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 Health Policy

BILL:	SB 1496
INTRODUCER:	Senator Bradley
SUBJECT:	Transparency in Health Care
DATE:	January 15, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 1496 increases the transparency and availability of healthcare pricing and quality of service information. The Agency for Health Care Administration (AHCA) is required to contract with a vendor to provide a consumer-friendly, Internet-based platform that allows a consumer to research the cost of health care services and procedures by a common-named service bundle to facilitate price comparison of typical health care services provided in hospitals and ambulatory surgery centers (ASC). Quality indicators for services at the facilities will also be made available to the consumer to facilitate health care decision making.

Hospitals and ASCs are required to provide access to the searchable service bundles on their website. Consumers will be presented with estimated average payment and estimated payment ranges for each service bundle, by facility, facilities within geographic boundaries, and nationally. The hospital and ASC must notify consumers of other health care providers that may bill separately from the facility as well as information about the facility's financial assistance policies and collection procedures.

The hospital's and ASC's website must also provide hyperlinks to the websites of insurers and health maintenance organizations (HMOs) for which the facility is in-network or a preferred provider to enable an insured patient to research cost-sharing responsibilities for the service bundle. Insurers and HMOs are required to provide on their websites a method for policy holders to estimate their cost-sharing responsibilities by service bundle based on the insured's policy and known plan usage. These estimates shall include both in-network and out-of-network providers. Insurers and HMOs are also required to provide hyperlinks on their website to the AHCA's performance outcome and financial data.

Consumers may request personalized good faith estimates of charges for nonemergency medical services from hospitals, ASCs, and health care practitioners relating to medical services provided in the hospital or ASC. The bill also requires nursing homes, home health agencies, and home

medical equipment providers to provide consumers with good faith estimates of medical services and supplies. These good faith estimates must be provided to the consumer within 7 days after the request. Information must also be provided about the health care provider's financial assistance policies and collection procedures.

A patient may also request an itemized bill or statement from the hospital and ASC after discharge. The hospital or ASC must provide an itemized bill or statement within 7 days that is specific, written in plain language, and identifies all services provided by the facility, as well as rates charged, amounts due, and the payment status. The itemized bill or statement must inform the patient to contact his or her insurer regarding the patient's share of costs. The facility must provide records to verify the bill or statement upon request.

The bill requires the Consumer Advocate in the Department of Financial Services to receive and investigate complaints from insured and uninsured patients concerning billing practices. If, after investigating a complaint, the Consumer Advocate determines the billing practices and charges were unfair, the Consumer Advocate will report these findings to the AHCA and the Department of Health (DOH) for regulatory and disciplinary action. The bill provides for penalties for unconscionable prices. The Consumer Advocate is also authorized to mediate billing complaints and negotiate payment arrangements.

The bill requires health insurers and HMOs that participate in the state group health insurance plan or Medicaid managed care to submit claims data to the vendor selected by the AHCA. The bill grants a premium tax credit of .05 percent to health insurers and HMOs that submit data to the vendor and establishes a tax credit of $50 per employee per submission, up to $500,000, which may be used against either Florida's sales and use tax or corporate income tax for employers with plans covered by the Employee Retirement Income Security Act of 1974 (ERISA) that submit qualifying health care claims information to the vendor selected by the AHCA.

II. Present Situation:

Healthcare Price and Quality Transparency

In general, the term transparency when applied to healthcare refers to the ability of a patient, or the public, to investigate and compare different healthcare providers for pricing and quality of care for one or more procedures. Although simple sounding, healthcare price transparency is difficult to implement due to legal challenges, the manner in which healthcare is provided, and the manner in which healthcare costs are paid. Demonstrating this difficulty, the Health Care Incentives Improvement Institute gave an F grade to 45 out of 50 states, including Florida, in their 2015 Report Card on State Price Transparency Laws.[1, 2]

Some difficulties in implementing healthcare price transparency include:

[1] Health Care Incentives Improvement Institute, *Report Card on State Price Transparency Laws*, (July 2015), *available at* http://www.hci3.org/wp-content/uploads/files/files/2015_Report_PriceTransLaws_06.pdf (last visited on Jan. 14, 2016).
[2] Only one state, New Hampshire, received an A rating, which Colorado and Maine received B's, and Vermont and Virginia received C's.

