Select Committee on Health Innovation

Tuesday, January 16, 2024
4:00 PM – 6:00 PM
Morris Hall (17 HOB)

Meeting Packet

Paul Renner
Speaker

Kaylee Tuck
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Select Committee on Health Innovation

Start Date and Time:	Tuesday, January 16, 2024 04:00 pm
End Date and Time:	Tuesday, January 16, 2024 06:00 pm
Location:	Morris Hall (17 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 63 Protection from Surgical Smoke by Woodson
HB 241 Coverage for Skin Cancer Screenings by Massullo, Payne
HB 659 Health Plans by Abbott
HB 877 Electronic Health Records by Overdorf

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m. Friday, January 12, 2024.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Friday, January 12, 2024.

To submit an electronic appearance form, and for information about attending or testifying at a committee meeting, please see the "Visiting the House" tab at www.myfloridahouse.gov.

NOTICE FINALIZED on 01/11/2024 3:43PM by Killings.Anola

HB 63

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 63 Protection from Surgical Smoke
SPONSOR(S): Woodson and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation		Guzzo	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Surgical smoke is the gaseous by-product produced when tissue is dissected or cauterized by heat generating devices such as lasers, electrosurgical units, ultrasonic devices, and high-speed burrs, drills and saws. Surgical smoke contains chemicals, blood and tissue particles, bacteria, and viruses, and has been proven to exhibit potential risks for surgeons, nurses, anesthesiologists, and technicians in the operating room due to long term exposure.

The bill requires hospitals and ambulatory surgical centers to adopt and implement policies by January 1, 2025, that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke. Smoke evacuation systems must effectively capture, filter, and eliminate surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room.

The bill has no fiscal impact on state or local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Surgical Smoke

Surgical smoke is the gaseous by-product produced when tissue is dissected or cauterized by heat generating devices such as lasers, electrosurgical units, ultrasonic devices, and high-speed burrs, drills and saws.[1] During a surgical procedure, the heat generated from one of these devices causes the target cell membranes to rupture, and subsequently generates and releases a plume of smoke into the operating room.[2] Surgical smoke contains chemicals, blood and tissue particles, bacteria, and viruses, and has been proven to exhibit potential risks for surgeons, nurses, anesthesiologists, and technicians in the operating room due to long term exposure.[3]

Potential known health effects from the exposure to surgical smoke include eye, nose, and throat irritation; headache; cough; nasal congestion; and asthma and asthma-like symptoms, but little is known about the health effects from chronic exposure to surgical smoke.[4] Other risks include the transmission of viruses through surgical smoke; for example, transmission of Human Papillomavirus (HPV) through surgical smoke from lasers has been documented,[5] and some researchers have suggested that surgical smoke may act as a vector for cancerous cells that may be inhaled.[6]

Surgical Smoke Evacuation Systems

Smoke evacuators are devices which contain a suction unit (i.e. a vacuum), filter, hose, and inlet nozzle. They are designed, as recommended by the Center for Disease Control, to capture air from where the nozzle is targeted and filter the air through a HEPA filter.[7] These systems may be stationary, with permanent construction requirements, or handheld portable systems with disposable filters, hand pieces, and hoses. While costs for these products range greatly, with installation of a stationary system costing as much as $120,000.[8] The more common handheld systems have recurring costs associated with disposable parts of roughly $19 per surgery, and total recurring costs including filter replacement between $8,000 and $10,000 annually depending on frequency of use.[9]

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[1] Liu Y, Song Y, Hu X, Yan L, Zhu X. Awareness of surgical smoke hazards and enhancement of surgical smoke prevention among the gynecologists. Journal of Cancer (June 2, 2019) available at https://www.jcancer.org/v10p2788.htm (last visited December 23, 2023).
[2] Id.
[3] Id.
[4] Steege AL, Boiano JM, Sweeney MH. NIOSH health and safety practices survey of healthcare workers: training and awareness of employer safety procedures, American Journal of Industrial Medicine (February 18, 2014) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504242/ (last visited December 23, 2023).
[5] *Id.*
[6] United States Department of Labor, Occupational Safety and Health Administration, *Surgical Suite >> Smoke Plume*, available at https://www.osha.gov/etools/hospitals/surgical-suite/smoke-plume, (last visited December 23, 2023).
[7] Centers for Disease Control, *Control of Smoke from Laser/Electrical Surgical Procedures*, available at https://www.cdc.gov/niosh/docs/hazardcontrol/hc11.html (last visited December 23, 2023).
[8] Relias Media, *Consider Overall Cost, Ease when Choosing Evacuators,* available at https://www.reliasmedia.com/articles/61664-consider-overall-cost-ease-when-choosing-evacuators (last visited December 23, 2023).
[9] *See* Relias Media, *OR Teams Often Exposed to Toxic Chemicals in Surgical Smoke*, Mar. 1, 2021, available at https://www.reliasmedia.com/articles/147530-or-teams-often-exposed-to-toxic-chemicals-in-surgical-smoke#:~:text=The%20estimated%20cost%20of%20using,for%20the%20standard%20electrosurgical%20pencil. (last visited December 23, 2023), Ohio Legislative Service Commission, *SB 161 Fiscal Note & Local Impact Statement*, available at https://www.legislature.ohio.gov/download?key=17773&format=pdf (last visited December 23, 2023); Kreuger, Steven, et al., *The Effect of a Surgical Smoke Evacuation System on Surgical Site Infections of the Spine*, available at https://www.oatext.com/pdf/CMID-3-132.pdf (last visited December 23, 2023).

Surgical Smoke Regulation

Hospitals and ambulatory surgical centers (ASCs) must comply with the 2021 National Fire Protection Association (NFPA) 101 Life Safety Code.[10] The 2021 version does not require the use of surgical smoke evacuation systems, but the 2024 version does. However, in Florida, the 2021 version will be enforceable until 2027, when the State Fire Marshal adopts the 2024 version.[11] The 2024 version requires facilities to capture surgical smoke using either a dedicated exhaust system (may share an established system for waste gas removal), a connection and return or exhaust duct after air cleaning through high efficiency particulate air (HEPA) and gas phase filtration, or a point of use smoke evacuator for air cleaning and return to the space. As a result, Florida will have no regulatory requirement to use surgical smoke evacuation systems in hospitals and ASCs until 2027.

The Occupational Safety and Health Administration (OSHA) recognizes potential risk factors and remedial measures, but it has not adopted regulations on protection from surgical smoke. OSHA's recognized controls and work practices for surgical smoke include:[12]

- Using portable local smoke evacuators and room suction systems with in-line filters.
- Keeping the smoke evacuator or room suction hose nozzle inlet within two inches of the surgical site to effectively capture airborne contaminants.
- Having a smoke evacuator available for every operating room where plume is generated.
- Evacuating all smoke, no matter how much is generated.
- Keeping the smoke evacuator "ON" (activated) at all times when airborne particles are produced during all surgical or other procedures.
- Considering all tubing, filters, and absorbers as infectious waste and dispose of them appropriately.
- Using new tubing before each procedure and replace the smoke evacuator filter as recommended by the manufacturer.
- Inspecting smoke evacuator systems regularly to ensure proper functioning.

Additionally, the Joint Commission, an accrediting organization for hospitals and ASCs, recommends the following actions to protect patients and staff from the dangers of surgical smoke:

- Implement standard procedures for the removal of surgical smoke and plume through the use of engineering controls, such as smoke evacuators and high filtration masks.
- Use specific insufflators for patients undergoing laparoscopic procedures.
- During laser procedures, use standard precautions to prevent exposure to the aerosolized blood, blood by-products and pathogens contained in surgical smoke plumes.
- Establish, review, and make available policies and procedures for surgical smoke safety and control.
- Provide surgical team members with initial and ongoing education and competency verification on surgical smoke safety, including the organization's policies and procedures.
- Conduct periodic training exercises to assess surgical smoke precautions and consistent evacuation for the surgical suite or procedural area."[13]

As of August, 2023, 11 states have adopted legislation to require the use of surgical smoke evacuation systems in certain health care facilities. Of those 11 states, 8 states require surgical smoke evacuation

[10] Rule 69A-3.012, F.A.C., and s. 633.206(1)(b), F.S.
[11] S. 633.202(1), F.S., requires the State Fire Marshal to adopt a new version of the fire prevention code every third year. The 2021 version becomes effective December 31, 2024, so the 2024 version will not become effective until December 31, 2027.
[12] *Id.*
[13] The Joint Commission, *Quick Safety Issue 56: Alleviating the Dangers of Surgical Smoke*, available at https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-56/quick-safety-issue-56/ (last visited December 23, 2023).

systems to be used in hospitals and ASCs for procedures that generate surgical smoke, and 3 states require them to be used in all health care facilities for procedures that produce surgical smoke.[14]

Effect of the Bill

The bill requires hospitals and ASCs to adopt and implement policies by January 1, 2025, that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke. Smoke evacuation systems must effectively capture, filter, and eliminate surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 395.1013, F.S., relating to smoke evacuation systems required.
Section 2: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will have a negative fiscal impact on hospitals and ASCs who do not currently use surgical smoke evacuation systems during procedures that generate surgical smoke. Such hospitals and ASCs could incur costs of up to $10,000 per surgical suite annually.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None. The bill does not appear to affect local or municipal governments.

[14] Staff of the Select Committee on Health Innovation conducted a 50-state analysis on laws relating to surgical smoke evacuation.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not necessitate rule-making for implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to protection from surgical smoke; creating s. 395.1013, F.S.; defining the terms "smoke evacuation system" and "surgical smoke"; requiring hospitals and ambulatory surgical centers to, by a specified date, adopt and implement policies requiring the use of smoke evacuation systems during certain surgical procedures; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.1013, Florida Statutes, is created to read:

395.1013 Smoke evacuation systems required.—

(1) As used in this section, the term:

(a) "Smoke evacuation system" means equipment that effectively captures, filters, and eliminates surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room.

(b) "Surgical smoke" means the gaseous byproduct produced by energy-generating devices such as lasers and electrosurgical devices. The term includes, but is not limited to, surgical plume, smoke plume, bio-aerosols, laser-generated airborne contaminants, and lung-damaging dust.

(2) By January 1, 2025, each licensed facility shall adopt

and implement policies that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke.

Section 2. This act shall take effect July 1, 2024.

HB 241

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 241 Coverage for Skin Cancer Screenings
SPONSOR(S): Massullo and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 56

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation		Lloyd	Calamas
2) Appropriations Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 241 requires the coverage and payment, without the imposition of a deductible, copayment, coinsurance, or any other cost sharing requirement, of an annual skin cancer screening by a dermatologist licensed under chapter 458 or chapter 459, Florida Statutes, to an insured with a policy or contract issued or renewed on or after January 1, 2025 and who is covered under:

- A health insurance policy issued under chapter 627.64198, F.S.;
- A group, blanket, or franchise health insurance policy issued under 627.66912, F.S., or
- A health maintenance (HMO) contract issued under 641.31091, F.S.

