

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 241 Coverage for Skin Cancer Screenings
SPONSOR(S): Select Committee on Health Innovation, Massullo and Payne
TIED BILLS: IDEN./SIM. **BILLS:** SB 56

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	14 Y, 0 N, As CS	Lloyd	Calamas
2) Appropriations Committee		Helpling	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida’s state employee health coverage is managed by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS). Under the authority of s. 110.123, F.S., the DSGI procures the benefits contracts, and manages the state’s benefits program (Program) for over 300,000 state employees, their spouses, and dependents.

Cancer is the second leading cause of death in the United States and skin cancer deaths represent 5 percent of all cancer deaths. Over 9,600 new cases of skin cancer in Florida are diagnosed every year; however, the long term survival rates of those diagnosed are high with early detection.

CS/HB 241 requires contracted state group health insurance plans or health maintenance organizations (HMOs) to provide coverage and payment, without the imposition of a deductible, copayment, coinsurance, or any other cost sharing requirement, an annual skin cancer screening by a dermatologist licensed under chapters 458 or 459, a physician assistant licensed under chapters 458 or 459, or an advanced practice registered nurse who is under the supervision of a dermatologist licensed under chapters 458 and 459, F.S. DSGI oversees the day to day operations of the State Group Program.

Additionally, the bill prohibits the DSGI-contracted health plans 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 employee group health plan within the DMS. See Fiscal Analysis and Economic Impact Statement.

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

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		FEMALES	
All Races	26.9	All Races	16.7
Hispanic	4.5	Hispanic	4.3
Non-Hispanic American Indian/Alaska Native	8.7	Non-Hispanic American Indian/Alaska Native	7.8
Non-Hispanic Asian/Pacific Islander	1.3	Non-Hispanic Asian/Pacific Islander	1.1
Non-Hispanic Black	1.0	Non-Hispanic Black	0.9
Non-Hispanic White	37.9	Non-Hispanic White	25.2

SEER 22 2016–2020, Age-Adjusted

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](https://www.cancer.gov/statistics/cancer-statistics-center) (last viewed January 13, 2024).

¹⁶ American Cancer Society, *Cancer Facts & Figures 2023*, p. 25, available at [Cancer Facts & Figures 2023](https://www.cancer.gov/factsheets), (last viewed January 12, 2024).

¹⁷ Id.

¹⁸ Id.

Skin Cancer in Florida

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 In 2020, 4,477 new cases were reported for males and 2,770 cases for women.²¹ Hospitalization rates and cost data for Florida are illustrated 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 vapor 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](https://fcds.med.miami.edu/downloads/FloridaAnnualCancerReport/2020/Table_No_T1_(2020).pdf) (last viewed January 11, 2024).

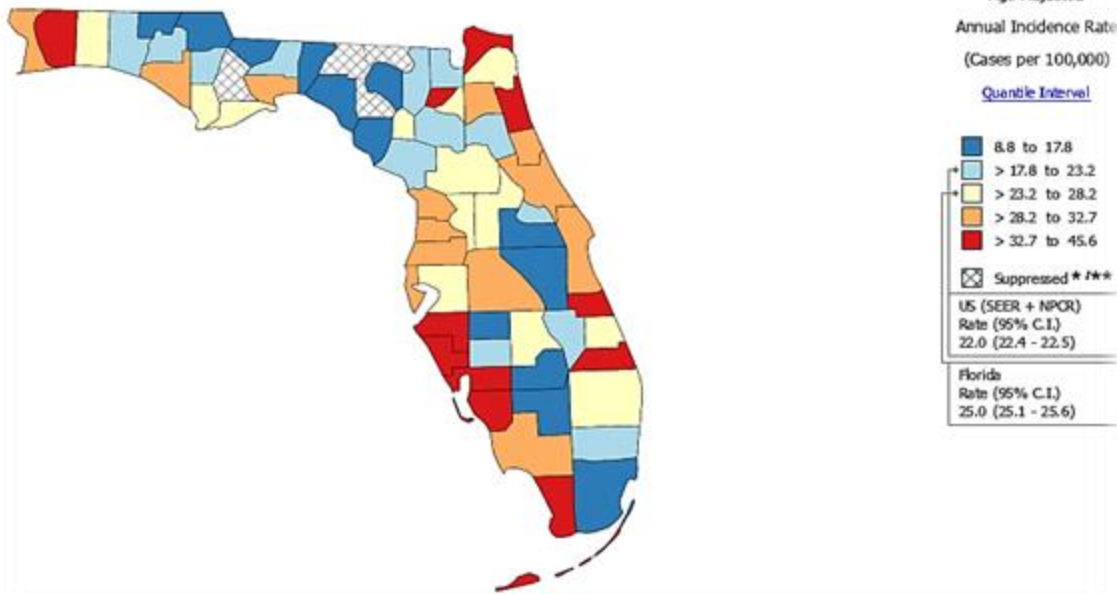
²² Florida Cancer Data System, *Tables 33– 38: Number of Cancer Hospitalizations by Sex*, reports generated at https://fcds.med.miami.edu/inc/statistics_data_vizf.shtml (last viewed January 12, 2024).

