by the Agency for Workforce Innovation (AWI) . The AWI is responsible for awarding, administering, and monitoring grants to small employers and small businesses to develop and offer cafeteria health plans that qualify under s. 125 of the Internal

Revenue Code and improve uninsured employee access to health insurance. A $250,000 nonrecurring general revenue appropriation is created for these grants.

This bill substantially amends the following sections of the Florida Statutes: 383.145, 408.909, 627.4236, 627.642, 627.657, 641.185, 641.2018, 641.31, 641.3107, 641.3922, and 641.513. The bill also creates the following section of the Florida Statutes: 445.015.

II. Present Situation:

Privacy and Security of Health Information

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 health 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

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

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) 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.

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.[3] 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. Laws governing automobile insurance in Florida require insurers to provide policyholders with proof of insurance.[4] Such proof generally is provided through an insurance card. Proof of insurance typically contains:

- 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.

Health Flex Plan Program

In 2002 the Legislature established the Health Flex Plan Program as a mechanism to provide basic affordable health care services to low-income, uninsured residents. The Health Flex Plan Program was designed to encourage health insurers, health maintenance organizations, and health care providers to develop alternative approaches to traditional health insurance, which emphasize coverage for basic and preventative care services. The Agency for Health Care Administration (agency) administers the Health Flex Plan Program.

[3] 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.

[4] 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.

In 2002 the Legislature established the Health Flex Plan Program as a mechanism to provide basic affordable health care services to low-income, uninsured residents. The Health Flex Plan Program was designed to encourage health insurers, health maintenance organizations, and health care providers to develop alternative approaches to traditional health insurance, which emphasize coverage for basic and preventative care services. The Agency for Health Care Administration (agency) administers the Health Flex Plan Program.

Health Flex Plans can be offered by licensed insurers, HMOs, health care providers, local governmental entities, health care districts, or other public or private organizations, and through small employers' business purchasing arrangements sponsored by local governmental entities. These entities must meet quality of care and financial guidelines jointly developed by the agency and the OIR. According to the Health Flex Program 2007 Annual Report ("report"), the OIR automatically deems HMOs, authorized health insurers, fraternal benefit societies, prepaid limited health plans, or prepaid health clinics in compliance with the financial requirements to offer a Health Flex Plan in order to expedite the financial determination process and qualify a large number of eligible sources to offer the health flex program.[5]

Currently eligibility to enroll in the Health Flex Plan is limited to individuals who meet the following requirements:

- Residents of Florida;
- Age 64 years of age or younger;
- Family income equal to or less than 200 percent of the federal poverty level; Uninsured status for at least 6 months prior to enrollment; and
- Not covered by a private insurance policy and are not eligible for coverage by a public health program.

The report noted that four health flex plans covering 1,776 members have been approved. For one of the four participating plans, the report found, "while enrollment is still below expectations, nearly 250 businesses participate in the Health Flex Program that did not offer health insurance benefits over a six month period. This represents a 50 percent increase over last year." For that plan, which is offered only through small employers, the report noted that the plan experienced problems in qualifying all employees of a business under the income guidelines. Since the employer pays the premium for qualifying members, non-qualifying employees viewed this as unfair treatment, and some business owners dropped out of the plan altogether.

Agency for Workforce Innovation

The Agency for Workforce Innovation (AWI) is responsible for ensuring that the state appropriately manages federal and state workforce funding by administering plans and policies of the Workforce Florida, Inc.[6] Workforce Florida, Inc., created in s. 445.004, F.S., as a not-for-profit corporation, is the principal workforce policy organization for the state. As

[5] Health Flex Plan Program Annual Report, January 2007, by the Agency for Health Care Administration and the Office of Insurance Regulation, *available at:* http://ahca.myflorida.com/MCHQ/Managed_Health_Care/Health_Flex/ANNUAL_REPORT-FINAL_2007.pdf.

[6] Section 20.50, F.S.

such, its purpose is to design and implement strategies that help Floridians enter, remain in and advance in the workplace, becoming more highly skilled and successful benefiting these Floridians, Florida businesses, and the entire state, and to assist in developing the state's business climate. It is administratively housed within the AWI.

