HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 449 Health Insurance
SPONSOR(S): Insurance & Banking Subcommittee; Health Innovation Subcommittee; Renner
TIED BILLS: **IDEN./SIM. BILLS:** SB 528

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 2 N, As CS	Tuszynski	Poche
2) Insurance & Banking Subcommittee	12 Y, 3 N, As CS	Peterson	Luczynski
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Consumers are bearing a greater share of health care costs, and more people are enrolling in consumer-directed health plans with high deductibles.

Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs and insurance coverage. Price transparency creates better-informed shoppers, and there is evidence that incentivizing the shopping of health care services can increase consumer involvement and avoid health care costs.

CS/CS/HB 449 creates the Patient Savings Act, which requires health insurers to create a shared savings incentive program (Program) to encourage insured individuals to shop for high quality, lower cost health care services and share any savings realized as a result of the insured's choice.

The bill requires certain health insurers to provide a method for an insured to request information on the contracted amount with a health care provider for certain health care services, called shoppable health care services, and the average price for those same services. The bill also requires insurers to post quality information on shoppable health care services and providers, if available. Upon the request of an insured, an insurer must provide within 2 working days a good faith estimate of the contracted amount for the shoppable health care service, as well as an estimate of copayments, deductibles, and other cost-sharing responsibilities.

Using the information from the health insurer, if the insured obtains a shoppable health care service for less than the average price for the service, the bill requires the savings to be shared by the health insurer and the insured. The cash payment can be calculated as a percentage between the contracted amount and the average price, or by an alternative method approved by the Office of Insurance Regulation (OIR). The bill requires the cash payment be at least 50 percent of the health insurer's saved cost as compared to the average price. The Program must be a component part of the policy, contract, or certificate of insurance provided by the health insurer, and the health insurer must notify its insureds of the Program annually and at the time of enrollment and renewal.

The bill provides significant enforcement provisions by permitting OIR to impose an administrative fine, or revoke or suspend the certificate of authority for health insurers who fail to comply with the requirements of the section.

The bill does not appear to have a fiscal impact on state or local governments.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Price Transparency

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Consumers are bearing a greater share of health care costs, and more people are enrolling in consumer-directed health plans with high deductibles. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Price transparency in health care can have different definitions. The term can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[1] Price can be defined as an estimate of a consumer's complete cost of a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and identifies a consumer's out-of-pocket cost.[2] Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."[3] Indeed, the definition of the price or cost of health care has different meanings depending on who is incurring the cost.[4]

Price Waterhouse Cooper's Health Research Institute projects health care costs to rise 6.5 percent in 2017.[5] While this is the same rise in cost as 2016, the rate is still expanding faster than inflation.[6]

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, more than one in four Americans with private insurance are enrolled in a high deductible health plan (HDHP). Enrollment in HDHPs has increased 8 percent since 2014. According to Mercer's latest survey of employer health plans, nearly 3 in 10 employees were enrolled in an HDHP in 2016.[7]