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).

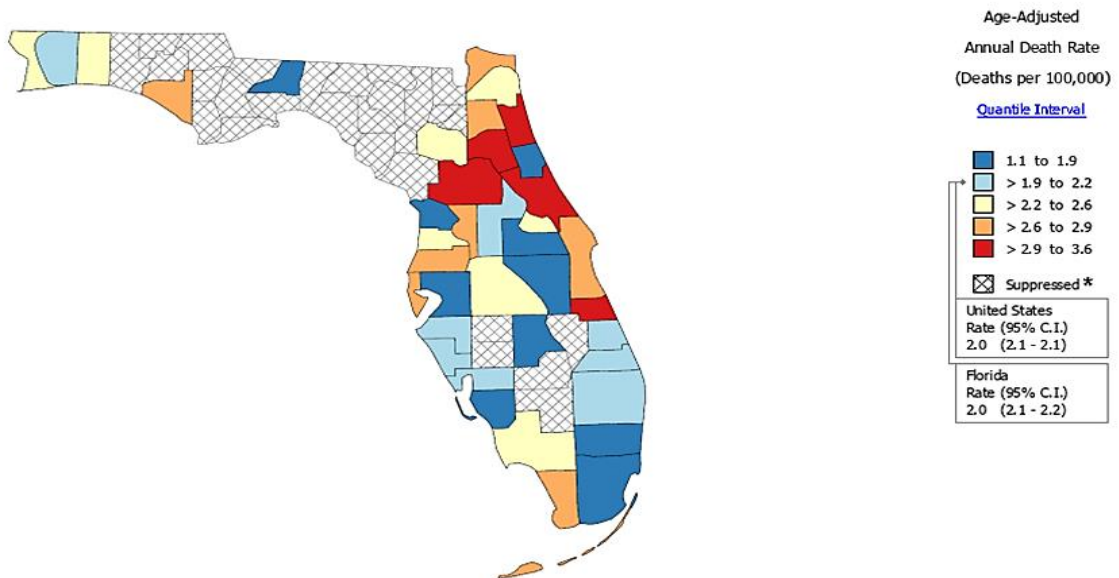
²⁵ National Cancer Institute, *Interactive Maps – Incident Rates for Florida by County, Melanoma of the Skin, 2016– 2020, All Races (includes Hispanic), Both Sexes, All Ages*, report can be re-generated at [Interactive Maps \(cancer.gov\)](#), (last viewed January 10, 2024).

**Incidence Rates⁷ for Florida by County
Melanoma of the Skin, 2016 - 2020
All Races (includes Hispanic), Both Sexes, All Ages**



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

**Death Rates for Florida by County
Melanoma of the Skin, 2016 - 2020
All Races (includes Hispanic), Both Sexes, All Ages**



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 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

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.²⁸ Individuals with a history of melanoma should have a full-body exam by a board-certified dermatologist 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 below and to record the location of the spot on one sheet.²⁹

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.³⁰

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.³¹ In April 2023, the USPSTF 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.³² The Task Force noted that

²⁷ National Cancer Institute, *Skin Cancer Screening (PDQ) – Patient Version*, available at [Skin Cancer Screening - NCI](#) (last viewed January 12, 2024).

²⁸ American Academy of Dermatologists, *Infographic: How to Spot Skin Cancer*, [Infographic: How to SPOT Skin Cancer™ \(aad.org\)](https://www.aad.org/public/diseases/skin-cancer/how-to-spot-skin-cancer), (last viewed January 12, 2024).

²⁹ 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).

³⁰ 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 viewed January 12, 2024).

³¹ 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.³¹ 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).

³² 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

evidence on screening is limited and Task Force members wanted the recommendation to draw attention more culturally diverse research and to be reflective of the nation's population.^{33,34} 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.³⁵

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 2018.³⁶ 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.³⁷ 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.³⁸

There are three categories of HPSA: primary care, dental health, and mental health.³⁹ As of September 30, 2023, Florida has 304 primary care HPSAs, 266 dental HPSAs, and 228 mental health HPSAs designated within the state. It would take 1,803 primary care physicians, 1,317 dentists, and 587 psychiatrists to eliminate these shortage areas.⁴⁰

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 2035.⁴¹ 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

https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/file/supporting_documents/skin-cancer-screening-final-rec-bulletin.pdf (last viewed January 13, 2024).

³³ Id.

³⁴ 45 CFR 156.100. et seq.

³⁵ Under the Patient Protection and Affordable Care Act (PPACA), 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. Under the PPACA, preventive services with an "A" or "B" rating from the USPSTF must be covered by most private health insurance plans. 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 \(hhs.gov\)](https://www.hhs.gov/preventive-services-ib-2022.pdf) (last viewed January 12, 2024).

³⁶ 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 Task Force \(uspreventiveservicestaskforce.org\)](https://www.uspreventiveservicestaskforce.org) (last viewed January 12, 2024).

³⁷ Id.

³⁸ *What is a Shortage Designation?*, HRSA, available at <https://bhwa.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas>, (last viewed January 8, 2024).