Health Insurance Coverage for Bone Marrow Transplants

Presently, s. 627.4236, F.S., 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." In 1992, the Legislature enacted s. 627.4236, F.S., prohibiting an insurer or a health maintenance organization from excluding coverage for bone marrow transplant procedures under policy exclusions for experimental, clinical investigative, educational, or similar procedure, if such procedures are recommended by the referring physician and the treating physician and the particular use of the procedure is accepted within the appropriate specialty and is determined by rule not to be experimental.

Bone marrow transplant is a highly technical therapy that offers hope to patients with bone marrow failure or various malignancies. It is the process of taking healthy bone marrow (blood stem cells) from a donor or the patient and transplanting (transfusing) it into a patient. The patient receives intensive chemotherapy or radiation therapy to destroy all cancerous cells in conjunction with the bone marrow transplant procedure. Such transplants are accepted treatments for a variety of cancer types, primarily leukemia, and including breast, ovarian, and lung cancer as well as Hodgkin's, non-Hodgkin's lymphoma, sarcoma and other non-cancerous hematological disorders.

The nine-member Bone Marrow Transplant advisory panel created within the Agency for Health Care Administration (agency), pursuant to s. 627.4236, F.S., must conduct, at least biennially, a review of scientific evidence to ensure that bone marrow transplant procedures are based on current research findings and that insurance policies offer coverage for the latest medically acceptable bone marrow transplant procedures. The agency has adopted a Rule 59B-12, F.A.C., which specifies the particular diseases and conditions for which the bone marrow transplant procedure are acceptable, specifies other conditions and diseases for which bone marrow transplant must be covered as long as the specified procedure is performed as part of a qualified clinical trial; and provides for approval of bone marrow transplant for unspecified diseases and conditions not otherwise addressed by the rule on a case-by-case basis.

Even though the rule requires coverage of a broad range of approved transplant procedures for various bone marrow diseases and conditions, non-myeloablative, or nonablative, stem cell transplantation is not addressed by the current law or rule. The statute defines bone marrow transplantation as "…cells administered to a patient…following *ablative* therapy…" Therefore, by definition, nonablative therapies are not considered bone marrow transplant procedures for which the agency or its panel may require insurer coverage.

The Bone Marrow Transplant Panel convened on November 22, 2005, to discuss various issues including proposed changes to s. 627.4236, F.S. In past meetings, the panel determined that the current statutory definition is no longer congruent with current practice. The panel noted that many therapy regimens, such as high dose Thytoxin for aplastic anemia,

are not ablative. The panel recommended deleting the term, "ablative," to ensure that ablative, as well as nonablative therapy is covered, and adding the phrase "life-prolonging intent." Currently, the law provides that ablative therapy must have curative intent. Many transplants offer considerable improvements in the both the quality of life and survival, yet do not cure the cancer.

III. Effect of Proposed Changes:

Section 1 amends s. 408.909, F.S. to revise eligibility criteria for enrollment in the Health Flex Plan and participation as a entity eligible to offer the plan. The bill expands the population eligible to purchase health flex plans by raising the income limit from 200 to 250 percent of the federal poverty level. The bill additionally expands the population eligible to purchase health flex plans by allowing all employees of a business to qualify if:

- The employer group is not covered by a private insurance policy;
- The employer group has not been covered at any time in the last 6 months; and
- At least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level.

The bill specifies that if the health flex plan is a licensed insurer, health plan, or health maintenance organization, only 50 percent of the employees have to have an income level up to 250 percent of the federal poverty level guidelines in order for the entire employee group to qualify.

The bill also provides that entities licensed under ch. 627, 632, 636, or 641, F.S., are deemed in compliance with the financial requirements to offer a Health Flex Plan in order to expedite the financial determination process and qualify a large number of eligible sources to offer the health flex program. This provision would significantly expand the types of entities who can offer Health Flex Plans to include entities, such as premium finance companies licensed under ch. 627, F.S., and discount medical plan organizations licensed under part II of ch. 636, F.S., which have not been eligible to offer such plans in the past. In contrast, the annual report noted that the OIR automatically deems HMOs, authorized health insurers, fraternal benefit societies, prepaid limited health plans, or prepaid health clinics in compliance with the financial requirements to offer a Health Flex Plan. Also, the bill does not require that such licensed entities to be in good standing.

