HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 535 Health Insurance
SPONSOR(S): Cretul and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1968

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Insurance		Reilly/Topp	Overton
2) Jobs & Entrepreneurship Council			
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

The bill revises the definition of "bone marrow transplant" to include, for insurance coverage purposes, nonablative therapy and transplants intended to prolong life.

Health insurers and health maintenance organizations (HMOs) are currently not required to provide insurance identification cards to policyholders/subscribers, but many choose to do so. The bill requires these entities to provide identification cards with specified information that can be used to identify the insured individual and type of plan, obtain authorization for services, and estimate the covered person's financial responsibility. The identification card must present information in a readily identifiable manner; the information may also be embedded on the card and be available through magnetic stripe/smart card or provided through other electronic technology.

At a minimum, the insurance identification card must contain the following information:

- The name of the organization issuing or administering the policy/contract and the name of the contract holder/certificate holder/subscriber;
- The type of plan if filed in the state, an indication that the plan is self-funded, or the name of the network (individual and group health plans only);
- The member identification number, contract number, and policy or group number, if applicable;
- A contact phone number or electronic address for authorizations and admission certifications;
- A phone number or electronic address for obtaining benefits verification and information to determine patient financial responsibility;
- The national plan identifier.

An HMO must also include a statement that it is indeed an HMO. The bill specifies that HMOs are only those authorized under the applicable Florida law.

This bill will become effective on January 1, 2009.

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 and to conform the information provided on the cards to meet certain criteria.

B. EFFECT OF PROPOSED CHANGES:

Insurance Coverage for Bone Marrow Transplants

Under current law, insurers and health maintenance organizations (HMOs) cannot exclude coverage for bone marrow transplant procedures under policy exclusions for experimental, clinical investigative, educational, or similar procedures, 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[1] not to be experimental.[2] Bone marrow transplant is defined to mean "human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy with curative intent."

The bill revises the definition of bone marrow transplant set forth in s. 627.4236, F.S., to expressly include insurance coverage for nonablative therapy, which prepares a patient for bone marrow transplant without destroying all of the bone marrow, and therapy undertaken to prolong life. These changes reflect current medical practice and advancements in the area of bone marrow transplants.

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 insured's choice of doctor – usually the insured can choose any doctor - and do not require a referral for services. However, they tend to be more expensive for the insured than managed care plans; typically requiring the insured to pay a certain amount each year (the deductible) before reimbursement begins and, after the deductible has been met, to pay a percentage of the cost for covered services, generally up to an out-of-pocket maximum. In contrast to traditional/indemnity 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, traditionally requiring the subscriber to select a primary care physician, who is responsible for coordinating all of the patient's care. HMOs benefit subscribers by generally having smaller co-payments and by being subject to tighter regulation. A person who obtains health insurance through their employer or other group to which they belong has coverage pursuant to a group health plan. Individuals who are unable to access a group health plan may choose to purchase individual health insurance directly from an insurance company. Individual coverage may also extend to dependent spouses and children. Health insurance may also be available through government programs, for example, Medicare and Medicaid.

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[1] Rule 59B-12, F.A.C, adopted by the Agency for Health Care Administration, specifies diseases and conditions for which bone marrow transplants are acceptable; diseases and conditions for which bone marrow transplants 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 transplants for unspecified diseases and conditions not otherwise addressed by the rule on a case-by-case basis.

[2] Section 627.4236, F.S.

Coverage Descriptions

Because the features of different insurance plans vary 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 health policies are required to provide policy holders with an outline of coverage that sets out general information about the policy or contract, such as the type of coverage, limitations on coverage, and coverage exclusions.[3] Group health insurance policy holders are entitled to a certificate that sets forth the essential features of the coverage.[4] HMO subscribers are entitled to a copy of the health maintenance contract, certificate, or member handbook.[5]

Member Identification Cards

Health insurers and HMOs are currently not required to provide insurance identification cards to policy holders/subscribers; however, many choose to do so. Given that issuing an identification card is optional, the information contained on these cards varies among issuers.

The bill amends s. 627.642, F.S., to require insurers offering individual health policies to issue an insurance identification card to policyholders; s. 627.657, F.S., to require group health insurers to issue an insurance identification card to policyholders; and s. 641.31, F.S., to require HMOs to issue an insurance identification card to HMO members. Pursuant to the amendments, the following information is required, at a minimum, to be contained on every health insurance card required by the bill:

- The name of the organization issuing or administering the policy/contract;
- The name of the contract holder/certificate holder/subscriber;
- The member identification number, contract number, and policy or group number, if applicable;
- A contact phone number or electronic address for authorizations and admission certifications;
- A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act;
- The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

Additionally, the insurance identification card issued by an insurer providing individual or group health insurance must include the type of plan if the plan is filed in Florida, an indication that the plan is self-funded, or the name of the network. An HMO's insurance identification card must include a statement that the health plan is in fact a health maintenance organization. The bill specifies that HMOs are only those authorized under the applicable Florida law.

The bill also requires that an insurance identification card present information in a readily identifiable manner, or alternatively, that the information be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

[3] Section 627.642, F.S.

[4] Section 627.657, F.S.

[5] Section 641.31, F.S.

C. SECTION DIRECTORY:

Section 1. Amends s. 627.4236, F.S., to revise the definition of bone marrow transplant to include insurance coverage for nonablative therapy and transplants intended to prolong life.

Section 2. Amends s. 627.642, F.S., to require individual health insurers to provide policy holders with an identification card that contains specified information.

Section 3: Amends s. 627.657, F.S., to require group health insurers to provide certificate holders with an identification card that contains specified information.

Section 4: Amends s. 641.31, F.S., to require all health maintenance organizations to provide subscribers with an identification card that contains specified information.

Section 5: States effective date of January 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   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.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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 . It is indeterminate how many insurers presently provide coverage for nonablative therapy regimens; however, nonablative therapy may result in lower hospital costs for patients than ablative therapy regimens

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The mandates provision does not apply because this bill does not: require counties or municipalities to spend funds or to take an 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:

The Florida Hospitals Association supports this bill because it will standardize the information contained on health insurance identification cards, thus expediting the process of determining financial responsibility for services rendered.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

None.