- Legal barriers including the confidentiality of some contractual information between healthcare providers and insurers as well and health insurer trade secret information.[3]
- Difficulty in determining who will be providing care and whether or not all providers are in a patient's insurance network.[4]
- General confusion over billing practices. Many hospital bills, and bills provided by other healthcare facilities, consist of billing codes and names of procedures or medications provided which may not be easily understood by a layperson. Additionally, it may be difficult to determine whether or not charges included on the bill have been paid, need to be paid, or will be paid by a third party such as a health insurer.
- Difficulty drawing comparisons between patient's particular situations. For example, an older patient may be more fragile and require more recovery time and caution when administering a procedure and, therefore, may be charged more than a younger patient for the same procedure. Additionally, actual payment amounts to the healthcare provider may differ from patient to patient depending on whether or not that patient has insurance and the magnitude of any discounts that the insurer has negotiated with that healthcare provider.

Common Definitions in Healthcare Pricing

Another basic difficulty in interpreting healthcare pricing is understanding the definition of many terms used. Some common definitions used include:

- "Charge," which means the dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.
- "Cost," the definition of which varies by the party incurring the expense:
  - To the patient, cost is the amount payable out of pocket for healthcare services.
  - To the provider, cost is the expense (direct and indirect) incurred to deliver healthcare services to patients.
  - To the insurer, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
  - To the employer, cost is the expense related to providing health benefits (premiums or claims paid).
- "Price," which means the total amount a provider expects to be paid by payers and patients for healthcare services.
- "Out-of-pocket payment," which means the portion of total payment for medical services and treatment for which the patient is responsible, including copayments, coinsurance, and deductibles.[5]

Current Florida Requirements for Healthcare Price and Quality Transparency

Current Florida law establishes multiple requirements regarding healthcare cost and quality transparency. Examples of such requirements include:

[3] Id.
[4] Anne Weiss and Susan Dentzer, *Three Key Lessons from the Health Care Transparency Summit*, Robert Wood Foundation, (April 16, 2015) http://www.rwjf.org/en/culture-of-health/2015/04/3_key_lessons_fromt.html?cid=xrs_rss-pr (last visited on Jan. 14, 2016).
[5] Healthcare Financial Management Association Price Transparency Taskforce, *Price Transparency in Health Care*, p.2 (2014) (on file with the Senate Committee on Health Policy).

- Florida's Patient's Bill of Rights and Responsibilities[6] which establishes the right of patients to, among other rights, be given information of known financial resources for the patient's health care, a reasonable estimate of charges before a procedure, and an itemized bill. The bill of rights also requires facilities to post a link to AHCA performance and financial data.
- Hospitals and ASCs as a licensure requirement must provide patients and their physicians with itemized bills upon request.[7]
- Pharmacies, health insurers, and HMOs are required to inform customers of the availability of the AHCA's quality and cost information.[8]
- HMOs are required to disclose financial data to customers and provide customers with estimated costs for services.[9]

The Florida Center for Health Information and Policy Analysis

Section 408.05, F.S., establishes the Florida Center for Health Information and Policy Analysis (Florida Center). The Florida Center is required to establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of collected and extant health-related data. The Florida Center is responsible for:

- Collecting adverse incident reports from hospitals, ASCs, HMOs, nursing homes, and assisted living facilities (ALF);
- Collecting discharge data from licensed hospitals, ASCs, emergency departments, cardiac catheterization laboratories and lithotripsy;
- Administering patient injury reporting, tracking, trending, and problem resolution programs for hospitals, ASCs, nursing homes, ALFs, and some HMOs
- Processing patient data requests and providing technical assistance;
- Administering www.FloridaHealthFinder.gov, Florida's state run webpage which provides easy access to health care information through health care quality comparison tools, a health encyclopedia, and other resources. The public may access the website to learn about medical conditions, compare health care facilities and providers, and find health care resources. The website also allows users to compare price ranges for some commonly offered healthcare services between healthcare providers.[10, 11]

