By Senator Garcia

36-00646-17 20171612__

A bill to be entitled

An act relating to health care consumer protection; amending s. 395.301, F.S.; revising the requirements for a good faith itemized estimate provided to a patient or prospective patient by a licensed facility for nonemergency medical services; providing that a facility and its contracted health care providers may bill a patient for certain medical services only if the patient consents in writing; providing a penalty for violations; amending s. 456.0575, F.S.; requiring written patient consent for certain health care practitioners to bill a patient for services listed on the itemized estimate which are not covered by the patient's health insurance; providing a penalty for violations; amending s. 627.6385, F.S.; requiring health insurers to provide certain information available on their websites or by request, rather than only on their websites; requiring a health insurer to provide a certain response to the policyholder and facility within a specified time after receiving an itemized estimate; providing construction and applicability; amending s. 627.64194, F.S.; providing that an insurer is solely liable for payment of certain fees for certain requested services under certain circumstances; providing applicability; conforming cross-references; amending s. 641.54, F.S.; requiring a health maintenance organization to provide a certain response to the subscriber and facility within a specified time after receiving an itemized

estimate; providing applicability; providing an effective date.

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

Section 1. Paragraph (b) of subsection (1) of section 395.301, Florida Statutes, is amended, present subsections (2) through (6) of that section are redesignated as subsections (3) through (7), respectively, and a new subsection (2) is added to that section, to read:

395.301 Price transparency; itemized patient statement or bill; patient admission status notification.—

(1) A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to patients and prospective patients of the facility, or to patients' survivors or legal guardians, as appropriate. Such information shall be provided in accordance with this section and rules adopted by the agency pursuant to this chapter and s. 408.05. Licensed facilities operating exclusively as state facilities are exempt from this subsection.

(b)1. Upon request or preregistration, and before providing any nonemergency medical services, each licensed facility shall provide in writing or by electronic means an itemized ~~a~~ good faith estimate of reasonably anticipated charges by the facility for the treatment of the patient's or prospective patient's specific condition, including services provided for such treatment in the facility by other health care providers under contract with the hospital who may bill the patient separately. The facility must provide the estimate to the patient or

prospective patient and the patient's health insurer within 7 business days after the receipt of the request and is not required to adjust the estimate for any potential insurance coverage. The estimate may be based on the descriptive service bundles developed by the agency under s. 408.05(3)(c) unless the patient or prospective patient requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient. The facility shall inform the patient or prospective patient that he or she may contact his or her health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities.

2. In the estimate, the facility shall provide to the patient or prospective patient information 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.

3. The estimate shall clearly identify any facility fees and, if applicable, include a statement notifying the patient or prospective patient that a facility fee is included in the estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.

4. ~~Upon request,~~ The facility shall notify the patient or prospective patient of any revision to the estimate.

5. In the estimate, the facility must notify the patient or prospective patient that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient, if applicable.

6. The facility shall take action to educate the public that such estimates are available upon request.

7. Failure to timely provide the estimate pursuant to this paragraph shall result in a daily fine of $1,000 until the estimate is provided to the patient or prospective patient. The total fine may not exceed $10,000.

The provision of an estimate does not preclude the actual charges from exceeding the estimate.

(2) The facility and health care providers under contract with the facility may bill the patient for a medical service that is on the itemized estimate and that is not covered by the patient's health insurance only if the patient has provided specific written consent for the service. A violation of this subsection is punishable by a fine of $1,000 per occurrence.

Section 2. Subsection (2) of section 456.0575, Florida Statutes, is amended to read:

456.0575 Duty to notify patients.—

(2) Upon request by a patient, before providing nonemergency medical services in a facility licensed under chapter 395, a health care practitioner shall provide, in writing or by electronic means, a good faith estimate of reasonably anticipated charges to treat the patient's condition at the facility. The health care practitioner shall provide the estimate to the patient within 7 business days after receiving the request and is not required to adjust the estimate for any potential insurance coverage. The health care practitioner shall inform the patient that the patient may contact his or her health insurer or health maintenance organization for additional

information concerning cost-sharing responsibilities. The health care practitioner shall provide information to uninsured patients and insured patients for whom the practitioner is not a network provider or preferred provider, which discloses the practitioner's financial assistance policy, including the application process, payment plans, discounts, or other available assistance, and the practitioner's charity care policy and collection procedures. Such estimate does not preclude the actual charges from exceeding the estimate. Written patient consent is required for a health care practitioner under contract with a facility licensed under chapter 395 to bill the patient for services on the itemized estimate under s. 395.301 which are not covered by the patient's health insurance. The billing of noncovered services without the patient's consent that is required in this subsection, or failure to provide the estimate in accordance with this subsection, without good cause, shall result in disciplinary action against the health care practitioner and a fine of $500 per bill, or a daily fine of $500 until the estimate is provided to the patient. The total fine may not exceed $5,000.