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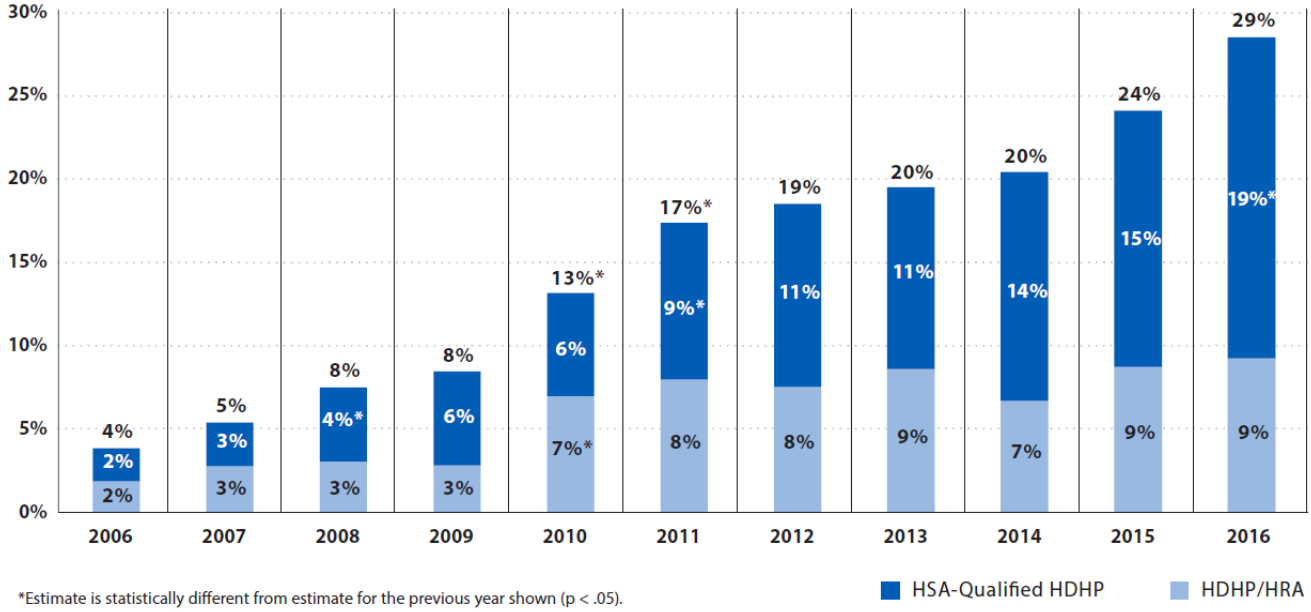
[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 2, available at http://www.gao.gov/products/GAO-11-791.
[2] Id.
[3] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, page 2, 2014, available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=22279.
[4] Id.
[5] PwC, Health Research Institute, *Behind the Numbers, 2017*, available at http://www.pwc.com/us/en/health-industries/behind-the-numbers.html (last accessed February 19, 2017).
[6] Here's Why You'll Likely Pay More for Your Employer-Sponsored Health Insurance, Fortune Health, June, 21, 2016, available at http://fortune.com/2016/06/21/health-care-rising-costs/ (last accessed February 19, 2017).
[7] Mercer, *Mercer survey: Health benefit cost growth slows to 2.4% in 2016 as enrollment in high-deductible plans climbs*, October 26, 2016, available at https://www.mercer.com/newsroom/national-survey-of-employer-sponsored-health-plans-2016.html (last viewed February 19, 2017).

Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2016



*Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information, see the Survey Methods Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2016.

Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. Eighty-three percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan.[8]

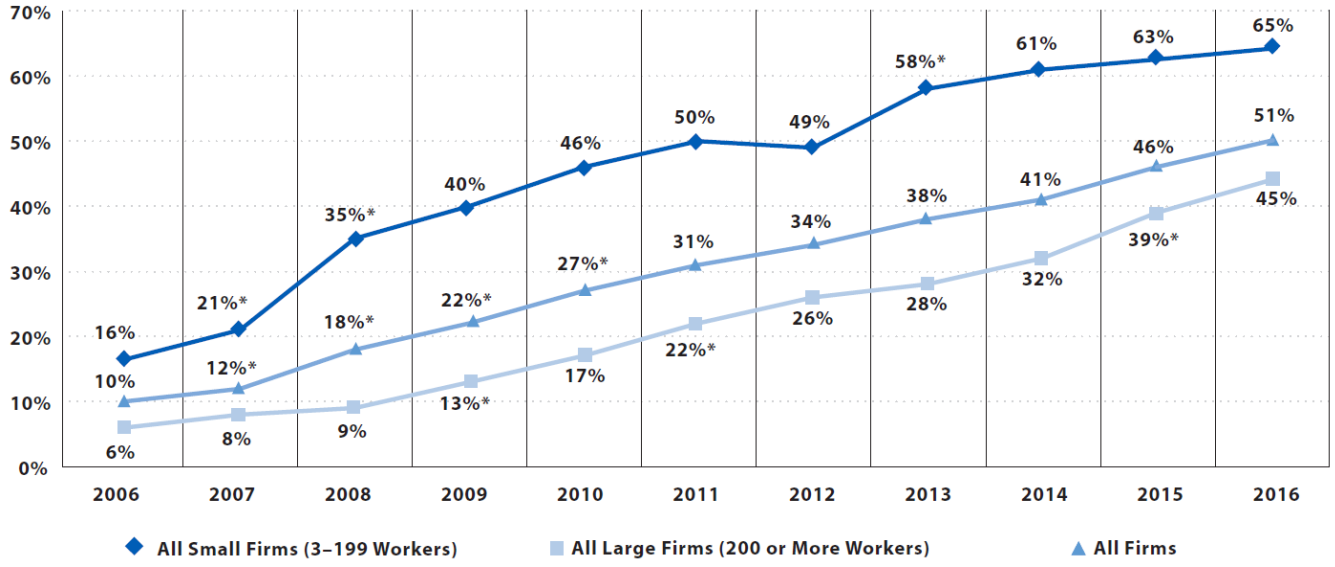
Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,478.[9] The average annual deductible is similar to last year ($1,318), but has increased from $1,077 in 2015.[10] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $2,069 in small firms, compared to $1,238 for workers in large firms.[11] Sixty-five percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 45 percent in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (41 percent for small firms vs. 16 percent for large firms).[12]