Additionally, the bill prohibits the insurer or HMO from bundling a payment for a skin cancer screening with any other procedure or service, including an evaluation or management visit, which is performed during the same office visit or subsequent office visit.

The bill has a significant negative fiscal impact on the state, a significant negative fiscal impact on the state employee group health plan within the Department of Management Services, and an indeterminate impact on local governments. See Fiscal Analysis.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Skin Cancer

Cancer is the second most common cause of death in the United States after heart disease and in 2023, a total of 1.9 million new cancer cases were diagnosed.[1] Of the estimated new cancer cases in the United States, 5 percent were skin cancer cases.[2]

Florida's 2023 rates show an estimated number of 162,410 total new cases and 47,410 deaths for all cancer types. The actual number of cases is not known as skin cancer diagnoses are not required to be reported to cancer registries.[3]

There are two main types of cancer: nonmelanoma or keratinocyte carcinoma which includes squamous cell carcinoma (SCC) and basal cell carcinoma and melanoma.[4] The most common types are the nonmelanoma types and most of these cancers can be cured.

Cutaneous melanoma can occur on any part of the skin. Unusual moles, exposure to sunlight, and health history can affect a person's risk of melanoma.[5] In men, melanoma is often found in the area from the shoulders to the hips, or the head and neck. In women, it is most often found on the arms and legs.[6] However, melanoma may also occur in the eyes. When it does occur in the eyes, it is known either intraocular or ocular melanoma.

Ocular melanoma (OM) is the most common primary eye tumor in adults and nearly 2,000 new cases are diagnosed each year in the United States, second only to cutaneous melanoma.[7] Intraocular melanoma is a type of melanoma that forms in the tissues of the eyes and is a rare cancer.[8] Risk factors for this particular disease including having a fair complexion, being of an older age, and being white.[9] Ocular melanoma is most commonly diagnosed around age 55 and will metastasize to another organ in about half of all cases.[10] In 90 percent of cases where the tumor does metastasize, it first spreads to the liver.[11] While there is no known cure for OM, several treatment options are available depending on the patient's status and symptoms, including watchful waiting, surgery, or radiation therapy.[12]

The long term survival rate of those diagnosed with skin cancer after 5 years is high at 93.5 percent and more than 1.4 million people were identified in the United States in 2020 as living with this

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[1] American Cancer Society, *Incidence Drops for Cervical Cancer But Rises for Prostate Cancer (January 12, 2024),* available at https://www.cancer.org/research/acs-research-news/facts-and-figures-2023.html (last viewed January 13, 2024).
[2] Id.
[3] American Cancer Society, *Cancer Facts & Figures 2023,* p. 25, available at Cancer Facts & Figures 2023 (last viewed January 13, 2024).
[4] National Cancer Institute, *Skin Cancer Screening (PDQ) – Patient Version,* available at Skin Cancer Screening - NCI (last viewed January 10, 2024).
[5] National Cancer Institute, *Melanoma Treatment (PDQ) – Patient Version,* available at Melanoma Treatment - NCI (cancer.gov) (last viewed January 12, 2024).
[6] Id.
[7] Melanoma Research Foundation, *Ocular Melanoma Fact Sheet (August 13, 2019),* available at Ocular Melanoma Fact Sheet (flippingbook.com) (last viewed January 12, 2024).
[8] National Cancer Institute, *Melanoma Treatment (PDQ) – Patient Version,* available at Melanoma Treatment - NCI (cancer.gov) (last viewed January 12, 2024).
[9] Id.
[10] Id.
[11] Melanoma Research Foundation, *Ocular Melanoma Patient Guide,* p.14, available at https://online.flippingbook.com/view/745990/16-17/ (last viewed January 12, 2024).
[12] Supra, note 8.

cancer.[13] The more localized the cancer is when it is found, meaning the cancer has been confined to a primary spot, the higher the survival rate is compared to a cancer that has spread to the regional lymph nodes or metastasized to another region of the body.[14]

Men and women are diagnosed with skin cancer at starkly different rates. The rate of new cases per 100,000 persons for the time period of 2016-2020 for males was 26.9 and for females was 16.7.[15] Incidence rates are higher in women than in men before age 50, but after that the incident rates are increasingly higher in men. These trends have been associated with age differences in historical occupational and recreational exposure to ultraviolet radiation (UV) for men, increased use of indoor tanning among young women, and improvements in early detection practices over time.[16]

National estimates for the probability of developing skin cancer over one's lifetime is 2.9 percent which is the sixth highest behind uterine (3.1 percent), colorectum (4.1 percent), lung and bronchus (6 percent), prostate (12.6 percent), and breast (12.9 percent).[17]

Differences by race and ethnicity nationally are also present as the chart below shows.[18]

Rate of New Cases per 100,000 Persons by Race/Ethnicity & Sex: Melanoma of the Skin

MALES	
All Races	26.9
Hispanic	4.5
Non-Hispanic American Indian/Alaska Native	8.7
Non-Hispanic Asian/Pacific Islander	1.3
Non-Hispanic Black	1.0
Non-Hispanic White	37.9

FEMALES	
All Races	16.7
Hispanic	4.3
Non-Hispanic American Indian/Alaska Native	7.8
Non-Hispanic Asian/Pacific Islander	1.1
Non-Hispanic Black	0.9
Non-Hispanic White	25.2

SEER 22 2016–2020, Age-Adjusted

Skin Cancer in Florida

[13] National Cancer Institute, *Cancer Stat Facts: Melanoma of the Skin,* available at https://seer.cancer.gov/statfacts/html/melan.html (last viewed January 12, 2024).
[14] National Cancer Institute, Cancer Stat Facts: Melanoma of the Skin, *Survival by State,* available at https://seer.cancer.gov/statfacts/html/melan.html (last viewed January 12, 2024).
[15] American Cancer Society, Cancer Statistic Center, *Probability of Developing or Dying of Cancer, by Type (data run on January 13, 2024)* available at Cancer Statistics Center - American Cancer Society (last viewed January 13, 2024).
[16] American Cancer Society, *Cancer Facts & Figures 2023,* p. 25, available at Cancer Facts & Figures 2023, (last viewed January 12, 2024).
[17] Id.
[18] Id.

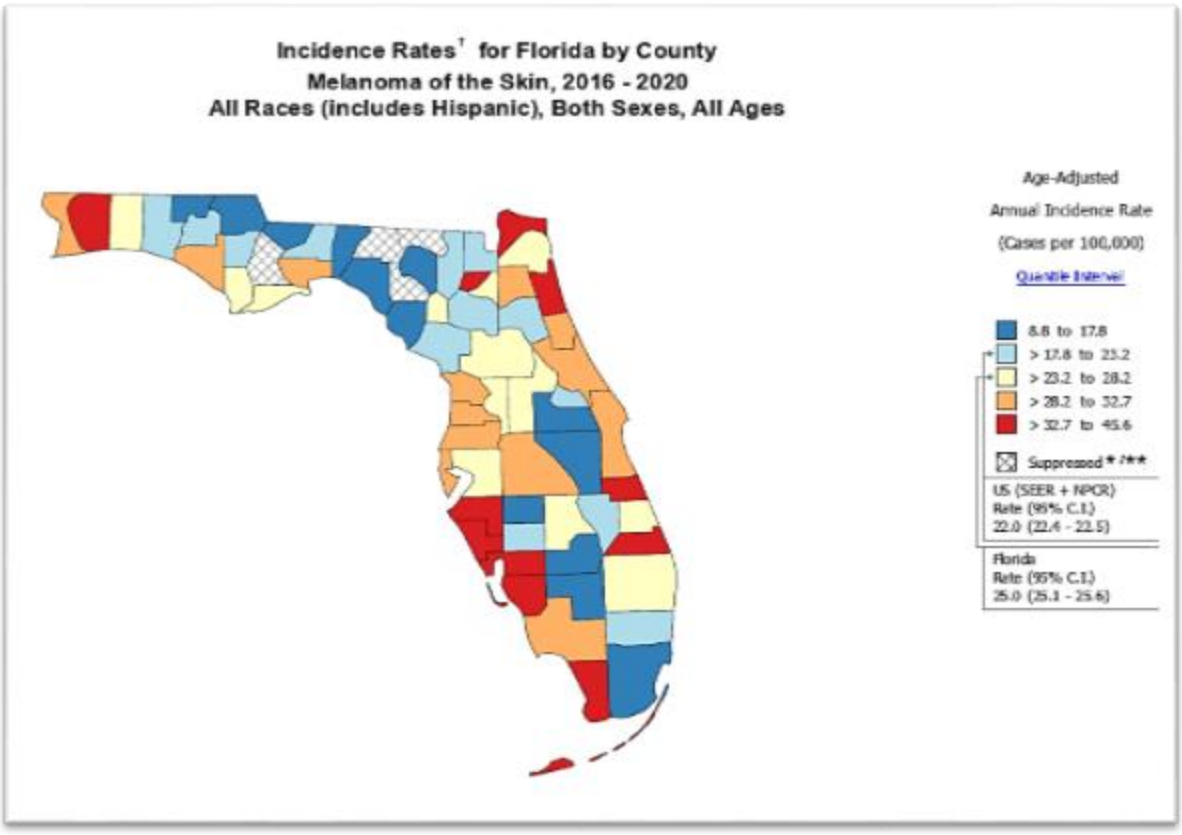
For Florida, the estimated new cases of skin cancer are 9,640 with projected deaths at 680 individuals.[19] The state's incidence rate was calculated at 25.70 indicating the number of diagnoses per 100,000 individuals.[20] 2020 data show that 4,477 new cases were reported for males while 2,770 cases were reported for women.[21] Incidence rates for men and women, and hospitalization and cost data, are in the chart below.