The Florida Commission on Healthcare and Hospital Funding

On May 5, 2015, Governor Rick Scott signed executive order 15-99 that established the Commission on Healthcare and Hospital Funding (commission).[12] The commission was created to investigate and advise on the role of taxpayer funding for hospitals, insurers, and healthcare

[6] Section 381.026, F.S.
[7] Section 395.301, F.S.
[8] Sections 465.0244, 627.54, and 641.54, F.S
[9] Section 641.54, F.S.
[10] See *Florida Center for Health Information and Policy Analysis*, http://www.ahca.myflorida.com/schs/index.shtml (last visited on Jan. 14, 2016) and the Florida Health Finder FAQ, http://www.floridahealthfinder.gov/media/training-video.aspx (last visited on Jan. 14, 2016)
[11] Quality and price data is available on the website and searchable for approximately 150 conditions. Email from Orlando Pryor, AHCA Legislative Affairs Office (Jan. 15, 2016) (on file with the Senate Committee on Health Policy).
[12] Executive order 15-99, *available at* http://www.flgov.com/wp-content/uploads/orders/2015/EO_15-99.pdf, (last visited on Jan. 15, 2016).

providers, and the affordability, access, and quality of healthcare services they provide. The commission has met 15 times between May 20, 2015 and January 19, 2016, and will continue meeting. In its meetings the commission has heard testimony and collected data from numerous sources including physicians, hospitals, state agencies, and the public but it has not yet published conclusions or final recommendations. On November 19, 2015, the commission endorsed proposed bill language from Governor Scott which addresses the issue of healthcare price and quality transparency.[13] [14] Many of the concepts inherent to the Governor's proposal are addressed in SB 1496.

III. Effect of Proposed Changes:

Section 1 amends the licensure requirements for hospitals and ambulatory surgical centers (ASC) in s. 395.301, F.S., to require that such facilities meet new standards for providing financial information and quality of service measures to patients and the public.[15]

General Requirements for the Provision of Information to the Public

The bill requires each facility to:

- Provide timely and accurate financial information and quality of service measures to prospective patients, actual patients, and patient's legal guardians or survivors.
- Make information on payments made to that facility available on the facility's website.
  - The posted information must be presented and searchable in accordance with the system and service bundles established by the AHCA.
  - The minimum information that must be provided by the facility for each service bundle includes:
    - The estimated average payment received from all payors except Medicaid and Medicare; and
    - The estimated payment range.
  - The facility must state in plain language that the information provided is an estimate of costs for and that actual costs will be based on services actually provided.
  - The facility must assist the consumer in accessing his or her health insurer's, or HMO's, website for information on estimated copayments, deductibles, and other cost-sharing responsibilities.
- Post information on its website including:
  - The names, and a link to the website, of all health insurers and HMOs for which the facility is a network provider or a preferred provider;
  - Information for uninsured or out-of-network patients on:
    - The facility's financial assistance policy including the application process, payment plans, and discounts; and
    - The facility's charity care policy and collection procedures.

[13] Letter from the Commission on Healthcare and Hospital Funding to Senate President Andy Gardiner and Speaker of the House Steve Crisafulli (November 19, 2015) (on file with the Senate Committee on Health Policy).
[14] Governor's Recommended Bill, *Health Care Transparency*, available at http://www.healthandhospitalcommission.com/docs/HealthcareTransparencyProposal.pdf (last visited on Jan. 15, 2016).
[15] Note: Some of the effects detailed in the analysis of section 1 of the bill are requirements that are in current law and which are either kept intact or revised and restated. Due to the significant reorganization of s. 395.301, F.S., the total effects of all new, current law, and revised requirements are included in this analysis as effects of the bill.

- A notification to patients and prospective patients that services may be provided in the facility by the facility and by other health care providers who may bill separately; and
- Information that patients and prospective patients may request a personalized estimate of charges from the facility.
- A link to health-related data, including quality measures and statistics that are disseminated by the AHCA.

- Take action to notify the public that health-related data is electronically available to the public and provide a hyperlink to the AHCA's website.

