The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 56
INTRODUCER:	Senate Committee on Banking and Insurance and Senator Harrell
SUBJECT:	Coverage for Skin Cancer Screenings
DATE:	January 23, 2024 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Thomas	Knudson	BI	**Fav/CS**
2.			HP	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 56 requires all contracted state group health insurance plans and HMO's to cover and pay for annual skin cancer screenings performed by a Florida licensed dermatologist. The bill prohibits an insurer or HMO from imposing any cost-sharing requirement for the annual skin cancer screening, including a deductible, copayment, coinsurance, or any other type of cost-sharing. The provider conducting the screening must be a dermatologist licensed as a medical doctor under chapter 458, F.S., or an osteopathic physician licensed under chapter 459, F.S, 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.

The bill requires payment for such annual skin cancer screenings to be consistent with the insurer's or HMO's payments for other preventive screenings. 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 Division of State Group Insurance within the Department of Management Services (DMS) estimates that the bill will result in an annual increase of $357,580 on the state employee group health plan.

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

II. Present Situation:

Background

Skin cancer is the most common cancer in the United States.[1] Approximately one in five Americans will develop skin cancer in their lifetime.[2] It is estimated that approximately 9,500 people in the U.S. are diagnosed with skin cancer every day.[3] Nearly 20 Americans die from melanoma every day.[4] 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. Of the estimated new cancer cases in the United States, 5 percent were skin cancer cases.[5]

Basal cell and squamous cell cancers are called nonmelanoma skin cancer, and are the most common of skin cancers. Melanoma accounts for about 1 percent of skin cancers but causes a large majority of skin cancer deaths.[6] 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 cancer.[7] 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.[8]

For Florida, the estimated new cases of melanoma skin cancer for 2023 is 9,640 with projected deaths of 680 individuals.[9] Of the top five cities in the U.S. for skin cancer prevalence rate, four are in Florida – Sarasota-Bradenton (10 percent), Fort Pierce-Port St. Lucie (9.5 percent), West Palm Beach-Boca Raton (9.5 percent), and Melbourne-Titusville-Palm Bay (8.6 percent).[10]

Skin Cancer Screening

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

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[1] Guy GP, Thomas CC, et al., *Vital signs: Melanoma incidence and mortality trends and projections – United States, 1982-2030,* MMWR Morb Mortal Wkly Rep. 2015;64(21):591-596.
[2] Sterns RS, *Prevalence of a history of skin cancer in 2007: results of an incidence-based model*, Arch Dermatol. 2010 Mar.;146(3):279-282.
[3] Rogers HW, Weinstock MA, et al., *Incidence estimate of nonmelanoma skin cancer (keratinocyte carcinomas) in the US population*, JAMA Dermatol, April 30, 2015, available at https://pubmed.ncbi.nlm.nih.gov/25928283/ (last viewed on January 18, 2024).
[4] https://www.cancercenter.com/community/blog (last viewed January 18, 2024).
[5] *Id.*
[6] American Cancer Society, *Key Statistics for Melanoma Skin Cancer*, available at https://www.cancer.org/melanoma-skin-cancer/about/key-statistics.html (last viewed on January 18, 2024).
[7] National Cancer Institute, *Cancer Stat Facts: Melanoma of the Skin*, available at https://seer.cancer.gov/statfacts/html/melan.html (last viewed January 18, 2024).
[8] 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 18, 2024).
[9] American Cancer Society, Cancer Statistics Center, *Estimated New Cancer Cases and Deaths by States (sexes combined, Florida) (data run on January 18, 2024)* available at Cancer Statistics Center - American Cancer Society (last viewed January 18, 2024).
[10] *Id.*

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.[11]

In Illinois, where preventative skin cancer screenings are covered by health insurance companies, a large dermatology practice reports a 99.15% (stage 0-2) early melanoma detection rate compared to the industry average early melanoma detection rate of 83.00%.[12] This results in a 97.9% five-year melanoma survival rate compared to industry average 87.0% five-year melanoma survival rate.[13]

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[14] As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.[15] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[16] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[17] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[18]

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.[19] 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.[20]

[11] National Cancer Institute, *Skin Cancer Screening (PDQ) – Patient Version*, available at Skin Cancer Screening - NCI (last viewed January 18, 2024).
[12] Almutairi, et al. Economic Evaluation Patients with Advanced Unresectable Melanoma versus Economic valuation of Talimogene Laherparepvec Plus Ipilimumab Combination Therapy vs Ipilimumab Monotherapy in Patients With Advanced Unresectable Melanoma. JAMA Dermatology. January 2019; 155(1):22-28.
[13] *Id.*
[14] Section 20.121(3)(a), F.S. The Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as agency head of the Office of Insurance Regulation for purposes of rulemaking. Further, the Financial Services Commission appoints the commissioner of the Office of Insurance Regulation.
[15] Section 624.418, F.S.
[16] Section 624.316(1)(a), F.S.
[17] Section 624.318(2), F.S.
[18] Section 624.3161, F.S.
[19] Section 641.21(1)(1), F.S.
[20] Section 641.495, F.S.