Skin Cancer – Comparisons by Sex – Florida Only[22]				
	# of Hospitalizations	Total and Length of Stay Per Hospitalization	Median Length of Stay Per Hospitalization	Total Charges (in millions)
All Cancers	72,456	441,678	4.0	$8,632.7
Melanoma TOTAL:	136	594	2.0	$12.1
Female	41	184	4.0	$3.5
Male	95	410	2.0	$8.6

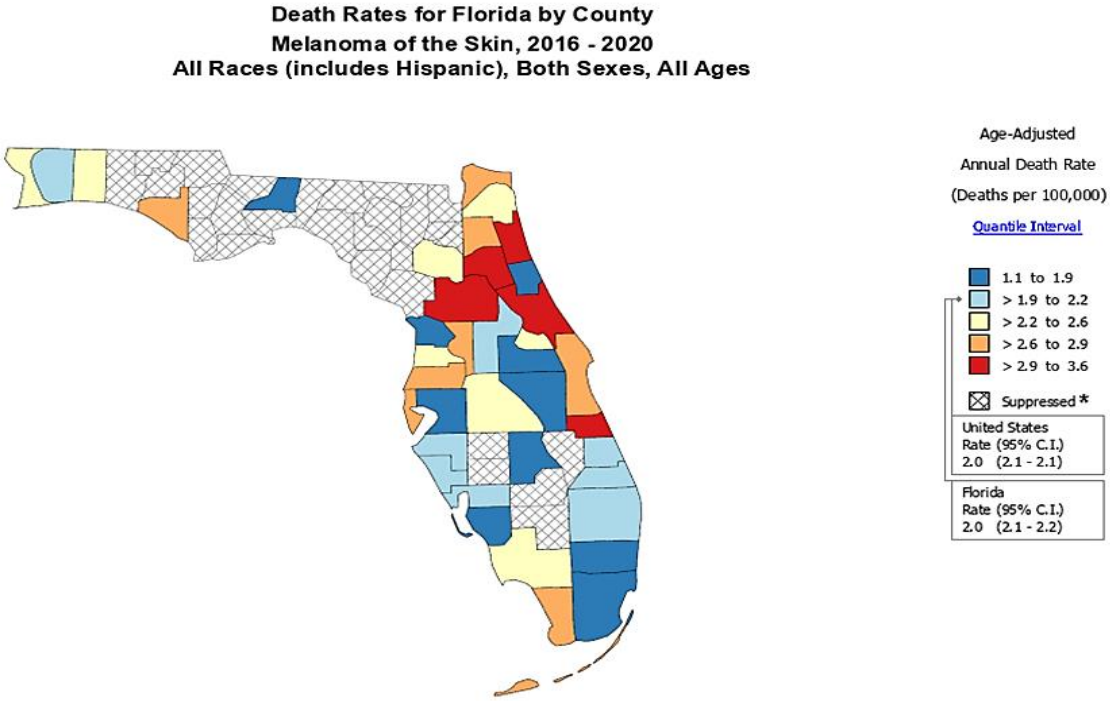
From a national perspective, Florida ranks 17th for the rate of melanoma per 100,000 people and 30th when compared to other states for mortality rates.[23] Increased exposure to UV radiation from the sun, and indoor or outdoor tanning beds are major risks for skin cancer and Floridians may carry a higher likelihood of such risks than individuals in other states. Other artificial sources of UV radiation include mercury vaping lighting which is usually found in stadiums and school gyms, some halogen, florescent and incandescent lights, and a few types of lasers.[24]

A few Florida counties have significantly higher incident rates for skin cancer with rates that fall in the 32.7 to 45.6 per 100,000 per incident rate.[25] Statistical models used by the National Cancer Institute show that new cases on the rise at the rate of 1.2 percent per year nationally from 2010 through 2019, but for the period of time of 2015 through 2020, Florida's incident rate has remained stable.

[19] American Cancer Society, Cancer Statistics Center, *Estimated New Cancer Cases and Deaths by States (sexes combined, Florida) (data run on January 13, 2024)* available at Cancer Statistics Center - American Cancer Society (last viewed January 13, 2024).
[20] American Cancer Society, Cancer Statistics Center, *Incidence Rates by State and By Type (data run on January 13, 2024)* available at Cancer Statistics Center - American Cancer Society (last viewed January 13, 2024).
[21] Florida Cancer Data System, *Table 1:Number of New Cancer Cases by Sex and Race,* available at https://fcds.med.miami.edu/downloads/FloridaAnnualCancerReport/2020/Table_No_T1_(2020).pdf (last viewed January 11, 2024).
[22] Florida Cancer Data System, *Tables 33 – 38: Number of Cancer Hospitalizations by Sex,* reports generated at https://fcds.med.miami.edu/inc/statistics_data_vizf.shtml (last viewed January 12, 2024).
[23] American Cancer Society, Cancer Statistic Center, *Cancer Statistic Center,* available at Cancer Statistics Center - American Cancer Society (last viewed January 14, 2024). .
[24] Centers for Disease Control and Prevention, *UV Radiation, available at https://www.cdc.gov/nceh/features/uv-radiation-safety/index.html* (last viewed January 10, 2024).
[25] National Cancer Institute, *Interactive Maps – Incident Rates for Florida by County, Melanoma of the Skin, 2016 – 2020, All Races (includes Hispanic), Both Sexes, All Ages,* report can be re-generated at Interactive Maps (cancer.gov), (last viewed January 10, 2024).



A corresponding map showing the death rate by county reflects a different set of counties. The grouping of counties in southwestern Florida are in one of the lowest death rate quartiles meaning those counties have fewer residents who were diagnosed succumb to death because of that diagnosis. Likewise, many of the southeastern Florida counties have also fallen into the lower death rates as shown in the next figure.[26]



Skin Cancer Screening

[25]Id.

During a skin cancer screening test, a doctor or nurse checks a patient's skin for moles, birthmarks, or other pigmented areas that may be abnormal in color, size, shape, or texture. If an area looks abnormal, a biopsy of the area may be done where the health care provider may remove as much of the suspicious tissue as possible with a local excision. A pathologist reviews this tissue under a microscope to check for cancer cells.[27]

Screening tests do have risks as finding skin cancer may always improve a person's health or help the individual live longer, false negative or false positives can occur, and a biopsy may cause scarring.[28] A false negative, for example, may lead someone to delay seeking further medical attention even if that individual has symptoms.

The American Academy of Dermatologists (AAD) encourages everyone to perform skin self-exams for signs of skin cancer and to get an exam from a doctor, especially if a new spot is found, or an existing spot changes, bleeds, or itches.[29] Individuals with a history of melanoma should have a full-body exam by a board-certified dermatology at least annually and perform regular self-exams to check for any changes.

A *Body Mole Map* is available on the AAD website which allows an individual to record a response for each of the A, B, C, D, and E components discussed above and to record the location of the spot on one sheet.[30]

The American Melanoma Foundation provides a "Record Your Spots" self-check body map on its website to help individuals document any new or changing areas. The AAD also has an infographic to assist individuals with self-checking through the ABCDEs of Melanoma. For each letter, the individual is reminded to look for a warning sign:

- A stands for asymmetry; does one half of the spot look different than the other?
- B stands for border; does the spot have an irregular, scalloped, or poorly defined border?
- C stands for color; does the spot have varying colors from one area to the next?
- D stands for diameter; what is the size?
- E stands for evolving; does the spot look different from the rest or is it changing in size, shape, or color?

However, for adults older than age 24 with fair skin types, the recommendation to clinicians was to selectively offer counseling about minimizing exposure to UV radiation to reduce skin cancer risks and received a C grade. The explanation provided pointed to small net benefit and that clinicians should consider the patient's potential risk factors in determining whether counseling is appropriate.[31]

Australia, Germany, the Netherlands, New Zealand, and the United Kingdom have adopted skin cancer and counseling guidelines based on certain subsets of patients who are at greater risk for melanoma.[32] All of these countries include in their guidelines a routine total body skin examination (TBSE) at least annually, but sometimes more frequently depending on the patient's condition.[33]

One 2017 paper published in *Melanoma Management* in 2017, proposed guidelines which incorporated a TBSE annually based on evidence based screening guidelines that identify high risk patients who will

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[27] National Cancer Institute, *Skin Cancer Screening (PDQ) – Patient Version,* available at Skin Cancer Screening - NCI (last viewed January 12, 2024).
[28] Melanoma Research Foundation, *Ocular Melanoma Patient Guide,* p. 20-21, available at Ocular Melanoma Patient Guide (flippingbook.com) (last viewed January 12, 2024).
[29] American Academy of Dermatologists, *Infographic: How to Spot Skin Cancer, Infogra https://www.aad.org/public/diseases/skin-cancer/how-to-spot-skin-cancer phic: How to SPOT Skin Cancer™ (aad.org),* (last viewed January 12, 2024).
[30] American Academy of Dermatology, *Infographic: Skin Cancer Body Mole Map,* available at https://www.aad.org/public/diseases/skin-cancer/find/mole-map (last viewed January 12, 2024).
[31] U.S. Preventive Services Task Force, *Skin Cancer Prevention: Behavioral Counseling (March 20, 2018)* available at Recommendation: Skin Cancer Prevention: Behavioral Counseling | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) (last reviewed January 12, 2024).
[32] Johnson, Leachman, Aspinall, *et al., Skin cancer screening: recommendation for data-driven screening guidelines and a review of the US Preventive Services Task Force controversy,* Melanoma Manag.(2017), 13-37, Table 4 at p. 24, available at mmt-04-13.pdf (nih.gov) (last reviewed January 13, 2024).
[33] Id.

benefit the most from a skin cancer screening.[34] A high risk patient under this model would include someone between the ages of 35 to 75 with a history of melanoma, is immunocompromised, a family history of melanoma in one or more family members, has certain physical features, or has over-exposure to UV radiation.[35]

The United States Preventive Services Task Force (USPSTF) is a volunteer board of national experts in prevention and evidence-based medicine who make recommendations using letters grades (A, B, C, D or I) after a review of the evidence and the balance of benefits and harms of a preventive service .[36]

In April 2023, the USPST issued its final recommendations on screening for skin cancer and determined that there was not enough evidence to recommend for or against screening individuals without symptoms. As a result, the recommendation, received an "I" grade.[37] The Task Force noted that evidence on screening is limited and members wanted this recommendation to draw attention to the need for research to be reflective of the nation's population, including studies with a diversity of skin tones and settings where access to health care varies.[38]

While not recommending a skin cancer screening for individuals without symptoms or a family history, the USPSTF does recommend counseling, via a *Behavioral Counseling to Prevent Skin Cancer Recommendation Statement* which has been in place since 2018.[39] For young adults, adolescents, children, and parents of young children, the recommendation for counseling to minimize exposure to UV radiation for persons aged six (6) months to 24 years with fair skin types to reduce their risk of skin cancer has a B grade.[40] As a screening or guidelines recommended by the USPSTF with a B grade, this counseling service is identified as a covered preventive service without cost sharing currently.

Dermatologist Workforce

The federal Health Resources and Services Administration (HRSA) identifies geographic areas, population groups, and health care facilities with a shortage of health professionals and designates them health professional shortage areas (HPSAs). HPSAs can be designated as geographic areas; areas with a specific group of people such as low-income populations, homeless populations, and migrant farmworker populations; or as a specific facility that serves a population or geographic area with a shortage of providers.[41]

There are three categories of HPSA: primary care, dental health, and mental health.[42] As of September 30, 2023, Florida has 304 primary care HPSAs, 266 dental HPSAs, and 228 mental health HPSAs

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[34] Id.
[35] Id.
[36] An "A" grade means the USPSTF recommends the service and there is a high certainty that the net benefit of the service is substantial. A service with a "B" grade is also recommended, and there is a finding of a high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial.[36] A service or screening receiving a "C" grade is recommended to be offered selectively or to be provided to patients based on professional judgment and patient preferences. There is at least a moderate certainty that the net benefit is small. A "D" grade reflects the task force's recommendation against the service finding moderate or high certainty that the service has no net benefit or that the harms outweigh the risks. U.S. Preventive Services Task Force, *Grade Definitions after July 2012,* available at https://www.uspreventiveservicestaskforce.org/apps/gradedef.jsp (last viewed January 12, 2024).
[37] An "I" grade by the USPSTF means the task force concluded that current evidence is inconclusive to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefit and harms cannot be determined. United States Prevention Services Task Force, *U.S. Preventive Services Task Force Issues Final Recommendation on Screening for Skin Cancer (April 18, 2023),* available at https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/file/supporting_documents/skin-cancer-screening-final-rec-bulletin.pdf (last reviewed January 13, 2024).
[38] Id.
[39] U.S. Preventive Services Task Force, *Skin Cancer Prevention: Behavioral Counseling (March 20, 2018)* available at Recommendation: Skin Cancer Prevention: Behavioral Counseling | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) (last reviewed January 12, 2024).
[40] Id.
[41] *What is a Shortage Designation?*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last visited January 8, 2024).
[42] *Health Professional Shortage Areas (HPSAs) and Your Site,* National Health Service Corps, available at https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited January 8, 2024).

designated within the state. It would take 1,803 primary care physicians, 1,317 dentists, and 587 psychiatrists to eliminate these shortage areas.[43]

HRSA does not identify shortages in physician specialty or sub-specialty care, including dermatology.