Requirements to Respond to Specific Requests for Information

Upon specific request, the bill requires each facility to provide:

- A written, good faith estimate of reasonably anticipated facility charges for the non-emergency treatment of the requestor's specific condition. The bill specifies that:
  - The estimate must be provided within seven business days after the receipt of the request.
  - The facility is not required to adjust the estimate to account for any insurance coverage.
  - The estimate may be based on the service bundles created by the AHCA unless the patient requests a more specific estimate.
  - The facility must inform the patient that he or she may contact his or her health insurer or HMO for additional information on cost-sharing responsibilities.
  - The estimate must provide information on the facility's financial assistance policy, including the application process, payment plans, and discounts.
  - The estimate must provide information on the facility's charity care policy and collection procedures.
  - Upon request, the facility must notify the requestor of any revision to the estimate.
  - The estimate must contain a notice that services may be provided by other health care providers who may bill separately.
  - The facility must take action to notify the public that such estimates are available.
  - The facility will be fined $500 for each instance of failing to timely provide a requested estimate.
  - The provision of the estimate does not preclude the charges from exceeding the estimate.
- An itemized bill or statement to the patient, or the patient's survivor or legal guardian, within 7 days of the patient's discharge or the request for the statement.
  - The initial itemized statement or bill:
    - Must be provided within 7 days of the patient's discharge or the patient's request;
    - Must detail the specific nature of charges or expenses in plain language, comprehensible to an ordinary layperson;
    - Must contain a statement of specific services received and expenses incurred by date
    - Must enumerate in detail, as prescribed by the AHCA, the constituent components of the services received within each department of the facility;
    - Must include unit price data on rates charged by the facility;
    - Must identify each item as paid, pending payment by a third party, or pending payment by the patient;
    - Must include the amount due, if applicable;
    - Inform the patient or the patient's legal survivor or guardian, to contact the patient's health insurer or HMO regarding the patient's cost-sharing responsibilities;

- Must include a notice of hospital-based physicians and other health care providers who bill separately;
- May not include any generalized category of expenses;
- Must list drugs by brand or generic name; and
- Must identify the date, type, and length of treatment for any physical, occupational, or speech therapy provided.
- Must prominently display the telephone number of the medical facility's patient liaison.

- When providing a subsequent bill, the bill must contain all of the information required in the initial bill with any revisions clearly delineated.
- A facility must make available at no charge except copying fees, both in the facility's office and electronically, all records necessary for the verification of the accuracy for the patient's statement or bill within 10 business days, reduced from 30 days, after a request for such records and before payment of the statement or bill.
- Each facility must establish a method of responding to patient question about his or her itemized bill within 7 business days, reduced from 30 days, after the question is received. If the patient is not satisfied with the facility's response the facility must provide the patient with the address and contract information for the consumer advocate as provided in s. 627.0613, F.S.

Miscellaneous Provisions

The bill strikes language:

- Stating that any person who receives an itemized statement is fully and accurately informed as to each charge and service provided by the institution preparing the statement;
- Requiring an itemized statement to contain a disclosure identifying the ownership status, either for-profit or not-for-profit, of the facility preparing the statement;
- Requiring an itemized bill to be provided to the patient's physician at no charge;
- Restricting physicians, dentists, podiatrists, and other licensed facilities from adding to the price charged by a third party except for a service or handling charge which represents a cost actually incurred.

The bill also makes other technical and conforming changes.

Section 2 creates s. 395.3012, F.S., to allow the AHCA to impose fines based on the findings of the consumer advocate's investigation of billing complaints pursuant to s. 627.0613(6), F.S. The bill sets the fines for noncompliance at the greater of $2,500 per violation or double the amount that the charges exceeded fair charges.

Sections 3, 4, and 5 amend ss. 400.165, 400.487, and 400.934, F.S., to require nursing homes, home health agencies, and home medical equipment providers, respectively, to, upon request, provide a written good faith estimate of reasonably anticipated charges for services provided by that healthcare provider within seven business days after receiving a request and to provide information disclosing payment plans, discounts, other available assistance, and collection procedures. Additionally, home health agencies and home medical equipment providers must

inform the requestor that he or she may contact his or her health insurer or HMO for additional information concerning cost sharing responsibilities.