Sections 2 and 3 establish and fund a small business health insurance grant program to be administered by the AWI. The bill directs the AWI to award, administer, and monitor grants to small employers and small businesses to develop and offer cafeteria health plans that qualify under s. 125 of the Internal Revenue Code and include options to improve uninsured employee access to health insurance. The bill gives priority to employer proposals that would improve access for previously uninsured employees or include long-term commitments to insure employees. The bill requires the AWI to consult with the OIR in the evaluation of each project funded by the grant to measure any increases in access to insurance and the long term viability of such increases. The bill directs the AWI to design informational materials to inform small employers and small business about cafeteria health plans and provide training to assist these entities in developing such plans. The AWI is required to submit an annual

report no later than February 1, to the Senate President, the Speaker of the House of Representatives, and the Governor regarding this small business health insurance grant initiative.

The bill provides a $ 250,000 nonrecurring, general revenue appropriation to the AWI for the purpose of awarding small business health insurance plan grants to eligible businesses.

Sections 4 and 6 amend ss. 627.642 and 627.657, F.S., respectively, to require an insurer to provide an identification card to a person with group or individual 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 or certificate 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.

Section 5 amends s. 627.4236, F.S., to revise the definition of bone marrow transplant for purposes of insurance coverage, to include coverage for nonablative therapy as a bone marrow transplant procedure. This section is also revised to provide coverage for such bone marrow transplant procedures with life-prolonging intent. These changes would update the coverage requirements to reflect current practice and advancements in the practice of transplantation. For example, the use of bone marrow transplants is employed in instances where it is not a curative procedure; rather, the treatment has a survival benefit. Also, many therapy regimens currently used are not ablative; instead, they are nonablative. The current law defines bone marrow transplant as, ". . . human blood precursors cells administered to a patient to restore normal hematological and immunological functions following ablative therapy with curative intent."

Section 7 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 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 8-13 amend ss. 383.145, 641.185, 641.2018, 641.3107, 641.3922, and 641.513, F.S., to provide conforming cross-references.

Section 14 provides that, except as otherwise provided in this act and except for this section, which will take effect July 1, 2007, this act will take effect on January 1, 2008, and will apply to 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 card 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.

By broadening the eligibility requirements for the Health Flex Plans, additional persons would be eligible to purchase health insurance coverage. The bill would allow additional entities, such as premium finance companies and discount medical plan organizations, to offer such coverage. Historically, these entities have not been eligible to offer such plans.

The small business health insurance grant administered by the AWI would assist small employers in providing their employees access to health insurance coverage.

Insurance coverage for nonablative regimen will assist recipients of bone marrow transplants since this type of regimen has been shown to be associated with less toxicity, improvements in survival, better quality of life, and shorter hospital stays and hospital costs. Nonablative therapy has been used for approximately 10 years and is now the preferred treatment for many bone marrow diseases and cancers. It is indeterminate how many insurers presently provide coverage for nonablative therapy regimens. The major transplant centers in the state have noted that nonablative therapy may result in lower hospital costs for patients than ablative therapy regimens.

C. Government Sector Impact:

The bill provides a $ 250,000 nonrecurring, general revenue appropriation to the AWI for the purpose of awarding small business health insurance plan grants to eligible businesses. The Agency for Workforce Innovation anticipates it would need at least 10 percent of the $250,000 nonrecurring appropriation, or $25,000, to establish and administer the Small Business Health Insurance Plan Grant program. The AWI notes that it may be more cost effective to have the program administered by another agency such as the Office of Insurance Regulation.

Changes in the bone marrow mandated coverage will have an indeterminate impact on the Division of State Group Health Insurance Program. To the extent nonablative therapies are more effective and less costly, medical costs for bone marrow transplants could be reduced. According to the Agency for Health Care Administration, the bill may have a fiscal impact on Medicaid, but the total cost cannot be determined until the bone marrow transplantation panel amends its rules relating to bone marrow transplant procedures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill provides that entities licensed under ch. 627, 632, 636, or 641 are deemed in compliance with the financial requirements to offer a Health Flex Plan in order to expedite the financial determination process and qualify a large number of eligible sources to offer the health flex program. This provision would significantly expand the type of entities who can offer Health Flex Plan Programs, to include premium finance companies licensed under ch. 627, F.S., and discount medical plan organizations licensed under part II of ch. 636, F.S., which have not been included in the entities eligible to offer such plans in the past. Also, the bill does not require that such entities be in good standing with the OIR. For example, an entity could be licensed, yet the license could be suspended or the OIR could be in litigation with the entity.

VIII. Summary of Amendments:

None.