A 2021 report for the Safety Net Hospital Alliance of Florida and the Florida Hospital Association examined Florida's statewide and regional physician workforce and made projections on workforce changes to 2035.[44] Between 2019 and 2035, the report estimates the physician supply will increase by six percent overall and by three to four percent for primary care; however, demand for physician services will grow 27 percent.[45] Estimates of current supply deficits indicate Florida needs 1,977 additional physicians for primary care and 1,650 for non-primary care. The significant growth in the demand for physician services will outpace physician workforce growth over the next decade, and is estimated to create a shortfall of 7,872 in primary care physicians by 2035 and an overall decline in the adequacy for all non-primary care specialties from 95 percent in 2019 to 77 percent in 2035.[46]

For dermatology specifically, the IHS Markit Report found a supply of 1,111 physicians and a projected demand rate of 1,044 physicians in 2035 leading to a supply-demand difference of 67 and an adequacy rating of 106 percent. This indicates Florida has a more than sufficient number of dermatologists for the projected demand.[47] The projected growth rate in the number of physicians in dermatology from 2019 to 2035 is 26 percent, which closely matches the growth rate for primary care physicians (27 percent) under what the report called the "status quo scenario".[48]

Also noted in the report was that Florida's current supply of dermatologists, which was cited as more than adequate at 135 percent adequacy, has a surplus of 293 physicians.[49] One possible reason cited was Florida's high rate of melanoma cases and reference to a study finding that nearly one in ten Floridians (9.2 percent) had been diagnosed with skin cancer.[50]

The HIS report did not address the distribution of dermatologists in Florida; it is likely that some areas of the state have sufficient dermatologists (or a surplus), while others have less access.

Regulation of Insurers and Health Maintenance Organizations

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations (HMOs), and other risk bearing entities.[51] The Agency for Health Care Administration (AHCA) regulates the quality of care by HMOs 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.[52] 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.[53]

[43] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited January 8, 2024). To generate the report, select "Designated HPSA Quarterly Summary."
[44] IHS Markit, Florida Statewide and Regional Physician Workforce Analysis: 2019 to 2035: 2021 Update to Projections of Supply and Demand (December 2021), available at Florida-Physician-Workforce-Analysis.pdf (fha.org) (last viewed January 12, 2024).
[45] Id.
[46] Id.
[47] Id.
[48] The "status quo" scenario assumes a 10 percent increase in newly trained physicians entering the workforce annually resulting in 3,191 FTEs (6 percent) physicians in the workforce in 2035, while also assuming the average physician would delay retirement by two years which added 1,543 FTE physicians in the 2035 workforce. *See* notation on Exhibit 13 of HIS Markit Report.
Id.
[50] Id.
[51] S. 20.121(3)(a), F.S.
[52] S. 641.21(1)(1), F.S.
[53] S. 641.495, F.S.

All persons who transact insurance in this state must comply with the Code.[54] The OIR has the authority to collect, propose, publish, and disseminate any information relating to the subject matter of the Code,[55] and may investigate any matter relating to insurance.[56]

Patient Protection and Affordable Care Act

Essential Health Benefits

Under the Patient Protection and Affordable Care Act (PPACA),[57] 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.[58]

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.

Because the USPSTF did not give skin cancer screening an "A" or "B" grade, these screenings are not required to be covered under the PPACA essential health benefits as preventive services.[59]

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.[60] Florida selected its EHB plan before 2012 and has not modified that selection.[61]

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

[54] S. 624.11, F.S.
[55] S. 624.307(4), F.S.
[56] S. 624.307(3), F.S.
[57] Affordable Care Act, (March 23, 2010), P.L.111-141, as amended.
[58] 45 CFR 156.100. et seq.
[59] Under the PPACA, preventive services with an "A" or "B" rating from the USPSTF must be covered by most private health insurance plans. These requirements do not apply to grandfathered plans which are defined as those plans that existed on March 23, 2010 , when the PPACA was enacted, meet certain requirements, and are exempt from certain other PPACA requirements. *See* Issue Brief, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services,: *Access to Preventive Services Without Cost Sharing: Evidence from the Affordable Care Act, Issue Brief HP 2022-01 (January 11, 2022), Office of Health Policy, Assistant Secretary for Planning and Evaluation,* available at preventive-services-ib-2022.pdf (hhs.gov) (last viewed January 12, 2024)
[60] 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 12, 2024).
[61] Centers for Medicare and Medicaid Services, *Information on Essential Health Benefits (EHB) Benchmark Plans,* Florida State Required Benefits, available at https://downloads.cms.gov/cciio/State%20Required%20Benefits_FL.pdf (last viewed on January 12, 2024).

industry.[62] 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.[63] Utah, for example, added a coverage mandate for applied behavioral analysis therapy for 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.[64]

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.[65] 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.[66]

Mandated Insurance Coverage in Florida

Prior to 2012, the Florida Office of Insurance Regulation (OIR) identified 18 state mandated benefits in its filings to the Centers for Medicare and Medicaid Services for purposes of establishing its benchmark plan under the PPACA.[67] Florida has not adopted any additional mandated benefits since 2012, so has not triggered the PPACA obligation to pay for the costs of newly-mandated benefits for the entire insurance industry.

Current Florida law requires every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurer, to submit to the Agency for Health Care Administration and the legislative committees having jurisdiction, a report that assesses the social and financial impacts of the proposed coverage.[68] To the extent information is available, the report should address:

- The extent to which the treatment or service is generally used by a significant portion of the population.
- The extent to which insurance coverage generally available.
- The extent to which insurance coverage is not generally available and results in persons avoiding necessary health care treatment.
- The extent to which 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.
- The extent to which coverage will increase or decrease the cost of the treatment or service.
- The extent to which coverage will increase the appropriate uses of the treatment or service.

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[62] 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 | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) (last reviewed January 12, 2024).
1(d)(3)(B) and implanted through 45 CFR 156.111.

[63] 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/default/files/2023-08/EHB_Defrayal_FINAL.pdf* (last viewed January 13, 2024).

[64] Utah Admin. Code R590-283 – Notice of Proposed Rule (November 1, 2019), available at DAR File No. 44181 (Rule R590-283), 2019-22 Utah Bull. (11/15/2019)DAR File No. 44181 (Rule R590-283), 2019-22 Utah Bull. (11/15/2019) (last viewed January 13, 2024).

[65] 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/hhs-notice-benefit-and-payment-parameters-2025-proposed-rule (last viewed January 12, 2024).

[66] 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).

[67] *Supra*, note 64.

[68] S. 624.215, F.S.

- The extent to which the treatment or service will be a substitute for a more expensive treatment or service.
- The extent to which the coverage will 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.

The House Health and Human Services Committee has not received a report for HB 241.

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) under the authority of section 110.123, F.S., administers the state group health insurance program (Program). The Program is a cafeteria plan managed consistent with section 125 of the Internal Revenue Service Code.[69] 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.

The state employee health plan contracts currently cover dermatology visits and skin cancer screenings as a specialist office visit. Depending on the plan chosen by the employee, the appropriate out of pocket cost or costs then applies for the specialist office visit.[70]

Effect of Proposed Changes

HB 241 requires large and small group health insurers, HMOs, and other insurers who provide health insurance policies to cover annual skin cancer screenings without a payment towards a deductible or co-insurance, copayment, or any other cost sharing by the covered individual conducted by a dermatologist licensed under chapter 458 or chapter 459. The payment for the screening is to be consistent with other payments for preventive screenings as defined by the American Medical Association Current Procedural Terminology code set.

The bill further prohibits an insurer or HMO from bundling a payment for the skin cancer screening with services performed with any other service or procedure, including an evaluation and management visit which is performed during the same office visit or a subsequent office visit. Under this provision, the insurer or HMO may not bundle payments to a provider which would include a patient's annual skin cancer screening service with the payments to that provider for any other service, even if conducted on another day.

When a benefit or service has a patient cost sharing requirement, such as a specialist office co-payment, that amount is deducted from the provider's reimbursement from the insurer or HMO as the amount becomes the responsibility of the provider to collect from the patient for full reimbursement. If there is no cost sharing for a service expected from the patient, then 100 percent of the reimbursement for the service is the responsibility of the insurer or HMO, depending on the contract terms between the health care provider and the insurer or HMO. The unbundling of visits provides assurances to the health care provider that 100 percent reimbursement for the skin care screening has been received from the insurer or the responsibility third party payor.

Depending on the outcome and final interpretation of the new federal proposed rule (discussed above), the applicability of the PPACA requirement for states to defray industry costs for new coverage mandates is not clear. Under current rules, the addition of a mandate to the EHB would require the

[69] 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.
[70] Department of Management Services, *Agency Bill Analysis – HB 241/SB 56 (January 12, 2024) (on file with the Select Committee on Health Innovation).*

State to defray the costs of the additional benefit. The OIR has estimated this amount to range from $9.3 million to $16 million per year.[71]

The change contemplated in HB 241 would be effective for contracts issued or renewed on or after January 1, 2015.

The bill will take effect on July 1, 2014.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.64198, F.S., coverage for skin cancer screenings; required coverage and payment.
Section 2: Creates s. 627.66912; F.S.; coverage for skin cancer screenings; required coverage and payment.
Section 3: Creates s. 641.31091, F.S.; coverage for skin cancer screenings; required coverage and payment.
Section 4: Providing an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill's additional mandated coverage on the state employee group health plan would generate an increase in premiums, and require additional revenue to the State Employee Group Health Insurance Trust Fund to cover that premium increase (see Expenditures, below). The bill has no impact on overall state revenues.

2. Expenditures:

Under current federal law (PPACA) and rule, Florida must defray the private sector costs to insurers and employers of the bill's skin cancer screening benefit and copayment restriction mandate current. The Office of Insurance Regulation (OIR) estimates that the state expenditures for defraying the private sector costs is between $9.3 million and $16 million annually.

For the state employee group health plan, the DSGI has estimated an annual increase of $357,580 for no cost sharing liability in the coverage of annual skin cancer screenings.