Section 3. Subsection (1) of section 627.6385, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

627.6385 Disclosures to policyholders; calculations of cost sharing.—

(1) Each health insurer shall make available on its website or by request:

(a) A method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities

for health care services and procedures. Such method of making an estimate shall be based on service bundles established pursuant to s. 408.05(3)(c). Estimates do not preclude the actual copayment, coinsurance percentage, or deductible, whichever is applicable, from exceeding the estimate.

1. Estimates shall be calculated according to the policy and known plan usage during the coverage period.

2. Estimates shall be made available based on providers that are in-network and out-of-network.

3. A policyholder must be able to create estimates by any combination of the service bundles established pursuant to s. 408.05(3)(c), a specified provider, or a comparison of providers.

(b) A method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities based on a personalized estimate of charges received from a facility pursuant to s. 395.301 or a practitioner pursuant to s. 456.0575.

(c) A hyperlink to the health information, including, but not limited to, service bundles and quality of care information, which is disseminated by the Agency for Health Care Administration pursuant to s. 408.05(3).

(4) Upon receipt of an itemized estimate from a facility pursuant to s. 395.301, the health insurer must provide a response indicating the coverage status of each item to the policyholder and the facility within 3 business days. Failure to respond to the policyholder and the facility within such time constitutes a waiver of the health insurer's right to contest or counter the facility's itemized estimate. This subsection does

not apply to Medicaid health plans.

Section 4. Present subsections (4) through (6) of section 627.64194, Florida Statutes, are redesignated as subsections (5) through (7), respectively, a new subsection (4) is added to that section, and present subsections (5) and (6) are amended, to read:

627.64194 Coverage requirements for services provided by nonparticipating providers; payment collection limitations.—

(4) If an insurer denies, reduces, or terminates coverage for an admission, availability of care, a continued stay, or a health care service after determining that such requested service, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, the insurer is solely liable for any potential payment of fees and the insured is not liable for payment of fees other than applicable copayments, coinsurance, and deductibles to a participating or nonparticipating provider if:

(a) The insurer's determination conflicts with a participating or nonparticipating provider's determination that the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness are met; and

(b) The insured did not receive both the itemized estimate from a facility under s. 395.301 and the indication of the coverage status of the item under s. 627.6385(4) or s. 641.54(6).

The provisions of s. 627.638 apply to this subsection. This subsection does not apply to Medicaid health plans.

(6)~~(5)~~ A nonparticipating provider of emergency services as provided in subsection (2) or a nonparticipating provider of nonemergency services as provided in subsection (3) may not be reimbursed an amount greater than the amount provided in subsection (5) ~~(4)~~ and may not collect or attempt to collect from the insured, directly or indirectly, any excess amount, other than copayments, coinsurance, and deductibles. This section does not prohibit a nonparticipating provider from collecting or attempting to collect from the insured an amount due for the provision of noncovered services.

(7)~~(6)~~ Any dispute with regard to the reimbursement to the nonparticipating provider of emergency or nonemergency services as provided in subsection (5) ~~(4)~~ shall be resolved in a court of competent jurisdiction or through the voluntary dispute resolution process in s. 408.7057.

Section 5. Subsection (6) of section 641.54, Florida Statutes, is amended to read:

641.54 Information disclosure.—

(6) Each health maintenance organization shall make available to its subscribers on its website or by request the estimated copayment, coinsurance percentage, or deductible, whichever is applicable, for any covered services as described by the searchable bundles established on a consumer-friendly, Internet-based platform pursuant to s. 408.05(3)(c) or as described by a personalized estimate received from a facility pursuant to s. 395.301 or a practitioner pursuant to s. 456.0575, the status of the subscriber's maximum annual out-of-pocket payments for a covered individual or family, and the status of the subscriber's maximum lifetime benefit. Such

estimate does not preclude the actual copayment, coinsurance percentage, or deductible, whichever is applicable, from exceeding the estimate. Upon receipt of an itemized estimate from a facility pursuant to s. 395.301, the health maintenance organization must provide a response indicating the coverage status of each item to the subscriber and the facility within 3 business days. This subsection does not apply to Medicaid health plans.

Section 6. This act shall take effect July 1, 2017.