Section 6 amends s. 408.05, F.S., to replace the Florida Center for Health Information and Policy Analysis with the Florida Center for Health Information and Transparency (center) which is housed within the AHCA. Responsibilities are streamlined and updated to reflect current data needs. The center is tasked with collecting, compiling, coordinating, analyzing, indexing, and disseminating health-related data and statistics. The center and the AHCA must meet the following requirements:[16]

Health Related Data

The bill:

- Requires that the center be staffed as necessary to carry out its functions.
- Requires that the center maintain data sets in existence before July 1, 2016, unless such data is duplicated and readily available from other credible sources.
- Requires that the center collect data on:
  - Health resources, including licensed health care practitioners by specialty and type of practice and including data collected by the DOH pursuant to ss. 458.3191 and 456.0081, F.S.
  - Health service inventories, including acute care, long-term care, and other institutional care facilities and specific services provided by hospitals, nursing homes, home health agencies, and other licensed health care facilities.
  - Service utilization for licensed health care facilities.
  - Health care costs and financing.
  - The extent of public and private health insurance coverage in Florida.
  - Specific quality-of-care initiatives involving various health care providers when extant data is not adequate to achieve the objectives of the initiatives.
- Eliminates the requirement that the center collect data on:
  - The extent and nature of illness and disability of the state population;
  - The impact of illness and disability of the state population on the state economy;
  - Environmental, social, and other health hazards;
  - Health knowledge and practices of the people in Florida; and
  - Family formation, growth, and dissolution.

Health Information Transparency

The bill:

- Requires the AHCA to:
  - Contract with a vendor to provide a consumer-friendly, Internet-based platform that allows a consumer to research the cost of health care services and procedures and allows for price comparison. The platform must allow a consumer to search by condition or service bundle that is comprehensible to an ordinary layperson and may not require registration, password, or user identification. The vendor must:

[16] Note: As similarly noted in section 1, due to significant revision and organizational changes in this section, the total effects of all new, revised, and current law requirements are included in this analysis as effects of the bill.

        - Be a nonprofit research institute that is qualified under s. 1874 of the Social Security Act to receive Medicare claims data and that receives claims data from multiple private insurers nationwide.
        - Have a national database consisting of at least 15 billion claim lines of administrative claims data from multiple payors capable of being expanded by adding third-party payors, including employers with Employee Retirement Income Security Act of 1974 (ERISA) plans.
        - Have a well-developed methodology for analyzing claims data within defined service bundles.
        - Have a bundling methodology that is available in the public domain to allow for consistency and comparison of state and national benchmarks with local regions and specific providers.
    - Collect and compile information on and coordinate the activities of state agencies involved in providing health information to consumers.
    - Promote data sharing by making state-collected data available, transferable, and readily usable.
    - Develop written agreements with local, state and federal agencies to facilitate the sharing of data related to health care.
    - Establish by rule the types of data collected, complied, processed, used, or shared.
    - Consult with contracted vendors, the State Consumer Health Information and Policy Advisory Council, and other public and private users regarding the types of data that should be collected and the use of such data.
    - Monitor data collection procedures and test data quality to facility the dissemination of data that is accurate, valid, reliable, and complete.
    - Develop methods for archiving data, retrieving archived data, and data editing and verification.
    - Make available health care quality measures that will allow consumers to compare outcomes and other performance measures for health care services.
    - Make available the results of special health surveys, health care research, and health care evaluations conducted or supported by under s. 408.05, F.S.
- Restricts the AHCA from establishing an all-payor claims database without express legislative authority.
- Except as detailed above, the AHCA, or the center, is no longer required to:
    - Review the statistical activities of state agencies to ensure they are consistent with the comprehensive health information system.
    - Establish minimum health-care-related data sets.
    - Establish advisory standards for the quality of health statistical and epidemiological data collection.
    - Prescribe standards for the publication of health-care-related data.
    - Establish a long-range plan for making health care quality measures and financial data available.
    - Provide technical assistance to persons or organizations engaged in health planning activities.
    - Administer, manage, and monitor grants related to health information services.
    - Aid in the dissemination of data through the publication of reports, including an annual report, and conducting special studies and surveys.