Health Plan	Member count utilized for fiscal analysis by health plan	Per Member Per Month (PMPM)	Annual increase
Self-Insured Plans			
United Health Care	56,000	$0.14	$39,000.00
Aetna	60,225	$0.07	$53,758.00
Florida Blue	151,290	$0.14	$256,000.00
Fully Insured Plans			
Capital Health Plan	54,073	$0.014	$8,822.00
Total			**$357,580.00**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

[71] Office of Insurance Regulation, *Agency Bill Analysis – SB 56/HB 241 (November 9, 2023) (on file with the Select Committee on Health Innovation).*

1. Revenues:

   Local governments providing health insurance coverage for employees may need to raise premiums to cover the cost of the additional coverage required by the bill, which would generate additional revenue. As noted in the OIR estimates for the added benefit and the prohibition of cost sharing by the insured, local governments who are not currently providing this benefit at this level may see a premium impact from $0.07 to $0.14 per member per month.[72]

2. Expenditures:

   While the additional coverage required by the bill would require local governments to pay for this coverage, the PPACA requirement for the state to defray such costs would negate the impact on local governments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The inclusion of coverage for skin cancer screenings with cost sharing restrictions may positively impact physicians who likely will see an increased demand for their services as well as collateral and ancillary medical supports such as laboratories and diagnostic offices which will be called upon to process additional lab slips, biopsies, and scans.

D. FISCAL COMMENTS:

The OIR noted that the current legislation authorizes only licensed dermatologists to perform the annual skin cancer screenings under HB 241. Since many skin cancer screenings are conducted by advanced practice registered nurses and physician assistants currently, there may be a significant decrease in the number of these practitioners available to conduct the screenings and it may make it difficult for insureds to get a timely appointment.[73]

The bill also prohibits an insurer from bundling payments for skin cancer screenings performed under this bill with any other procedure. According to DSGI, State Group insurers do bundle payments currently based on the primary code and there is no current CPT code for “skin cancer screenings.” As a result, the insurers may have to manually review clinical records to input these changes and update several systems and processes. Plans may incur costs related to this administrative burden and for updates to claims processing systems.[74]

The OIR will need to amend its form review checklists and procedures to incorporate this new requirement. A higher incidence of skin cancer diagnosis may also result in higher premiums with an enhanced screening program.[75]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The county/municipality mandates provision of Art. VII, section 18, of the Florida Constitution may apply because this bill requires local governments to provide an additional health insurance coverage item with no cost sharing. However, the cost of the additional coverage is likely to be insignificant, based upon the OIR estimates of required premium increases and depending on plan enrollment size. In addition, counties and municipalities can expect to be made whole by the state for any increased expenditures under the bill, based on application of current federal law requiring states to defray the costs of additional health insurance coverage mandates.

[72] Supra note 73.
[73] Id.
[74] Supra note 72.
[75] Supra note 73.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The OIR and the DSGI have sufficient rule-making authority under current law to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The OIR notes that as the bill is currently written, the requirement to include coverage for skin cancer screenings would apply to all types of health insurance policies, including supplemental products such as dental and vision insurance products.[76]

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

[76] Id.

A bill to be entitled

An act relating to coverage for skin cancer screenings; creating ss. 627.64198, 627.66912, and 641.31091, F.S.; requiring individual health insurance policies; group, blanket, and franchise health insurance policies; and health maintenance contracts, respectively, to provide coverage and payment for annual skin cancer screenings performed by a licensed dermatologist without imposing any cost-sharing requirement; specifying a requirement for and a restriction on payments for such screenings; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.64198, Florida Statutes, is created to read:

627.64198 Coverage for skin cancer screenings; required coverage and payment.—

(1) A health insurance policy issued or renewed on or after January 1, 2025, must provide coverage and payment, without imposing a deductible, copayment, coinsurance, or any other cost-sharing requirement, for annual skin cancer screenings performed by a dermatologist licensed pursuant to chapter 458 or chapter 459. Payment for such screenings must be

consistent with the insurer's payments for other preventive screenings as defined by the American Medical Association's Current Procedural Terminology code set.

(2) An insurer may not bundle a payment for skin cancer screenings performed pursuant to subsection (1) with any other procedure or service, including an evaluation and management visit, which is performed during the same office visit or a subsequent office visit.

Section 2. Section 627.66912, Florida Statutes, is created to read:

627.66912 Coverage for skin cancer screenings; required coverage and payment.—

(1) A group, blanket, or franchise health insurance policy issued or renewed on or after January 1, 2025, must provide coverage and payment, without imposing a deductible, copayment, coinsurance, or any other cost-sharing requirement, for annual skin cancer screenings performed by a dermatologist licensed pursuant to chapter 458 or chapter 459. Payment for such screenings must be consistent with the insurer's payments for other preventive screenings as defined by American Medical Association's Current Procedural Terminology code set.

(2) An insurer may not bundle a payment for skin cancer screenings performed pursuant to subsection (1) with any other procedure or service, including an evaluation and management visit, which is performed during the same office visit or a

subsequent office visit.

Section 3. Section 641.31091, Florida Statutes, is created to read:

641.31091 Coverage for skin cancer screenings; required coverage and payment.—

(1) A health maintenance contract issued or renewed on or after January 1, 2025, must provide coverage and payment, without imposing a deductible, copayment, coinsurance, or any other cost-sharing requirement, for annual skin cancer screenings performed by a dermatologist licensed pursuant to chapter 458 or chapter 459. Payment for such screenings must be consistent with the health maintenance organization's payments for other preventive screenings as defined by American Medical Association's Current Procedural Terminology code set.

(2) A health maintenance organization may not bundle a payment for skin cancer screenings performed pursuant to subsection (1) with any other procedure or service, including an evaluation and management visit, which is performed during the same office visit or a subsequent office visit.

Section 4. This act shall take effect July 1, 2024.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___ (Y/N)
ADOPTED AS AMENDED	___ (Y/N)
ADOPTED W/O OBJECTION	___ (Y/N)
FAILED TO ADOPT	___ (Y/N)
WITHDRAWN	___ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Select Committee on Health Innovation

Representative Massullo offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (5) is added to section 110.12303, Florida Statutes, to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting.—

(5) Coverage for annual skin cancer screenings.

(a) Effective with any state group health insurance plan policies issued or after January 1, 2025, the department shall require coverage and payment, without imposing a deductible, copayment, coinsurance, or any other cost sharing requirement on the covered individual, for annual skin cancer screenings

performed by a dermatologist licensed under chapter 458 or chapter 459, an or an advanced practice registered nurse licensed pursuant to chapter 464 who is under the supervision of a dermatologist licensed under chapter 458 or chapter 459. Payment for such screenings must be consistent with how the covered individual's plan pays for other preventive screenings as preventive screenings is defined by the American Association's Current Procedural Terminology code set.

(b) An insurer or health plan participating under this section may not bundle a payment for skin cancer screenings performed pursuant to subsection (5) with any other procedure or service, including an evaluation and management visit which is performed during the same office visit or a subsequent office visit.

Section 2. This act shall take effect July 1, 2024.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert: A bill to be entitled an act relating to coverage for skin cancer screenings; amending s. 110.12303, F.S.; requiring the department to provide coverage and payment for annual skin cancer screenings performed by a licensed dermatologist, licensed physician assistant, or licensed advanced practice nurse practitioner under certain conditions without imposing any

cost-sharing requirement; specifying a requirement for and a restriction on payments for such screenings; providing an effective date.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___ (Y/N)
ADOPTED AS AMENDED	___ (Y/N)
ADOPTED W/O OBJECTION	___ (Y/N)
FAILED TO ADOPT	___ (Y/N)
WITHDRAWN	___ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Select Committee on Health Innovation

Representative Tramont offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (5) is added to section 110.12303, Florida Statutes, to read:

110.12303 State group insurance program; additional benefits; price transparency program; reporting.—

(5) Coverage for annual skin cancer screenings.

(a) Effective January 1, 2025, the department shall require all contracted state group health insurance plans and HMO's to provide coverage and payment, without imposing a deductible, copayment, coinsurance, or any other cost sharing requirement on the covered individual, for annual skin cancer screenings

performed by a dermatologist licensed under chapter 458 or chapter 459, or by a physician assistant licensed under chapter 458 or chapter 459 or an advanced practice registered nurse licensed under chapter 464 who is under the supervision of a dermatologist licensed under chapter 458 or chapter 459. Payment for such screenings must be consistent with how the state group health insurance plan or HMO pays for other preventive screenings as preventive screenings as defined by the American Medical Association Current Procedural Terminology code set.

(b) A state group health insurance plan or HMO participating under this section may not bundle a payment for skin cancer screenings performed under this subsection with any other procedure or service, including, but not limited to, an evaluation and management visit which is performed during the same office visit or a subsequent office visit.

Section 2. This act shall take effect July 1, 2024.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert: A bill to be entitled an act relating to coverage for skin cancer screenings; amending s. 110.12303, F.S.; requiring the Department of Management Services to provide coverage and payment through state employee group health insurance contracts for annual skin cancer screenings, performed by a licensed

dermatologist, physician assistant, or advanced practice registered nurse under specified conditions without imposing any cost-sharing requirement; specifying a requirement for and a restriction on payments for such screenings; providing an effective date.

HB 659

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 659 Health Plans
SPONSOR(S): Abbott
TIED BILLS: **IDEN./SIM. BILLS:** SB 584

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation		Lloyd	Calamas
2) Insurance & Banking Subcommittee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

The Agency for Health Care Administration (AHCA) contracts with a third party resolution organization for the review of the claim disputes between health care providers, health insurers and health maintenance organizations. Claims are reviewed by the organization and then submitted to the AHCA with a payment recommendation based on desk reviews by the third party resolution organization and, if requested, a review of evidence and additional documentation in a hearing. Acting as an alternative dispute resolution process for eligible heath care providers and insurers, the AHCA issues any final order after receipt of the recommendation and the non-prevailing party or parties has 35 days to pay. Non-prevailing parties are also responsible for review costs incurred by the review organization and their share of any costs from a hearing.

HB 659 prohibits a health plan from declining to participate in Program when the health plan had a disputed claim under review. However, providers, both group and individual health insurers, and health plans still retain the ability to file a dispute in state or federal court, but once a suit has been filed, the claim can no longer be considered by the Statewide Provider and Health Plan Claim Dispute Program (Program). Additionally, if a provider or a plan fails to respond to a request for supporting documentation within 15 days after receipt of a request from the Program, the AHCA will issue a default against the provider and notify the AHCA of the default.

The bill creates requirements for a standardized identification card for insureds that clearly identifies whether or not the plan is subject to state regulation and which provides the insured with quick access information to the consumer services website of the Department of Financial Services' Division of Consumer Services website.

The bill has an indeterminate fiscal impact on state, local, governments and the private sector.

