The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL:	SB 1968
INTRODUCER:	Senator Posey
SUBJECT:	Health Insurance
DATE:	March 4, 2008
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	**Pre-meeting**
2.			HP	
3.			GA	
4.				
5.				
6.				

I. Summary:

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 also revises the definition of bone marrow transplant for purposes of required 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.

This bill substantially amends the following sections of the Florida Statutes: 627.4236, 627.642, 627.657, and 641.31.

II. Present Situation:

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. 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. 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.

Insurance Cards

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.[1] Many health insurers and HMOs currently issue cards to their policyholders or subscribers; however, each insurer or HMO 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.[2] Such proof generally is provided through an insurance card. Proof of insurance typically contains: 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.

Privacy and Security of Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted in 1996. The law requires the 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.

The Privacy Rule, as well as the Administrative Simplification rules, applies to health plans and any health care provider who transmits health information in electronic form in connection with transactions for which the 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*."[3] "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.[4]

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

[1] 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.

[2] 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.

[3] 45 C.F.R. s. 160.103.

[4] 45 C.F.R. s. 164.502(a).

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 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.

III. Effect of Proposed Changes:

Section 1 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. 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.

Sections 2 and 3 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. This provision also applies to HMOs, which are addressed in Section 4 of the bill.

Section 4 amends s. 641.31. F.S., to require the contract, certificate, or member handbook of the HMO 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.

Section 5 provides that this act will take effect on January 1, 2009, 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. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Insurance coverage for nonablative regimen will assist recipients of bone marrow transplants since this type of regimen is now the preferred treatment for many bone marrow diseases and cancers and has been shown to be associated with less toxicity, improvements in survival, better quality of life, and shorter hospital stays and hospital costs. 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.

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.

C. Government Sector Impact:

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.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.