Looking at the increase in deductible amounts over time does not capture the full impact of health care coverage for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 55 percent in 2006 to 70 percent in 2010 to 83 percent in 2016. The average deductible for all covered workers in 2016 is $1,318, up 28 percent from $1077 in 2015, up 104 percent from $646 in 2010, and up 335 percent from $303 in 2006.

Sixty-five percent of covered workers employed by a firm of 3 to 199 employees are in a plan with a deductible of $1,000 or more, while 45 percent of covered workers employed by a firm with 200 or more employee are in such a plan, more than four times the average in 2006.[13] The following chart shows the percent of workers enrolled in employer-sponsored insurance with an annual deductible of $1,000 or more for single coverage by employer size for 2006 through 2016.[14]

[8] The Henry J. Kaiser Family Foundation, *2016 Employer Health Benefits Survey*, September 2016, page 3, available at http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey (last accessed February 19, 2017).
[9] Id. at pg. 4.
[10] Id.
[11] Id.
[12] Id.
[13] Id.
[14] Supra, FN 5, Exhibit G.

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2016



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

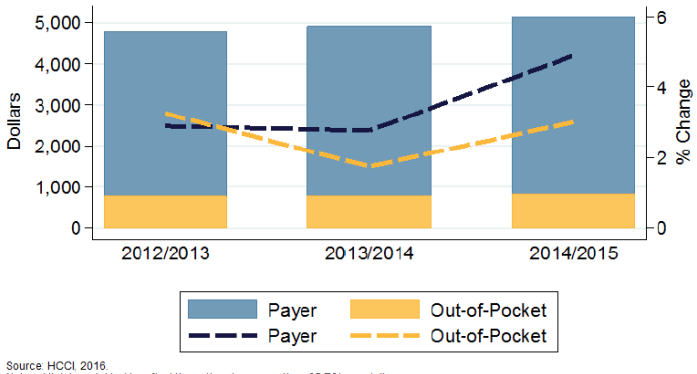
NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2016.

According to the 2016 Mercer National Survey of Employer-Sponsored Health Plans, 61 percent of employers with 500 or more employees currently offer consumer-driven health plans (CDHPs), up from 39 percent in 2013, while 80 percent of jumbo employers, those with 20,000 or more employees, offer CDHPs, up from 63 percent the previous year.[15] Further, according to the survey, more employers planned on offering CHDPs in 2017.

These trends, coupled with overall increases in health care expenditures, mean consumers now spend $338.1 billion out-of-pocket annually.[16] Out-of-pocket medical spending by adults with employer-sponsored health insurance rose from $810 per capita in 2014 to $813 per capita in 2015.[17] Such spending accounted for 15.8 percent of total per capita health care expenditures in 2015.[18]

Payer and Out-of-Pocket Spending Per Capita for Insureds Younger than Age 65, 2012-2015



Source: HCCI, 2016.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2014 and 2015 adjusted using actuarial completion.