The bill provides for an effective date of January 1, 2025.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Statewide Provider and Health Plan Claim Dispute Resolution Program

The Statewide Provider and Health Plan Claim Dispute Resolution Program (Program) assists contracted and non-contracted providers and managed care organizations with the resolution of claim disputes.[1] The Agency for Health Care Administration (AHCA) contracts with a third party resolution organization (MAXIMUS) for the timely review, consideration, and recommendation for these filed claim disputes. The Program serves as a modified alternative dispute resolution process for health plans and providers who have payment disputes. Typically, these payment disputes are between larger facilities and smaller providers who do not have an existing contractual relationship. The program was designed to resolve only disputes between providers, health maintenance organizations (HMOs), prepaid health clinics, exclusive provider organizations, prepaid health plans, medical expense insurance policies, preferred provider organizations, and Statewide Medicaid Managed Care Plans.[2] The existing contract language has been repeated in the 2023-2024 re-procurement of the SMMC contracts.

Certain types of claims are excluded from consideration such as those related to interest payments, or claims that do not meet a minimum aggregate threshold as established by agency rule.[3] A physician or health care facility filing an appeal must aggregate claims for one or more patients from the same insurer, which is also referred to as batching of claims.

Claims are also excluded if:

- Related to an internal Medicare managed care organization;
- Part of a reconsideration of a claim appeal through the Medicare appeals process;
- Related to a health plan not regulated in Florida;
- Is the basis for an action pending in state or federal court;
- Part of a Medicaid Fair Hearing Process pursued under 42 C.F.R. ss. 431.220 et seq.; or,
- Is the subject to a binding-claim-dispute-resolution process provided by contract entered into prior to October 1, 2000, between the provider and managed care organization.[4]

[1] S. 408.7057. F.S.
[2] *Supra,* note 7.
[3] *See* 59A-12.030, Statewide Provider and Health Plan Claim Dispute Resolution Program. The jurisdictional threshold amounts are the minimum, aggregate amount that a claim or claims must total for consideration by the Program. For health plan contracted hospitals, the threshold is $25,000 and for non-contracted hospitals, the threshold is $10,000.
[4] S. 408.7057(2)(b)1.-7, F.S.

MAXIMUS operated a toll-free hotline to provide information and dispute application forms to interested parties while the contractor. The contract was a "no cost" contract to the state in that MAXIMUS was paid by the users of the Program. Costs for the Program were to be set by the AHCA through the rulemaking process. The final rule established that the non-prevailing party would pay the review costs. If both parties prevailed in parts of the action, then the costs of the review fee are required to be apportioned based on the final judgement.[5]

When a claim is received, it is investigated either through a desk review of the documentation submitted by the parties or sometimes through the involvement of other experts. Either party may call an evidentiary hearing to review the evidence and call witnesses.[6] Each party pays for the costs of their own witnesses, but the parties share the cost of the hearing equally.[7]
The AHCA's responsibility is to issue a final order adopting the recommendation of the resolution entity. The failure of the non-prevailing party to pay the ordered review cost within 35 days of the agency's order subjects the nonpaying party to a penalty of not more than $500 per day until the penalty is paid.[8]

The chart below shows the volume of claims received by the Program and the status of claims at the end of each reporting year. The total number of claims filed with the system has dramatically increased in the past two years.[9]

Statewide Provider Health Plan Claim Dispute Program - Trends					
Year	Claims Received	Claims Reviewed	Claims Withdrawn	Claims Ineligible/ Dismissed	Highest Claim (aggregated)
2019	74	45	7	19	$675,209
2020	68	41	13	19	$669,012
2021	111	73	13	19	$2,320,399
2022	563	443	7	19	$1,001,694,838

Currently, the Program does not have a vendor to process claims. The contract with previous third party administrator ended June 30, 2023 and the AHCA has started a new procurement for a replacement vendor. No new claims are being accepted until a new vendor is in place.

Federal External Review Process

As part of the federal Patient Protection and Affordable Care Act (PPACA), patients were to be provided both an internal and external appeals process for review of unpaid claims.[10] For states which did not have an external review process that met those standards or if the individual was in a certain type of plan such as a self-insured plan, then the federal external review process would apply. Similarly, for claims disputes between providers and facilities, for disputes between providers and facilities.[11]

Standard Health Plan Identification Cards

The *No Surprises Act* addressed many health care transparency and consumer empowerment provisions which ensure that the patient receives accurate and up to date information from his or her

[5] Rule 59A-12.030(4)(a), F.A.C.
[6] 59A-12.030, F.A.C.(7).
[7] Id.
[8] S. 408.7057(5), F.S.
[9] Agency for Health Care Administration, *Statewide Health Provider and HealthPlan Claim Dispute Resolution Program,* available at https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-health-facility-regulation/certificate-of-need-and-commercial-managed-care-unit/commercial-managed-care/statewide-provider-and-health-plan-claim-dispute-resolution-program (last reviewed January 10, 2024). Chart created from data retrieved from individual Annual Reports from 2019 through 2022.
[10] Public Law 111-148 (March 10, 2010) and Public Law 111-152 (March 30, 2010).
[11] Sec. 340B of the Public Health Service Act (42 U.S.C. 256b) (PHSA), as amended.

insurer on a consistent basis allowing the patient to make better informed health care choices. One provision included in the *No Surprises Act* addresses the standard content to be included on every group or individual health plan identification card whether the card is a physical card or digital.

Current law addresses information on both health plan and prescription benefits cards. For prescription drug cards, a list of requirements includes the name of the claims processor, the processor's address and the help desk phone number; the insured's prescription group number, identification number and name; and any other information helpful to the timely processing of a claim. Information can be embedded on the card or through a magnetic stripe.[12] The HMOs must provide information in a readily identifiable manner or have the information be embedded on the card such that it can be easily accessed through a magnetic reader or smart card also . The information may also be provided through other electronic technology.[13]

Beginning January 1, 2022, the law required health plans and insurers to include the following minimum information on the insured's card:

- Any deductible applicable to coverage.
- Any out of pocket maximum applicable to the coverage.
- A telephone number and website address that individuals can use to find consumer assistance information and facilities and providers under contract with the plan.[14]

Effect of Proposed Changes

Statewide Provider and Health Plan Claim Dispute Resolution Program Authority

HB 659 modifies the Statewide Provider and Health Plan Claim Dispute Resolution Program (Program) to require eligible health insurers and health plans with claims that meet the designated thresholds to participate in the program. Currently, the only plans required to participate in the Program are those contracted plans in the SMMC program. Participants retain the option of seeking recourse for claims disputes through litigation in state or federal court rather than through this alternative dispute resolution process. The proposed changes provide the AHCA with the necessary authority to assess sanctions on non-responsive participants and to implement final orders once issued..

HB 659 establishes a specific time standard for payment of any orders at 35 days after the order is entered and provides a daily fine for each day such payment is not made. Existing statutes does not include such a standard and the AHCA does not currently have the authority to enforce the orders issued from the current process. If the Program today issues an order for payment to a party, the AHCA is not able to set a timeline or deadline for payment and cannot anticipate when a payment may or may not be received or for what amount.

Standard Health Plan Identification Cards

The requirements to incorporate certain standardized components to any hard copy or digital health insurance benefits card became effective under the *No Surprises Act* in 2022. HB 693 enhances those provisions for any plan subject to state regulation and provides other requirements for non-state regulated plans.

For the card, the bill requires:

- The letters "FL" on the back, left-hand side of the card; and
- A quick response code (QR) on the card which directs the insured or subscriber to a consumer services website of the Division of Consumer Services of the Department of Financial Services.

On the website, requirements for posting information will depend on the type of plan and may include:

[12] Ch. 627.4302, F.S.
[13] Ch. 641.31(42), F.S. Similar provisions for identification cards issued under individual coverage can be found at 627.642, F.S., and at 627.657, F.S. for group health insurance policies.
[14] 42 U.S.C. 300gg-111(e).

- Name of regulatory entity with relevant contact information, including a telephone number or website hyperlink; and
- A notice that if the letters "FL" are not included, that the plan may not be regulated by the State of Florida and direct the consumer to the Division of Consumer Services website.

These changes are effective with any identification cards issues or reissued on or after January 1, 2025.

The bill provides an effective date of January 1, 2025.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.7057, F.S.; prohibits health plans from declining to participate in filed claims and provides defaults against health plans for failure to respond; requires the Agency for Health Care Administration to provide health plans with notices of failure to pay providers the amounts provided in claim dispute orders within a specified period of time; requires health plans to pay providers the amounts provided in the claims dispute process under certain circumstances; and provides penalties for failure to pay such amounts.

Section 2: Amends s. 627.4302, F.S.; requires certain health insurance plans and health maintenance organization benefit identification cards to include specific information in a certain manner and provides the Agency for Health Care Administration with rulemaking authority.

Section 3: Amends s. 627.642, F.S., requires certain health maintenance organization benefit identification card to include specific information in a certain manner and provides the AHCA with rulemaking authority.

Section 4: Amends s. 627.657, F.S.; requires certain health insurers to include specific information in a certain manner on its identification cards and provides the AHCA with rulemaking authority.

Section 5: Amends s. 641.31, F.S.; requires certain health insurers to include specific information in a certain manner on its identification cards and provides the AHCA with rulemaking authority.

Section 6: Authorizes the AHCA to conduct rulemaking to implement the provisions of the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

HB 659 authorizes the AHCA to assess a penalty on non-prevailing providers who fail to pay the required amount within 35 days of a final order. The amount of the penalty must be established by rule and may not exceed $500 per day. Currently, the statute does not permit the AHCA to assess a fee or penalty on parties who fail to pay an order.

Any fees collected would be additional revenue to the AHCA. The amount can be no more than $500 and AHCA indicates that the current rule for the Program would be revised and updated to allow for this assessment and collection.

The total amount that could be collected is indeterminate given a number of unknown variables, including the penalty amount or methods to be set out in the AHCA rule, the amount collection rate, and also unknown is how much participation behavior or negotiation behavior may change under a revised participation model.

2. Expenditures:

The AHCA is required to contract with a third party vendor to handle the Program. Previous contracts with the prior vendor were "no cost" contracts where the vendor was paid from the fees

collected from the voluntary participants in the process. However, the vendor's contract ended June 30, 2023 and no new disputes are being considered until a new contract is awarded.[15]

The state has required all contracted SMMC plans to participate in the Program and has prohibited opt outs by those plans. An alternative dispute process on disputed claims may result in lower than expected claims costs for the SMMC plans which can result in lower than expected trend rates with medical costs from out of network providers over time.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

More extensive use of the Program by providers and insurers to resolve disputes could result in lower costs to all parties leading in the long term to lower premiums. Insurers and health plans as well as providers spread risk and costs among all paying customers. When there are more claims that are paid rather than unpaid, then the plans and providers have less financial responsibility or risk to spread to other customers.

2. Expenditures:

If local governments are self-funded, those local governments may incur costs related to the new identification cards that must be produced to the federal specifications. Additionally, self-funded plans are subject still to the federal external review process and not the state process. If local government were to file a claims dispute as a payor, the federal review process does have fees associated with such filings; however, the amounts are currently under review.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A health plan that does not comply with a final order would face the suspension or loss of its Health Care Provider Certificate, according to the AHCA, as it is considered a sanction. Such non-compliance with an order has the practical effect of prohibiting the entity from conducting business as a managed care entity. The disruption in health care to its members and to that company's operations would likely be significant.

