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 Committee on Banking and Insurance

BILL: SB 932

INTRODUCER: Senators Berman and Davis

SUBJECT: Coverage for Diagnostic and Supplemental Breast Examinations

DATE: January 26, 2024 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Thomas	Knudson	BI	**Pre-meeting**
2.			AEG	
3.			AP	

I. Summary:

SB 932 prohibits the state group insurance program from imposing any cost-sharing liability for diagnostic breast examinations and supplemental breast examinations in any contract or plan for state employee health benefits that provides coverage for diagnostic breast examinations or supplemental breast examinations.

The bill also prohibits the imposition of cost-sharing requirements for diagnostic and supplemental breast examinations by individual accident and health insurance policies; group, blanket, or franchise accident and health insurance policies; and health maintenance contracts issued, amended, delivered, or renewed on or after January 1, 2025, that provide coverage for diagnostic breast examinations and supplemental breast examinations.

The bill provides that if, under federal law, this prohibition would result in health savings account ineligibility under s. 223 of the Internal Revenue Code, the prohibition applies only to health savings account qualified high-deductible health plans with respect to the deductible of such a plan after the person has satisfied the minimum deductible under such plan.

The bill provides rulemaking authority to the Financial Services Commission to adopt rules necessary to implement the new requirements.

The bill has a negative fiscal impact on the state. See V. Fiscal Impact Statement.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Background

Rates of breast cancer vary among different groups of people. Rates vary between women and men and among people of different ethnicities and ages. Rates of breast cancer incidence (new cases) and mortality (death) are much lower among men than among women. The American Cancer Society made the following estimates regarding cancer among women in the U.S. during 2023:

- 297,790 new cases of invasive breast cancer (This includes new cases of primary breast cancer, but not breast cancer recurrences);
- 55,720 new cases of ductal carcinoma in situ (DCIS), a non-invasive breast cancer; and
- 43,170 breast cancer deaths.[1]

The estimates for men in the U.S. for 2023 were:

- 2,800 new cases of invasive breast cancer (This includes new cases of primary breast cancers, but not breast cancer recurrences); and
- 530 breast cancer deaths.[2]

Breast Cancer Screening

In Florida, a group, blanket, or franchise accident or health insurance policy issued, amended, delivered, or renewed in this state must provide coverage for at least the following:

- A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
- A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendation.
- A mammogram every year for any woman who is 50 years of age or older.
- One or more mammograms a year, based upon a physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has or has had breast cancer, or because a woman has not given birth before the age of 30.[3]

Each such insurer must offer, for an appropriate additional premium, this same coverage without such coverage being subject to the deductible or coinsurance provisions of the policy.[4]

However, mammography is only the initial step in early detection and, by itself, unable to diagnose cancer. A mammogram is an x-ray of the breast.[5] While screening mammograms are routinely performed to detect breast cancer in women who have no apparent symptoms,

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[1] *Cancer Facts & Figures*, p. 4, American Cancer Society - https://www.cancer.org/cancer-facts-and-statistics (last visited January 25, 2024).
[2] *Id.*
[3] Section 627.6613(1), F.S.
[4] Section 627.6613(3), F.S.
[5] *What Is The Difference Between A Diagnostic Mammogram And A Screening Mammogram?* National Breast Cancer Foundation - https://www.nationalbreastcancer.org/diagnostic-mammogram (last visited January 25, 2024).

diagnostic mammograms are used after suspicious results on a screening mammogram or after some signs of breast cancer alert the physician to check the tissue.[6]

If a mammogram shows something abnormal, early detection of breast cancer requires diagnostic follow-up or additional supplemental imaging required to rule out breast cancer or confirm the need for a biopsy.[7] An estimated 12-16 percent of women screened with modern digital mammography require follow-up imaging.[8] Out-of-pocket costs are particularly burdensome on those who have previously been diagnosed with breast cancer, as diagnostic tests are recommended rather than traditional screening.[9] When breast cancer is detected early, the 5-year relative survival rate is ninety-nine percent.[10]

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[11] As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.[12] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[13] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[14] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[15]

The Agency for Health Care Administration (AHCA) regulates the quality of care by health maintenance organizations (HMO) under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from AHCA.[16] As part of the certificate process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[17]

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[6] *Id.*
[7] *Breast Cancer Screening & Early Detection*, Susan G. Komen Organization - https://www.komen.org/breast-cancer/screening/ (last visited January 25, 2024).
[8] *Id.*
[9] *Id.*
[10] *Early Detection*, National Breast Cancer Foundation - https://www.nationalbreastcancer.org/early-detection-of-breast-cancer (last visited January 25, 2024).
[11] Section 20.121(3)(a), F.S. The Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as agency head of the Office of Insurance Regulation for purposes of rulemaking. Further, the Financial Services Commission appoints the commissioner of the Office of Insurance Regulation.
[12] Section 624.418, F.S.
[13] Section 624.316(1)(a), F.S.
[14] Section 624.318(2), F.S.
[15] Section 624.3161, F.S.
[16] Section 641.21(1)(1), F.S.
[17] Section 641.495, F.S.