³⁹ *Health Professional Shortage Areas (HPSAs) and Your Site*, National Health Service Corps, available at <https://bhwa.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf>, (last viewed January 8, 2024).

⁴⁰ 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 viewed January 8, 2024). To generate the report, select "Designated HPSA Quarterly Summary."

⁴¹ 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 \(fha.org\)](https://www.fha.org/Florida-Physician-Workforce-Analysis.pdf) (last viewed January 12, 2024).

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services will grow 27 percent.⁴² Estimates of current supply deficits indicate Florida needs 1,977 additional physicians for primary care and 1,650 for non-primary care.

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.⁴³ 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.”⁴⁴

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.⁴⁵ 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.⁴⁶

The IHS 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. The Department of Health publishes data on dermatologist distribution. The chart below shows the number of dermatologists per county in Florida.⁴⁷

⁴² Id.

⁴³ Id.

⁴⁴ 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 IHS Markit Report.

Id.

⁴⁶ Id.

⁴⁷ Florida Department of Health, Physician Workforce Annual Report (November 2023) available at 2023 Physician Workforce Annual Report (floridahealth.gov) (last viewed January 18, 2024).

Licensed Florida Dermatologists by County 2023 Physicians Workforce Annual Report			
COUNTY	#	COUNTY	#
Alachua	23	Leon	10
Baker	0	Levy	0
Bay	26	Liberty	0
Bradford	1	Madison	0
Brevard	79	Manatee	18
Broward	330	Marion	13
Calhoun	0	Martin	14
Charlotte	9	Miami-Dade	152
Citrus	6	Monroe	3
Clay	3	Nassau	1
Collier	38	Okaloosa	10
Columbia	1	Okeechobee	1
Desoto	0	Orange	42
Dixie	0	Osceola	5
Duval	43	Palm Beach	148
Escambia	14	Pasco	20
Flagler	2	Pinellas	72
Franklin	0	Polk	22
Gadsden	0	Putnam	0
Gilchrist	0	St. Johns	15
Glades	0	St. Lucie	5
Guif	1	Santa Rosa	3
Hamilton	1	Sarasota	46
Hardee	0	Seminole	23
Hendry	0	Sumter	8
Hernando	4	Suwannee	0
Highlands	4	Taylor	0
Hillsborough	78	Union	0
Holmes	0	Volusia	20
Indian River	9	Wakulla	0
Jackson	0	Walton	2
Jefferson	0	Washington	0
Lafayette	0	Out of State	21
Lake	18	No County	13
Lee	34		

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 s. 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.⁴⁸ To administer the program, DSGI contracts with third party administrators for self-insured plans, a fully

⁴⁸ 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.

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.⁴⁹

Effect of Proposed Changes

CS/HB 241 requires health insurers and HMOs under contract with the DSGI to cover annual skin cancer screenings without payment towards a deductible or co-insurance, copayment, or any other cost sharing by the covered individual when conducted by a dermatologist licensed under chapters 458 or 459, a physician assistant licensed under chapters 458 or 459, or an advanced practice nurse practitioner licensed under chapter 464 who is licensed under the supervision of a dermatologist licensed under chapters 458 or 459, F.S. 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 contracted with Division of State Group Insurance 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.

The DSGI has estimated the annual increase in costs associated with the addition of this benefit for the state group employee group population as \$357,580.

The change contemplated in CS/HB 241 would be effective for contracts issued or renewed on or after January 1, 2025.

The bill will take effect on July 1, 2024

B. SECTION DIRECTORY:

Section 1: Amends s. 110.12303, F.S.; coverage for annual skin cancer screenings.

Section 2: Providing an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

⁴⁹ Department of Management Services, *Agency Bill Analysis – HB 241/SB 56 (January 12, 2024) (on file with the Select Committee on Health Innovation)*.

2. Expenditures:

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

Expenditures:	<p>Based on an analysis by the state group insurance health plans' actuaries, the estimated Fiscal Impact is \$357,580.00 annually to DSGI health insurance program, if there is no cost sharing liability for the coverage of annual skin cancer screenings.</p> <p>The fiscal impact reflects a combination of the effect of projected changes in health care utilization behavior of insured members and the removal of copayments for services.⁵⁰</p>			
	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:

1. Revenues:

Not Applicable.

2. Expenditures:

Not Applicable.

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 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.⁵¹

⁵⁰ Department of Management Services, *Email correspondence from Jake Holmgreen, Deputy Legislative Affairs Director (January 16, 2024)(on file with the Select Committee on Health Care Innovation).*

⁵¹ Supra note 50.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 16, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Limits application of the requirement for annual skin cancer screenings without cost sharing restrictions to the State Group Health Insurance Plan effective January 1, 2025.
- Removes provisions requiring health insurers and HMOs to provide coverage for annual skin cancer screenings without cost sharing restrictions.
- Adds physician assistants and advanced practice registered nurses practicing under the supervision of a dermatologist to conduct skin cancer screenings.
- Prohibits State Group Plan insurers and health plans from bundling a payment for a skin cancer screening with any other procedure or service which is performed during the same or a subsequent visit.

The analysis is drafted to the committee substitute as passed by the Select Committee on Health Innovation.