D. FISCAL COMMENTS:

The cost of the new vendor contract to oversee the state's provider dispute process is unknown. Until the vendor is selected and a schedule of fees or other costs are released, it is difficult to determine the total fiscal impact of revised participation provisions in the state process.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable.

2. Other:

The federal process has been challenged in different jurisdictions from the amount of the filing fees to how claims are batched together and reviewed. The federal portal has opened and closed several times during these different legal challenges and federal CMS has recently re-opened the portal and began processing claim requests.

[15] MyFloridaCFO, *Consumer Services – Medical Providers,* available at https://myfloridacfo.com/division/consumers/medicalprovider/ (last viewed January 9, 2024).

B. RULE-MAKING AUTHORITY:

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health plans; amending s. 408.7057, F.S.; prohibiting health plans from declining to participate in filed claims; providing defaults against health plans for failure to respond; requiring the Agency for Health Care Administration to provide health plans with notices of failure to pay providers the amounts provided in claim dispute orders under certain circumstances; requiring health plans to pay providers the amounts provided in claim dispute orders under certain circumstances; providing penalties for failure to pay such amounts; amending s. 627.4302, F.S.; requiring certain health insurance and health maintenance organization benefits-identification cards to include specified information in a certain manner; providing applicability; providing rulemaking authority; amending ss. 627.642, 627.657, and 641.31, F.S.; requiring certain health insurance and health maintenance organization identification cards to include specified information in a certain manner; providing applicability; providing rulemaking authority; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (7) of section 408.7057, Florida Statutes, is renumbered as subsection (8), subsection (5) is amended, paragraph (i) is added to subsection (2), and a new subsection (7) is added to that section, to read:

408.7057 Statewide provider and health plan claim dispute resolution program.—

(2)

(i) A health plan may not decline to participate in a filed claim. Failure to respond as provided in paragraph (f) shall result in a default against the health plan.

(5) The agency shall notify within 7 days the appropriate licensure or certification entity whenever there is:

(a) A failure to pay as provided in subsection (7); or

(b) A violation of a final order issued by the agency pursuant to this section.

(7) A health plan that does not prevail in the agency's order shall pay the provider the amount provided in the order within 35 days after the order is entered. A health plan that does not pay the required amount within this timeframe is subject to a penalty of not more than $500 per day until the amount is paid.

Section 2. Subsection (2) of section 627.4302, Florida Statutes, is amended to read:

627.4302 Identification cards for processing prescription drug claims.—

(2) Any health insurer or health maintenance organization and all state and local government entities entering into an agreement to provide coverage for prescription drugs on an outpatient basis shall provide a benefits-identification card containing the following information:

(a) The name of the claim processor.

(b) The electronic-claims payor identification number or the issuer identification number, also referred to as the Banking Identification Number or "BIN," assigned by the American National Standards Institute.

(c) The insured's prescription group number.

(d) The insured's identification number.

(e) The insured's name.

(f) The claims submission name and address.

(g) The help desk telephone number.

(h) The type of plan, only if the plan is filed in this state; an indication that the plan is self-funded; or the name of the network.

1. If the plan is subject to state regulation, the identification card must include the letters "FL" on the back left-hand corner of the card, under which a quick response (QR) code must be displayed directing the insured or the subscriber to the consumer services website of the Division of Consumer Services of the department. Based on the plan, the website may display the name of the regulatory entity with relevant contact

information, including a telephone number or website hyperlink for the entity. The website may also include the following notice: "If your plan card does not display 'FL' on the back left-hand corner of the card, your plan may be regulated by another state, another Florida state agency, or the Federal Government. If you need assistance in locating the appropriate regulator for your plan, please visit the Get Insurance Help web page of the Division of Consumer Services."

2. Subparagraph 1. applies to benefits-identification cards issued or reissued on or after January 1, 2025.

3. The department may adopt rules to implement necessary changes to the consumer services website and hotline of the Division of Consumer Services to best assist insureds or subscribers who are at an impasse with their insurers or health maintenance organizations, respectively.

(i) ~~(h)~~ Any other information that the entity finds will assist in the processing of the claim.

The information required in paragraphs (a), (b), (g), and (i) ~~(h)~~ must be provided on the card, unless instruction is provided on the card for ready access to such information by electronic means.

Section 3. Paragraph (c) of subsection (3) of section 627.642, Florida Statutes, is amended to read:

627.642 Outline of coverage.—

(3) In addition to the outline of coverage, a policy as specified in s. 627.6699(3)(k) must be accompanied by an identification card that contains, at a minimum:

(c) The type of plan, only if the plan is filed in this ~~the~~ state; ~~,~~ an indication that the plan is self-funded; ~~,~~ or the name of the network.

1. If the plan is subject to state regulation, the identification card must include the letters "FL" on the back left-hand corner of the card, under which a quick response (QR) code must be displayed directing the insured to the consumer services website of the Division of Consumer Services of the department. Based on the plan, the website may display the name of the regulatory entity with relevant contact information, including a telephone number or website hyperlink for the entity. The website may also include the following notice: "If your plan card does not display 'FL' on the back left-hand corner of the card, your plan may be regulated by another state, another Florida state agency, or the Federal Government. If you need assistance in locating the appropriate regulator for your plan, please visit the Get Insurance Help web page of the Division of Consumer Services."

2. Subparagraph 1. applies to identification cards issued or reissued on or after January 1, 2025.

3. The department may adopt rules to implement necessary changes to the consumer services website and hotline of the

Division of Consumer Services to best assist insureds who are at an impasse with their insurers.

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 4. Paragraph (c) of subsection (2) of section 627.657, Florida Statutes, is amended to read:

627.657 Provisions of group health insurance policies.—

(2) The medical policy as specified in s. 627.6699(3)(k) must be accompanied by an identification card that contains, at a minimum:

(c) 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.

1. If the plan is subject to state regulation, the identification card must include the letters "FL" on the back left-hand corner of the card, under which a quick response (QR) code must be displayed directing the insured or the subscriber to the consumer services website of the Division of Consumer Services of the department. Based on the plan, the website may display the name of the regulatory entity with relevant contact information, including a telephone number or website hyperlink

for the entity. The website may also include the following notice: "If your plan card does not display 'FL' on the back left-hand corner of the card, your plan may be regulated by another state, another Florida state agency, or the Federal Government. If you need assistance in locating the appropriate regulator for your plan, please visit the Get Insurance Help web page of the Division of Consumer Services."

2. Subparagraph 1. applies to identification cards issued or reissued on or after January 1, 2025.

3. The department may adopt rules to implement necessary changes to the consumer services website and hotline of the Division of Consumer Services to best assist insureds who are at an impasse with their insurers.

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. Paragraph (c) of subsection (42) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(42) The contract, certificate, or member handbook must be accompanied by an identification card that contains, at a minimum:

(c) 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.

1. If the plan is subject to state regulation, the identification card must include the letters "FL" on the back left-hand corner of the card, under which a quick response (QR) code must be displayed directing the insured or the subscriber to the consumer services website of the Division of Consumer Services of the department. Based on the plan, the website may display the name of the regulatory entity with relevant contact information, including a telephone number or website hyperlink for the entity. The website may also include the following notice: "If your plan card does not display 'FL' on the back left-hand corner of the card, your plan may be regulated by another state, another Florida state agency, or the Federal Government. If you need assistance in locating the appropriate regulator for your plan, please visit the help web page of the Division of Consumer Services."

2. Subparagraph 1. applies to identification cards issued or reissued on or after January 1, 2025.

3. The department may adopt rules to implement necessary changes to the consumer services website and hotline of the Division of Consumer Services to best assist subscribers who are at an impasse with their health maintenance organizations.

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 6. This act shall take effect January 1, 2025.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 877 Electronic Health Records
SPONSOR(S): Overdorf
TIED BILLS: **IDEN./SIM. BILLS:** SB 668

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation		Guzzo	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Health information exchange networks allow health care providers to access and securely share a patient's electronic health record. Health care facilities and providers use national health information exchange networks to securely share comprehensive clinical records with participating providers. These national networks use standardized approaches to sharing health information, share health information securely, and reduce the need for multiple connections.

The Florida Health Information Exchange (FHIE) facilitates the secure statewide exchange of health information between health care providers, hospital systems, and payers. The FHIE also offers an encounter notification service (ENS), which provides real-time notice of patient health encounters from acute and post-acute care facilities across Florida. These facilities send admit, discharge, and transfer data messages in real-time and ENS compares them to patient lists provided by subscribing health care organizations.

The Emergency Patient Look-Up System (E-Plus) is a HIPAA compliant, cloud-based software solution designed for public health officials and emergency responders to fill critical information gaps during times of disaster. AHCA administers E-PLUS for disaster response organizations and agencies throughout the state of Florida

HB 877 requires all hospitals, including specialty hospitals, to connect to a national network directly or through a third-party vendor to support the exchange of patient medical records. The bill also requires all hospitals with certified electronic health records systems to share ADT data with the Florida ENS. The bill provides rulemaking authority to AHCA to implement these provisions.

The bill also requires community pharmacies that are enabled to accept electronic prescriptions to share pharmacy data with E-PLUS. This will allow medical personnel involved in disaster preparedness and response to have access to a patient's medication history to ensure they can provide patient care during declared emergencies.

The bill has no fiscal impact on state or local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

National Health Information Exchange Networks

Health information exchange (HIE) networks allow health care providers to access and securely share a patient's electronic health record (EHR). EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

There are over 6,000 Florida provider organizations connected to the national networks. The national networks are made up of trusted exchange partners that securely share comprehensive clinical records across participating providers and across state lines. These national networks use standardized approaches to sharing health information, share health information securely, and reduce the need for multiple connections. The three largest networks, eHealth Exchange, Commonwell, and Carequality are working together to facilitate data exchange between each other.[1]

The largest health care information network in the country is eHealth exchange. It is a nonprofit health information exchange network made up of 72 regional and state health information exchanges, five Federal Agencies, 75% of all U.S. hospitals, 70,000 medical groups, and 5,800 dialysis centers. Other provider types that are connected to the eHealth Exchange include pharmacies, academic institutions, provider collaboratives, and integrated delivery networks.[2]

Fees for participating in eHealth Exchange vary depending on how large a connecting entity's network is, the technical infrastructure they are connecting with, and other factors. The range of annual fees for providers and health information networks is based on their net patient revenue or total expenses. The range of annual fees starts at $5,000 for providers with less than $1 million in net patient revenue and up to $41,000 for those with more than $5 billion in net patient revenue.[3]

The Florida Health Information Exchange

The Florida Health Information Exchange (FHIE) facilitates the secure statewide exchange of health information between health care providers, hospital systems, and payers. The FHIE is governed by the Agency for Health Care Administration (AHCA) by establishing policy, convening stakeholders, providing oversight, engaging federal partners, and promoting the benefits of health information technology.[4] AHCA uses a contracted vendor, Audacious Inquiry, to contribute innovative technology solutions and strategic insight, and manage the day-to-day operations of the FHIE.[5]

The FHIE electronically makes patient health information available to participating providers, including doctors, nurses, hospitals, and health care organizations. The exchange of patient information is protected through strict medical privacy and confidential procedures.[6] The FHIE consists of two services, patient record exchange and encounter notification, to improve the speed, quality, safety, and cost of patient care.