[15] Supra, FN 7.
[16] U.S. Dept. of Health and Human Services, Centers for Medicaid and Medicare Services, *National Health Expenditure Data Fact Sheet-Historical National Health Expenditures, 2015*, available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html (last accessed February 19, 2017).
[17] Health Care Cost Institute, *2015 Health Care Cost and Utilization Report*, November 2016, page 6, available at http://www.healthcostinstitute.org/report/2015-health-care-cost-utilization-report/ (last viewed February 19, 2017).
[18] Id.

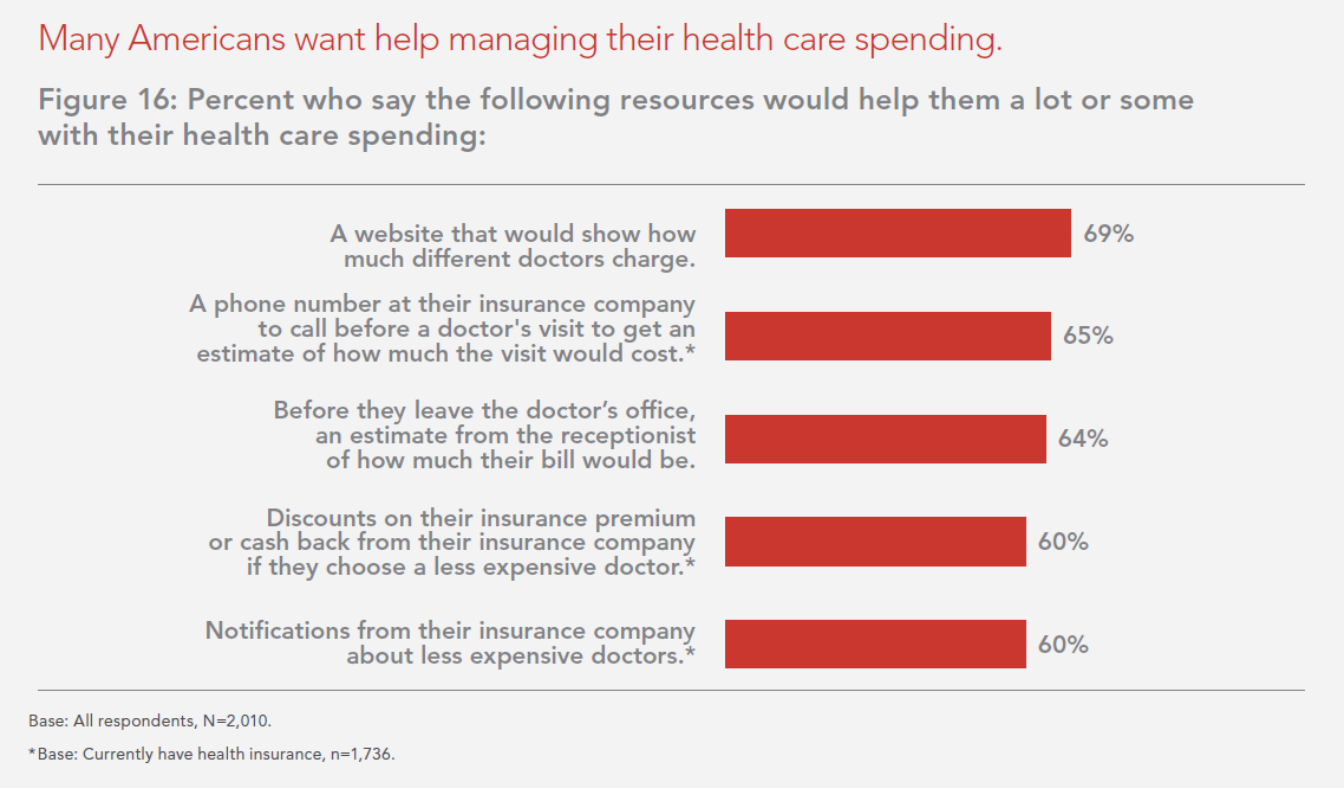
National Price Transparency Studies

To explore how expanding price transparency efforts could produce significant cost savings for the healthcare system, the Gary and Mary West Health Policy Center funded an analysis, "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending." This report, conducted in collaboration with researchers from the Center for Studying Health System Change and RAND, found that implementation of three policy changes could save $100 billion over ten years.

- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.
- Expand state-based all-payer health claims databases (APCDs), which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[19]

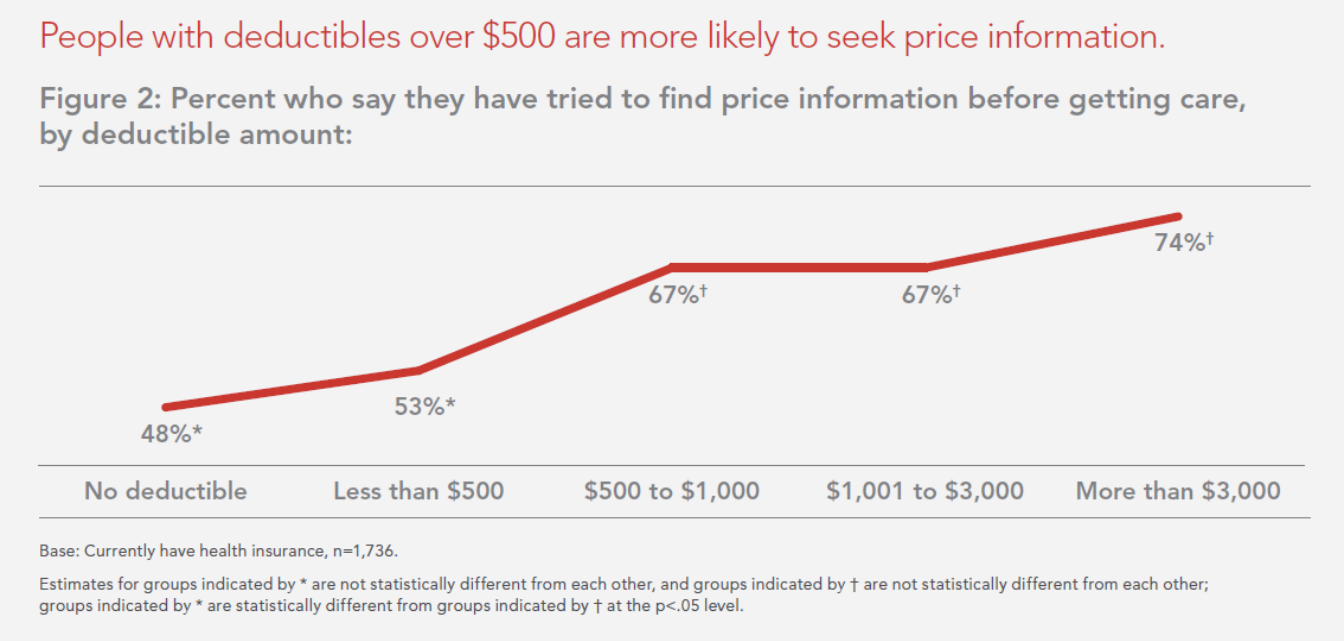
The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the next 10 years.[20]

As Americans shoulder more health care costs, research suggests that they are looking for more and better price information.[21]



[19] White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, available at: http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf.
[20] Id. at pg. 1.
[21] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at https://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf (last viewed February 19, 2017).

One study in 2014, which conducted a nationally representative survey of more than 2,000 adults, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[22] The following chart illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.[23]



The individuals who compared prices stated that such research impacted their health care choices and saved them money.[24] In addition, the study found that most Americans do not equate price with quality of care. Seventy one percent do not believe higher price imparts a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[25] Because of the high level of cost-sharing associated with CDHPs, these consumers are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. In fact, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price transparency tool.[26] Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.[27]

Additional research has found the use of price transparency tools to be associated with lower total claims payments for common medical services and procedures.[28] A recent study sought to measure the impact of consumer access to health care price data on the cost of three of the most common health services laboratory tests, advanced imaging services, and clinician office visits.[29] Medical claims from 2010 to 2013 of more than 500,000 patients insured in the U.S. by 18 employers who provided a

[22] Id. at pg. 3.
[23] Id. at pg. 13.
[24] Id. at pg. 4.
[25] Supra, FN 23.
[26] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, page 4, available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126.
[27] Hibbard, JH, et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, Health Affairs 2012; 31(3): 560-568.
[28] Whaley, C., Schneider Chafen, J., et al., *Association Between Availability of Health Service Prices and Payments for These Services*, Journal of the American Medical Association. 2014;312(16): 1670-1676.
[29] Id.