Section 7 amends s. 408.061, F.S., to:

- Require that the AHCA mandate the submission of data from health care facilities, health care providers, and health insurers in order to facilitate transparency in health care pricing and quality measures.
- State that data submitted by health care providers may include actual charges to patients as specified by rule.
- State that data submitted by health insurers may include payments to health care facilities and health care providers as specified by rule.

Section 8 amends s. 456.0575, F.S., to require that every licensed health care practitioner must provide, upon request by a patient, a good faith estimate of reasonably anticipated charges for any nonemergency services to treat the patient's condition at a hospital or ASC. This estimate must be provided within seven business days after receiving the request and before providing the service for which the request for an estimate was made. The practitioner must inform the patient that he or she may contact his or her health insurer or HMO for additional information concerning cost-sharing responsibilities. The practitioner must also provide information to uninsured or out of network patients on the practitioner's financial assistance policy, including the application process, payment plans, discounts, and other available assistance; the practitioner's charity care policy, and the practitioner's collection procedures.

The bill states that providing such an estimate does not preclude the actual charges from exceeding the estimate and that failure to provide a requested estimate in accordance with the provisions stated and without good cause will result in disciplinary action and a fine of $500 for each instance of failure to provide the requested estimate.

Section 9 amends s. 456.072, F.S., to include the failure to comply with fair billing practices pursuant to s. 627.0613, F.S., (see section 10) in the list of grounds for which disciplinary actions may be taken against a health care practitioner.

Section 10 amends s. 627.0613, F.S., to expand the duties of the consumer advocate.[17]

The bill requires:

- The consumer advocate to maintain a process for receiving and investigating complaints concerning billing practices by hospitals, ASCs, and health care practitioners licensed under ch. 456, F.S. Such investigations are limited to determining compliance with the following:
  - The patient was informed before a nonemergency procedure of the expected payments related to the procedure, the contact information for health insurers or HMOs, and the expected involvement of other providers who may bill separately;
  - The patient was informed of policies and procedures to qualify for discounts;
  - The patient was informed of collection procedures and given the opportunity to participate in an extended payment schedule;
  - The patient was given a written, personal, and itemized estimate as required in ss. 395.301 for facilities and 456.0575 for health care practitioners for services in a facility;

[17] The consumer advocate is appointed by, and reports to, the Chief Financial Officer and is tasked with representing the general public before various state agencies.

  - The statement or bill delivered to the patient was accurate and included all required information; and
  - The billed amount were fair charges, defined as "the common and frequent range of charges for patients who are similarly situated requiring the same or similar medical services.
- The consumer advocate to report to the AHCA and the DOH the findings resulting from investigation of unresolved complaints concerning the billing practices of any hospital, ASC, or healthcare practitioner licensed under ch. 456, F.S.
- The AHCA and the DOH to grant the consumer advocate access to any files, records, and data which are necessary for such investigations.
- The consumer advocate to provide mediation between providers and patients to resolve billing complaints and negotiate arrangements for extended payment schedules.

Section 11 creates s. 627.6385, F.S., to require each health insurer to:
- Make available on its website:
  - A method for policyholders to estimate their cost-sharing responsibilities for health care services and procedures based on the service bundles established in s. 408.05(3)(c), F.S., or based on a personalized estimate.
    - The provision of the estimate does not preclude the actual amount from exceeding the estimate.
    - The estimates must be calculated according to the policyholder's policy and known plan usage during the coverage period and must be available based on providers that are in-network and out-of-network.
    - A policyholder must be able to create estimates from any combination of service bundles or by a specified provider or comparison of providers.
  - A link to the health and quality information disseminated by the AHCA.
- Include in every policy delivered or issued to a person in Florida a notice that the information required by this section is available electronically and the address of the website where the information can be accessed.
- If the health insurer participates in the state group health insurance plan or Medicaid managed care, provide all claims data to the fullest extent possible to the contracted vendor selected by the AHCA under s. 408.05(3)(c), F.S. A health insurer that provides such data is eligible for .05 percent credit against the premium tax established pursuant to s. 624.509, F.S. This credit may exceed the limitation on such tax credits that is imposed by that section of law.