FHIE Services

[1] Agency for Health Care Administration, Agency Analysis of 2024 House Bill 877 (Oct. 20, 2023).
[2] *Id.*
[3] eHealth Exchange, Pricing, Annual Fees for Providers and Health Information Networks, available at https://ehealthexchange.org/pricing/ (last visited January 11, 2024).
[4] Agency for Health Care Administration, Florida HIE Services, *What is the Florida HIE?*, available at https://florida-hie.net/about/ (last visited January 11, 2024).
[5] *Id.*
[6] *Id.*

Patient Record Exchange

Currently, Florida hospitals are not required to connect to national health information exchange networks. The FHIE encourages health care organizations to connect to one of three national exchanges — eHealth exchange, Carequality, or CommonWell — or to regional HIEs. Currently, 236 of the 323 licensed hospitals in Florida are connected to a national network.[7]

Encounter Notification Service

The FHIE also offers an encounter notification service (ENS), which provides real-time notice of patient health encounters from acute and post-acute care facilities across Florida. These facilities send patient admission, discharge, and transfer data messages in real-time and ENS compares them to patient lists provided by subscribing health care organizations. When a listed patient receives care at a participating facility, paid subscribers receive an alert containing details about that patient's health encounter. Currently, over 10 million monthly alerts are being sent and more than 800 data sources are supported by ENS. Of the 800, 236 are Florida hospitals with 87 hospitals not currently connected. The data subscription agreements, made up in part by 551 data sources, include the following:[8]

- 95% of licensed acute care hospitals;
- 225 skilled nursing facilities;
- 64 urgent care centers;
- 22 hospice providers;
- 5 crisis stabilization units;
- Statewide emergency medical services treat-and-release providers; and
- All 67 county health departments.

There are no costs to connect to ENS as a data source. There may be some cost to the hospital from their EHR vendor to integrate into the ENS.[9] ENS as a data source provides patient information that gets matched with a subscriber's patient list.

While there are no costs to connect to ENS as a data source, providers do have to pay a fee if they wish to subscribe to receive alerts on their patients. The annual fee ranges from $500 up to $7,500.[10] The benefit of this type of subscription is that they receive real-time admission, discharge, and transfer alerts on their patients for follow-up and care coordination. Additionally, providers can target specific diagnoses and/or conditions, such as asthma, behavioral health conditions, and other conditions at higher risk for potential hospital readmissions.

Additionally, ENS supports public health activities including real-time reporting of inpatient hospital stays for syndromic surveillance, data sharing with county health departments, emergency medical services, and health care registries. Although data sharing has grown and improved over time, AHCA indicates that several providers do not share complete data sets. This is due to various reasons such as workflow issues or staff turnover. The incomplete data limits the ability for subscribers of ENS to have a complete picture of patient care.[11]

Hospitals that receive Low Income Pool funding are required to participate in the Florida HIE's Encounter Notification Service and Medicaid Managed Care Plans also participate as a contractual requirement.

[7] *Supra* note 1.
[8] *Id.*
[9] *Id.* at pg. 3. Vendor costs are approximately $5,000 for integration.
[10] *Supra* note 1. *See also* AHCA, Florida HIE Services, Pricing Guide for ENS, available at https://floridahie.wpengine.com/wp-content/uploads/2022/05/Pricing_Guide_for_ENS_2022.pdf (last visited January 11, 2024).
[11] *Supra* note 1.

Emergency Patient Look-Up System (E-PLUS)

E-PLUS is a HIPAA compliant, cloud-based software solution designed for public health officials and emergency responders to fill critical information gaps during times of disaster. AHCA administers E-PLUS for disaster response organizations and agencies throughout the state of Florida. At the county level, organizations utilizing E-PLUS include county health departments, emergency management authorities, health systems, and law enforcement agencies. At the regional and state level, users include Department of Health regional planners and special needs shelter consultants, state emergency operations center Emergency Support Function 8 (ESF-8) staff, and disaster response organizations such as End Stage Renal Disease (ESRD) Network 7 and the Florida chapter of the Red Cross.[12]

The system includes the ability to electronically track patients entering and leaving a special needs shelter and adds this to the ENS, thereby improving care coordination by alerting providers and health plans that their patients or members have been evacuated to a special needs shelter. E-PLUS also allows users to search for missing persons by loading lists of missing people which are bounced against the ENS to see if a recent encounter has occurred.[13]

The system also allows authorized users to query patient clinical records and medication fill histories via the national health information exchange networks. E-PLUS is connected to two national networks, the eHealth Exchange and Surescripts. Surescripts is a national network which connects pharmacies and supplies E-PLUS with a 12-month medication fill history, meaning the medications were filled and paid for at a pharmacy. For example, Medicaid prescription filling histories are fed into Surescripts directly by the pharmacy or through claims data held by a plan's pharmacy benefit manager.

E-PLUS was activated on September 24, 2022, following the governor's emergency declaration, Executive Order 22-218 related to Hurricane Ian. During that activation, Publix Pharmacy was requested on behalf of Lee County to assist in performing medication reconciliations at shelters still in operation during the week after landfall. AHCA discovered that not all pharmacies that share data with Surescripts have opted to share data with E-PLUS during declared disasters. As of the end of 2022, 97.1 percent of all Florida pharmacies were connected to the Surescripts network, but AHCA cannot determine which pharmacies are and are not sharing data through Surescripts.[14]

The E-PLUS activation for Hurricane Ian resulted in the following:

- 234 queries for clinical documents and 386 medication searches;
- 10 shelters had access to search for patients;
- 131 people were checked into special needs shelters;
- 42 subscribers received alerts originating from the special needs shelters; and
- 47 percent of the dialysis patients reported missing by ESRD Network 7 were located.

Effect of the Bill

HB 877 requires all hospitals, including specialty hospitals, to connect to a national network directly or via another health information exchange provider to support the exchange of patient medical records. The bill also requires all hospitals with certified electronic health records systems to share ADT data with the Florida ENS. The bill provides rulemaking authority to AHCA to implement these provisions.

The bill also requires community pharmacies that are enabled to accept electronic prescriptions to share pharmacy data with E-PLUS. This will allow medical personnel involved in disaster preparedness and response to have access to a patient's medication history to ensure they can provide patient care during declared emergencies.

[12] *Id.*
[13] *Id.*
[14] *Id.*

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

B. SECTION DIRECTORY:

Section 1: Amends s. 408.051, F.S., relating to Florida electronic health records exchange act.
Section 2: Amends s. 465.018, F.S., relating to community pharmacies; permits.
Section 3: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

For those hospitals that are not currently connected to a national network, there would be some connectivity costs depending on how their electronic health records systems are structured and the services that those vendors offer. The known costs for connecting to the largest national network, the eHealth Exchange, would be based on their net patient revenue or total expenses. The range of annual fees starts at $5,000 for providers with less than $1 million in net patient revenue and up to $41,000 for those with more than $5 billion in net patient revenue.

There are no costs for a hospital to connect to ENS as a data source.

There are also no costs for community pharmacies to participate in E-PLUS.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to AHCA to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to electronic health records; amending s. 408.051, F.S.; requiring certain hospitals to make patient's electronic health records available through a specified network directly or through a third-party vendor; amending s. 408.0611, F.S.; requiring certain hospitals and pharmacies to make available specified information for certain purposes; providing exemptions; providing rulemaking authority; amending s. 408.821, F.S.; requiring certain licensees to report specified information in a certain manner; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (5) and (6) of section 408.051, Florida Statutes, are renumbered as subsections (6) and (7), respectively, and a new subsection (5) is added to that section, to read:

408.051 Florida Electronic Health Records Exchange Act.—

(5) TRUSTED EXCHANGE NETWORK.—A hospital as defined in s. 395.002 that maintains a certified electronic health record program must make patients' electronic health records available through a trusted exchange network.

(a) National network connectivity may be made directly or

through a third-party vendor.

(b) A hospital with 25 beds or fewer is exempt from this subsection.

(c) The agency shall adopt rules necessary to administer this subsection.

Section 2. Subsections (5) and (6) are added to section 408.0611, Florida Statutes, to read:

408.0611 Electronic prescribing clearinghouse.—

(5) A hospital as defined in s. 395.002 that maintains a certified electronic health record program must make admission, transfer, and discharge data available to the agency's Florida Health Information Exchange service to support public health data registries and patient care coordination.

(6) Effective January 1, 2025, a community pharmacy as defined in s. 465.003(20)(a)1. that maintains a system for electronic prescribing, as defined in s. 408.0611(2), shall participate in the agency's Emergency Patient Look-Up System for the purpose of supporting declared state of emergency events.

(a) An electronic pharmacy is exempt from this subsection if or until the pharmacy's electronic prescribing vendor is connected to the Emergency Patient Look-Up System service.

(b) The agency shall adopt rules necessary to administer this subsection.

Section 3. Subsection (4) of section 408.821, Florida Statutes, is amended to read:

408.821 Emergency management planning; emergency operations; inactive license.—

(4)(a) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.

(b) Licensees required to report under paragraph (a) must do so in a manner, time, and frequency prescribed by the agency.

Section 4. This act shall take effect July 1, 2024.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	_____	

Committee/Subcommittee hearing bill: Select Committee on Health Innovation

Representative Overdorf offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsections (5) and (6) of section 408.051, Florida Statutes, are renumbered as subsections (6) and (7), respectively, and a new subsection (5) is added to that section, to read:

408.051 Florida Electronic Health Records Exchange Act.—

(5) A hospital as defined in s. 395.002 that maintains a certified electronic health record program must:

(a) Make patient electronic health records available through an established national health information exchange

network. Connectivity may be made directly or through a third-party vendor.

(b) Make admission, transfer, and discharge data available to the agency's Florida Health Information Exchange service to support public health data registries and patient care coordination.

The agency may adopt rules necessary to administer this subsection.

Section 2. Section 465.018, Florida Statutes, is amended to read:

465.018 Community pharmacies; permits.—

(8) By January 1, 2025, a community pharmacy that maintains a system for electronic prescribing, as defined in s. 408.0611(2), shall participate in the Agency for Health Care Administration Emergency Patient Look-Up System for the purpose of supporting declared state of emergency events.

Section 3. This act shall take effect July 1, 2024.

T I T L E A M E N D M E N T

Remove lines 6-11 and insert:

vendor; requiring certain hospitals and pharmacies to make available specified information for a certain purpose; providing rulemaking authority; amending s. 465.018, F.S., requiring

certain pharmacies to make available specified information for a certain purpose;