health care price transparency platform were reviewed to determine the total claims payment for the three services.[30]

Researchers accessed the price transparency platform to determine which claims were associated with a prior search of the platform. In the study sample, 6 percent of lab test claims, 7 percent of advanced imaging claims, and nearly 27 percent of clinician office visit claims were associated with a search.[31] Prior to accessing the price transparency platform, searchers had higher claim payments than non-searchers for each of the services. After using the price transparency platform, searchers paid nearly 14 percent less for lab test services, 13 percent less for advanced imaging services, and 1 percent less for physician office visits than non-searchers.[32] The study concluded that patient access to pricing information before obtaining clinical services may result in lower overall payments made for clinical care.[33]

Florida Efforts in Health Care Price Transparency

Florida Patient's Bill of Rights and Responsibilities

In 1991, the Legislature enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[34] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[35] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient's knowledge of rights and responsibilities.

The Patient's Bill of Rights gives a patient the right to request certain financial information from health care providers and facilities.[36] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[37] Estimates must be written in language "comprehensible to an ordinary layperson."[38] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[39] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[40]

[30] Id.
[31] Id.
[32] Id.
[33] Id.
[34] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.; The Florida Patient's Bill of Rights and Responsibilities is intended to promote better communication and eliminate misunderstandings between the patient and health care provider or health care facility. The rights of patients include standards related to individual dignity; information about the provider, facility, diagnosis, treatments, risks, etc.; financial information and disclosure; access to health care; experimental research; and patient's knowledge of rights and responsibilities. Patient responsibilities include giving the provider accurate and complete information regarding the patient's health, comprehending the course of treatment and following the treatment plan, keeping appointments, fulfilling financial obligations, and following the facility's rules and regulations affecting patient care and conduct.
[35] S. 381.026(3), F.S.
[36] S. 381.026(4)(c), F.S.
[37] S. 381.026(4)(c)3., F.S.
[38] Id.
[39] Id.
[40] S. 381.026(4)(c)5., F.S.

Currently, under the Patient's Bill of Rights' financial information and disclosure provisions:

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility.
- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Patient's Bill of Rights does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A health care facility must place a notice in its reception area that financial information related to that facility is available on the Agency for Health Care's (AHCA) website.
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or AHCA may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[41]

In 2011, the Legislature passed HB 935,[42] which amended the Patient's Bill of Rights to authorize, but not require, primary care providers[43] to publish a schedule of charges for the medical services offered to patients.[44] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[45] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and that the posted schedule be at least 15 square feet in size.[46] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single 2-year period.[47]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[48] The schedule requirements are the same as those established for primary care providers.[49] An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than $1,000 per day (until the schedule is published and posted).[50]

[41] S. 381.0261, F.S.
[42] Ch. 2011-122, Laws of Fla.
[43] S. 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[44] S. 381.026(4)(c)3., F.S.
[45] Id.
[46] Id.
[47] S. 381.026(4)(c)4., F.S.
[48] S. 395.107(1), F.S.
[49] S. 395.107(2), F.S.
[50] In 2012, the Legislature considered, but did not pass, HB 1329. The bill required ambulatory surgical centers and diagnostic-imaging centers to comply with the provisions of s. 395.107, F.S., established by HB 935 in 2011, and required physicians to publish, in writing, a schedule of medical charges. The bill would have imposed a fine of $1,000, per day, on an urgent care center, ambulatory surgical center, or diagnostic-imaging center that fails to post the schedule of medical charges. The failure of a practitioner to publish and distribute a schedule of medical charges subjected the practitioner to discipline under the applicable practice act and s. 456.072, F.S. Lastly, the bill addressed balance billing by requiring health insurers, hospitals, and medical providers to disclose contractual relationships among the parties and to disclose, in advance of the provision of medical care or services, whether or not the patient will be balance billed as a result of the contractual relationship, or lack thereof, among the insurer, hospital, and medical provider. Failure to provide disclosure to the insured as required by this provision of the bill resulted in a $500 fine, per occurrence, to be imposed by the AHCA.