Patient Protection and Affordable Care Act

Essential Benefits

Under the Patient Protection and Affordable Care Act (PPACA),[21] 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.[22]

The 10 EHB categories are:

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

PPACA requires each state to select its own reference benchmark plan as its EHB benchmark plan which all other health plans in the state use as a model. Beginning in 2020, states could choose a new EHB plan using one of three options, including: selecting another's state benchmark plan; replacing one or more categories of EHB benefits; or selecting a set of benefits that would become the State's EHB benchmark plan.[23] Florida selected its EHB plan before 2012 and has not modified that selection.[24]

State Insurance Coverage Mandates

If a state elects to amend its benchmark plan later by imposing a statutory mandate to cover a new service, PPACA requires the state to pay for the additional costs of that mandate for the entire industry.[25] According to a recent study, only two states have chosen to enhance their EHB

[21] Affordable Care Act, (March 23, 2010), P.L.111-141, as amended.
[22] 45 CFR 156.100. et seq.
[23] 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 18, 2024).
[24] 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 18, 2024).
[25] 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 18, 2024).

benchmark plans and have incurred the additional benefits penalty: Utah and Massachusetts.[26] 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.[27]

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.[28] 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.[29]

State Employee Health Plan

For state employees who participate in the state employee benefit program, the Department of Management Services (DMS) through the Division of State Group Insurance (DSGI) administers the state group health insurance program (Program).[30] The Program is a cafeteria plan managed consistent with section 125 of the Internal Revenue Service Code.[31] 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.[32]

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[26] 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 18, 2024).

[27] 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 18, 2024).

[28] 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 18, 2024).

[29] 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).

[30] Section 110.123, F.S.

[31] 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.

[32] Department of Management Services, *Agency Bill Analysis – HB 241/SB 56 (January 12, 2024) (on file with the Senate Committee on Banking and Insurance).*

Legislative Proposals for Mandated Health Benefit Coverage

Any person or organization proposing legislation which would mandate health coverage or the offering of health coverage by an insurance carrier, health care service contractor, or health maintenance organization (HMO) as a component of individual or group policies, must submit to AHCA and the legislative committees having jurisdiction a report which assesses the social and financial impacts of the proposed coverage.33 Guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage, to the extent that information is available, must include:

- To what extent is the treatment or service generally used by a significant portion of the population.
- To what extent is the insurance coverage generally available.
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- To what extent will the coverage increase or decrease the cost of the treatment or service.
- To what extent will the coverage increase the appropriate uses of the treatment or service.
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.
- The impact of this coverage on the total cost of health care.[34]

Proponents of the bill submitted a report to the Senate Committee on Banking and Insurance on March 7, 2023, to comply with s. 624.215, F.S., addressing the guidelines for assessing the impact of the proposed annual skin cancer screening mandated benefit, at no cost to the insured.[35]

III. Effect of Proposed Changes:

The bill requires all contracted state group health insurance plans and HMO's to cover and pay for annual skin cancer screenings performed by a Florida licensed dermatologist. The bill prohibits an insurer or HMO from imposing any cost-sharing requirement for the annual skin cancer screening, including a deductible, copayment, coinsurance, or any other type of cost-sharing. The provider conducting the screening must be a dermatologist licensed as a medical doctor under chapter 458, F.S., or an osteopathic physician licensed under chapter 459, F.S, or an

[33] Section 624.215(2), F.S.
[34] Section 624.215(2)(a)-(l), F.S.
[35] Florida Academy of Dermatology, *Coverage for Skin Cancer Screenings*, March 2023 (Report submitted pursuant to s. 624.215, F.S.) *(on file with the Senate Committee on Banking and Insurance).*

advanced practice registered nurse licensed under chapter 464 who is under the supervision of a dermatologist licensed under chapter 458 or chapter 459, F.S.

The bill requires payment for such annual skin cancer screenings to be consistent with the insurer's or HMO's payments for other preventive screenings as defined by the Current Procedural Terminology code set of the American Medical Association. Lastly, the bill prohibits such insurers and HMOs from bundling a payment for skin cancer screenings with any other procedure or service performed during the same or a subsequent office visit as the screening.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The 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.

The intent of the bill is to save costs, as well as lives, by detecting and treating skin cancers earlier.

C. Government Sector Impact:

The Division of State Group Insurance within the Department of Management Services (DMS) administers the State Group Insurance Program (SGI Program). For the state employee group health plan, the DMS has estimated an annual increase of $357,580 for no cost sharing liability in the coverage of annual skin cancer screenings.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following section of the Florida Statutes: 110.12303.

IX. Additional Information:

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

CS by Banking and Insurance Committee on January 22, 2024:
The committee substitute removes the entire substance of the bill and amends s. 110.12303, F.S., to provide that the provisions of the bill as filed apply only to the contracted state group health insurance plans and HMOs.

B. Amendments:

None.