Section 12 amends s. 641.54, F.S., to require each HMO to:
- Make available electronically or by request the estimated amount of any cost-sharing responsibilities for any covered services described by the service bundles established pursuant to s. 408.05(3)(c), F.S., or as described in a personalized estimate received from a health care facility or health care practitioner.
- If the HMO participates in the state group health insurance plan or Medicaid managed care, provide all claims data to the fullest extent possible to the contracted vendor selected by the AHCA under s. 408.05(3)(c), F.S. An HMO that provides such data is eligible for .05 percent credit against the premium tax established pursuant to s. 624.509, F.S. This credit may exceed the limitation on such tax credits that is imposed by that section of law.

- Create a link on its website to the health information disseminated by the AHCA.

Section 13 amends s. 409.967, F.S., to require that Medicaid managed care plans provide all claims data to the fullest extent possible to the contracted vendor selected by the AHCA under s. 408.05(3)(c).

Section 14 amends s. 110.123, F.S., to require that the DMS make arrangements to provide claims data of the state group health insurance plan to the contracted vendor selected by the AHCA pursuant to s. 408.05(3)(c), F.S. The bill also requires that each contracted vendor for the state group health insurance plan provide claims data to the selected vendor.

Sections 15 and 16 create ss. 212.099 and 220.197, F.S., to establish tax credits against sales and use tax and corporate income tax, respectively, to encourage the submission of healthcare claims data for employees receiving health coverage under ERISA. These provisions take effect on January 1, 2017. The bill:

- Defines:
  - "Eligible employer" as an employer that provides a health plan covered by the ERISA to eligible employees and provides qualifying health care claims information submissions on a quarterly basis.
  - "Eligible employee" as an employee who is employed by an eligible employer and is covered under the eligible employer's ERISA plan.
  - "Qualifying health care claims information submission" as the submission of health care claims information on eligible employees to the contract vendor selected by the AHCA pursuant to s. 408.05(3)(c), F.S.
- Establishes each tax credit to equal the number of eligible employees included on each qualifying health care claims information submission multiplied by $50 up to a maximum of $500,000.
- Allows any excess credit amounts to be taken within 12 months after such submission for sales tax and within 5 years for corporate income tax.
- States that corporations may use only one of the tax credits established in ss. 212.099 and 220.197, F.S.
- States that any person who fraudulently claims such a tax credit must repay 100 percent of the credit and commits a misdemeanor of the second degree.

Sections 17 - 23 amend various sections of law to make technical and conforming changes.

Section 24 states that, except as otherwise expressly provided in this act, the act takes effect on July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

SB 1496 establishes two new tax credits:

- A .05 percent tax credit against a health insurer or HMO's premium tax available to health insurers and HMOs that provide claims data to the vendor selected by the AHCA. This credit may exceed the statutory limitation on such tax credits established in s. 624.509, F.S.; and
- A tax credit of up to $500,000 against either state sales and use tax or state corporate income tax available to employers with ARISA plans who submit qualifying health care claims information to the vendor selected by the AHCA.

An estimate of these amounts is not available at this time.

B. Private Sector Impact:

SB 1496 may have a positive fiscal impact on consumers of healthcare services to the extent the transparency measures allow consumers to make better informed choices on where to obtain their healthcare services based on price and quality, take advantage of discounts or other financial assistance, or to negotiate with healthcare service providers on the specific costs of services.

The bill may have a negative fiscal impact on providers of healthcare services, health insurers, and HMOs related to posting healthcare information on their webpages or providing patient specific estimates.

The bill may have a positive fiscal impact on health insurers, HMOs, and employers with ERISA plans that are able to take advantage of the tax credits established in the bill.

C. Government Sector Impact:

The cost to the AHCA and the consumer advocate are unknown at this time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.301, 400.165, 400.487, 400.934, 408.05, 408.061, 456.0575, 456.072, 627.0613, 641.54, 409.967, 110.123, 20.42, 381.026, 395.602, 395.6025, 408.07, 408.18, and 465.0244.

This bill creates the following sections of the Florida Statutes: 212.099, 220.197, 395.3012, and 627.6385.

IX. Additional Information:

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

None.

B. Amendments:

None.