In 2012, the Legislature passed HB 787,[51] which built upon the transparency requirements established by HB 935. The law amended the definition of "urgent care center" to include any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures; and licensed health care clinics that operate in three or more locations.

The law requires a schedule of charges for medical services posted by an urgent care center to describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. The law also requires the text of the schedule of medical charges to fill at least 12 square feet of the total 15 square feet area of the posted schedule, and allows use of an electronic device for the posting. The device must measure at least three square feet in size and be accessible to all consumers during business hours.

In 2016, the Legislature passed, and the Governor signed, HB 1175, which requires the greatest amount of health care price and quality transparency in Florida to date. The law ensures greater consumer access to health care price and quality information by requiring certain heath care providers, insurers and health maintenance organizations (HMO) to give that information to patients. The law also required AHCA to contract with a vendor for an all-payer claims database (APCD), which provides an online, searchable method for consumers to compare provider price and quality, and a Florida-specific data set for price and quality research purposes. On January 3, 2017, AHCA recommended that the Health Care Cost Institute (HCCI) be awarded the contract to build and maintain the APCD and the Florida-specific data set. AHCA and HCCI continue to discuss the terms of the contract necessary to implement the provisions of the law. The law requires insurers and HMOs to submit data to the APCD.

The law creates pre-treatment transparency obligations for hospitals, ambulatory surgery centers (ASC), health care practitioners providing non-emergency services in these facilities, insurers, and HMOs. Facilities must post online the average payments and payment ranges received for bundles of health care services defined by AHCA. This information must be searchable by consumers. Facilities must provide, within 7 days of a request, a written, good faith, personalized estimate of charges, including facility fees, using either bundles of health care services defined by AHCA or patient-specific information. Failure to provide the estimate results in a daily licensure fine of $1,000, up to $10,000. Facilities must inform patients of health care practitioners providing their nonemergency care in hospitals and these practitioners must provide the same type of estimate, subject to a daily fine of $500, up to $5,000.

Facilities and facility practitioners must publish information on their financial assistance policies and procedures. Insurers and HMOs must create online methods for patients to estimate their out-of-pocket costs, both using the service bundles established by AHCA and HCCI and based on patient-specific estimates using the personalized estimate the patient obtains from facilities and practitioners. In addition, diagnostic-imaging centers owned by a hospital but located off of the premises must publish and post charges for services pursuant to s. 395.107, F.S., which currently requires urgent care centers to do the same.

Post-treatment facilities must provide an itemized bill within 7 days of discharge or request, whichever is later, meeting certain requirements for comprehension by a layperson, and identifying any providers who may bill separately for the care received in the facility.

[51] SS. 1-3, Ch. 2012-160, Laws of Fla.

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center) provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data. The Florida Center is housed within AHCA and is funded through appropriations in the General Appropriations Act, through grants, gifts, and other payments, and through fees charged for services. Offices within the Florida Center, which serve different functions, are:

- Data Collection and Quality Assurance, which collects patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units), comprehensive rehabilitation hospitals, ASCs and emergency departments.
- Risk Management and Patient Safety, which conducts in-depth analyses of reported incidents to determine what happened and how the facility responded to the incident.
- Data Dissemination and Communication, which maintains AHCA's health information website, provides technical assistance to data users, and creates consumer brochures and other publications.
- Health Information Exchange and Policy Analysis, which monitors innovations in health information technology, informatics, and the exchange of health information and provides a clearinghouse of technical resources on health information exchange, electronic prescribing, privacy and security, and other relevant issues.

The Florida Center electronically collects patient data from every Florida-licensed hospital, ASC, emergency department, and comprehensive rehabilitation hospital on a quarterly basis. The Florida Center must maintain any data sets in existence before July 1, 2016, unless such data sets duplicate information that is readily available from other credible sources, and may collect or compile data on:

- Health resources, including licensed health care practitioners, by specialty and type of practice, including information collected by the Department of Health.
- 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, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.
- The extent of public and private health insurance coverage in this state; and
- Specific quality-of-care initiatives involving various health care providers when extant data is not adequate to achieve the objectives of the initiative.