Patient Protection and Affordable Care Act

Essential Benefits

Under the Patient Protection and Affordable Care Act (PPACA),[18] all non-grandfathered health plans in the non-group and small-group private health insurance markets must offer a core package of health care services known as the essential health benefits (EHBs). While not specifying the benefits within the EHB, the PPACA provides 10 categories of benefits and services which must be covered and then required the Secretary of Health and Human Services to further define the EHB.[19]

The 10 EHB categories are:
- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitation and habilitation services.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

PPACA requires each state to select its own reference benchmark plan as its EHB benchmark plan which all other health plans in the state use as a model. Beginning in 2020, states could choose a new EHB plan using one of three options, including: selecting another's state benchmark plan; replacing one or more categories of EHB benefits; or selecting a set of benefits that would become the State's EHB benchmark plan.[20] Florida selected its EHB plan before 2012 and has not modified that selection.[21]

State Insurance Coverage Mandates

If a state elects to amend its benchmark plan later by imposing a statutory mandate to cover a new service, PPACA requires the state to pay for the additional costs of that mandate for the entire industry.[22] According to a recent study, only two states have chosen to enhance their EHB benchmark plans and have incurred the additional benefits penalty: Utah and Massachusetts.[23] Utah, for example, added a coverage mandate for applied behavioral analysis therapy for

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[18] Affordable Care Act, (March 23, 2010), P.L.111-141, as amended.
[19] 45 CFR 156.100. et seq.
[20] Centers for Medicare and Medicare Services, *Marketplace – Essential Health Benefits,* available at https://www.cms.gov/marketplace/resources/data/essential-health-benefits (last reviewed January 25, 2024).
[21] Centers for Medicare and Medicaid Services, *Information on Essential Health Benefits (EHB) Benchmark Plans,* Florida State Required Benefits, available at https://downloads.cms.gov/ (last viewed on January 25, 2024).
[22] 42 U.S.C. section 1803 U.S. Preventive Services Task Force, *Skin Cancer Prevention: Behavioral Counseling (March 20, 2018)* available at Recommendation: Skin Cancer Prevention: Behavioral Counseling (last reviewed January 25, 2024).
[23] California Health Benefits Program, (CHBRP) (August 2023), *Issue Brief: Essential Health Benefits: Exceeding EHBs and the Defrayal Requirement,* p.2. available at *https://www.chbrp.org/sites/* (last viewed January 25, 2024).

individuals with autism in 2014 and subsequently implemented a state rule to allow the state to reimburse the estimated five affected carriers for the autism claims with state funds.[24]

Annually, the federal Centers for Medicare and Medicaid Services issues a *Notice of Benefit and Payment Parameters (NBPP)* for the next plan year. The NBPP typically includes minor updates to coverage standards, clarifications to prior policy statements, and announcements relating to any major process changes. For the 2025 Plan Year which begins on January 1, 2025, the NBPP proposes to codify that any new, additional benefits included in a state's EHB plan would *not* be considered an addition to the state's EHB, and therefore not subject to the PPACA provision requiring the state to defray the cost for the industry.[25] This change is part of a proposed rule which has not yet been finalized, so it is unclear whether the PPACA state defrayal provision will apply in future.[26]

State Employee Health Plan

For state employees who participate in the state employee benefit program, the Department of Management Services (DMS) through the Division of State Group Insurance (DSGI) administers the state group health insurance program (Program).[27] The Program is a cafeteria plan managed consistent with section 125 of the Internal Revenue Service Code.[28] To administer the program, DSGI contracts with third party administrators for self-insured plans, a fully insured HMO, and a pharmacy benefits manager for the state employees' self-insured prescription drug program, pursuant to s.110.12315, F.S.

Legislative Proposals for Mandated Health Benefit Coverage

Any person or organization proposing legislation which would mandate health coverage or the offering of health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, must submit to AHCA and the legislative committees having jurisdiction a report which assesses the social and financial impacts of the proposed coverage.[29] Guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage, to the extent that information is available, include:

- To what extent is the treatment or service generally used by a significant portion of the population?
- To what extent is the insurance coverage generally available?

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[24] Utah Admin. Code R590-283 – Notice of Proposed Rule (November 1, 2019), available at https://rules.utah.gov/publicat/bulletin/2019/20191115/44181.htm (last viewed January 25, 2024).
[25] CMS.GOV, *HHS Notice of Benefit and Payment Parameters for 2025 Proposed Rule (November 15, 2023),* available at https://www.cms.gov/newsroom/fact-sheets/ (last viewed January 25, 2024).
[26] Patient Protection and Affordable Care Act, *HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program, and Basic Health Program*, 88 Fed. Reg. 82510, 82553, 82630-82631, 82649, 82653-82654 (November 24, 2023)(to be codified at section 45 CFR 155.170 and 156.11).
[27] Section 110.123, F.S.
[28] A section 125 cafeteria plan is a type of employer offered, flexible health insurance plan that provides employees a menu of pre-tax and taxable qualified benefits to choose from, but employees must be offered at least one taxable benefit such as cash, and one qualified benefit, such as a Health Savings Account.
[29] Section 624.215(2), F.S.

- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment?
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship?
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- To what extent will the coverage increase or decrease the cost of the treatment or service?
- To what extent will the coverage increase the appropriate uses of the treatment or service?
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service?
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders?
- The impact of this coverage on the total cost of health care.[30]

To date, such a report has not been received by the Senate Committee on Banking and Insurance.

III. Effect of Proposed Changes:

Section 1 amends s. 110.123, F.S., to prohibit the state group insurance program from imposing any enrollee cost-sharing liability with respect to coverage for diagnostic breast examinations and supplemental breast examinations in any contract or plan for state employee health benefits that provides coverage for diagnostic breast examinations or supplemental breast examinations, as those terms are defined in s. 627.64181(1), F.S.

Section 2 creates s. 627.64181, F.S., to prohibit the imposition of cost-sharing requirements for diagnostic and supplemental breast examinations by individual accident and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025, that provide coverage for diagnostic breast examinations and supplemental breast examinations.

The bill provides definitions of “Cost-sharing requirement,” “Diagnostic breast examination,” and “Supplemental breast examination.”

The bill provides that if, under federal law, this prohibition would result in health savings account ineligibility under s. 223 of the Internal Revenue Code, the prohibition applies only to health savings account qualified high-deductible health plans with respect to the deductible of such a plan after the person has satisfied the minimum deductible under such plan.

The bill provides rulemaking authority to the Financial Services Commission to adopt rules necessary to implement the new requirements.

Section 3 creates s. 627.66131, F.S., to prohibit the imposition of cost-sharing requirements for diagnostic and supplemental breast examinations by group, blanket, or franchise accident and

[30] Section 624.215(2)(a)-(l), F.S.

health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025, that provide coverage for diagnostic breast examinations and supplemental breast examinations.

The bill provides that the terms "cost-sharing requirement," "diagnostic breast examination," and "supplemental breast examination" have the same meanings as in s. 627.64181(1), F.S.

The bill provides that if, under federal law, this prohibition would result in health savings account ineligibility under s. 223 of the Internal Revenue Code, the prohibition applies only to health savings account qualified high-deductible health plans with respect to the deductible of such a plan after the person has satisfied the minimum deductible under such plan.

The bill provides rulemaking authority to the Financial Services Commission to adopt rules necessary to implement the new requirements.

Section 4 creates s. 641.31093, F.S to prohibit the imposition of cost-sharing requirements for diagnostic and supplemental breast examinations by health maintenance contracts issued, amended, delivered, or renewed on or after January 1, 2025, that provide coverage for diagnostic breast examinations and supplemental breast examinations.

The bill provides that the terms "cost-sharing requirement," "diagnostic breast examination," and "supplemental breast examination" have the same meanings as in s. 627.64181(1), F.S.

The bill provides that if, under federal law, this prohibition would result in health savings account ineligibility under s. 223 of the Internal Revenue Code, the prohibition applies only to health savings account qualified high-deductible health plans with respect to the deductible of such a plan after the person has satisfied the minimum deductible under such plan.

The bill provides rulemaking authority to the Financial Services Commission to adopt rules necessary to implement the new requirements.

Section 5 provides that the bill takes effect July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill eliminates out-of-pocket costs for diagnostic and supplemental imaging which is anticipated to improve access to these tests and likely to result in more patients receiving an earlier diagnosis. Early diagnosis increases the likelihood of successful treatment, which may result in savings for health insurers and HMOs.

The bill provides that individual accident and health insurance policies; group, blanket, or franchise accident and health insurance policies; and health maintenance contracts that provide coverage for diagnostic breast examinations and supplemental breast examinations may not impose any cost-sharing requirement with respect to such coverage. Since there is no cost share then the insurance provider will be responsible for the entire payment to the entity that provides the diagnostic and supplemental breast examinations. This has the potential to cause a higher insurance premium for the consumer if the cost of providing the treatment without cost-sharing exceeds the savings realized from better outcomes related to early detection. At this time the cost to the insurance provider is unable to be determined.

C. Government Sector Impact:

The Division of State Group Insurance within the Department of Management Services (DMS) estimated in 2023 for similar legislation that the bill will have an estimated fiscal impact of $3.6 million annually in increased claim costs to state health plans.

The legislation does not appear to implicate the Patient Protection and Affordable Care Act as it is a cost-sharing bill only and does not mandate any new coverage and/or service or require any additions to the benchmark plan. Florida's EHB Benchmark Plan already includes diagnostic imaging.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following section of the Florida Statutes: 110.123.
This bill creates the following sections of the Florida Statutes: 627.64181, 627.66131, and 641.31093.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.