The Florida Center maintains www.FloridaHealthFinder.gov, which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public which allow easy access to information on hospitals, ASCs, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida. The website also provides tools to researchers and professionals to allow specialized data queries, but requires users to have some knowledge of medical coding and terminology. Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator; hospital and ASC performance data; data on mortality, complication, and infection rates for hospitals; and a facility/provider locator. AHCA is frequently improving the functionality of the website by adding more information and search capabilities.

The New Hampshire State Employee SmartShopper Incentive Program

In 2010, the State of New Hampshire began offering state employees a new pilot program called Compass SmartShopper.[52] The program was designed to lower healthcare costs by providing consumers cost information for common elective procedures, and providing cash incentives when they chose to receive care from a cost-effective provider as identified by Compass Healthcare Advisers.[53] The program rewarded employees for being more engaged in the cost of their healthcare decisions, while also helping the state avoid unnecessary claims costs.[54] The incentives are tied to choosing the "most cost-effective", "2nd most cost-effective," or "3rd most cost-effective" option for a list of particular services. The chart below provides an example of the options available for a variety of services within the program:[55]

Incentive Reward Services	Incentive Amount		
	Most Cost-Effective	2nd Most Cost-Effective	3rd Most Cost-Effective
Back Surgery (inpatient laminectomy)	$500	$250	n/a
CT Scan	$150	$75	$50
Hernia Repair	$250	$100	$50
Mammogram	$50	$25	n/a
Tonsillectomy	$150	$75	$50
Ultrasound (non-maternity)	$50	$25	n/a

With three years of education and outreach, the program had produced $12 million in savings and over $1 million paid in incentives.[56] The data shows that:

- Consumers are 11 times more likely to use a transparency program when incentives are included;
- Roughly 90 percent of enrollees have shopped at least once, and 66 percent repeatedly shop and earn incentives;
- The program averages approximately $650 in savings each time an employee shops; and
- In 2015, the program achieved a 13:1 return on investment.

Insurance Regulation

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR), administratively housed within the Department of Financial Services, is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency,

[52] State of New Hampshire, Department of Administrative Services, Vitals SmartShopper Program, available at https://das.nh.gov/hr/Vitals_SmartShopper.html (last accessed February 19, 2017).
[53] Id.
[54] Compass SmartShopper Program Personnel Memo, June 28, 2010, available at https://das.nh.gov/hr/documents/compass%20memo.pdf (last accessed February 19, 2017).
[55] State of New Hampshire, Department of Administrative Services, Incentive List, available at https://das.nh.gov/hr/documents/VitalsSmartShopperIncentiveList.pdf (last accessed February 19, 2017).
[56] Right to Shop: The Next Big Thing in Health Care, Forbes: The Apothecary, August 5, 2016, available at http://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care/ (last accessed February 19, 2017).

viatical settlements, premium financing, and administrative supervision, as provided under the insurance code.[57]

All persons who transact insurance in the state must comply with the Insurance Code (Code).[58] Under the Code, OIR has the power to collect, propose, publish, and disseminate any information relating to the subject matter of the Code,[59] and may investigate any matter relating to insurance.[60] OIR also has the power to levy administrative fines against insurers who violate the Code,[61] as well as deny, suspend, or revoke any certificates of authority, license, or permit.[62]

Effect of the Bill

CS/CS/HB 449 creates the Patient Savings Act, which requires health insurers to create a shared savings incentive program (Program) to encourage insured individuals to shop for high quality, lower cost health care services and share any savings realized as a result of the insured's choice. The bill requires implementation of these incentive programs for plan years beginning on or after January 1, 2018.

Definitions

The bill defines the following terms:

- "Average price" means the average amount paid to an in-network health care provider for a shoppable health care service within a 1-year period or as determined by another method approved by OIR.
- "Contracted amount" means the amount agreed to be paid by the health insurer to a health care provider for shoppable health care services, including any facility fees charged by the provider.
- "Health care provider" is defined as a comprehensive list of more than 25 individual entities or groups that provide a health care service.
- "Health insurer" means an insurer offering individual or group major medical insurance or an HMO.
- "Shared savings incentive program" means the program established by a health insurer that shares any savings with an insured based on that insured's choice of a high quality, lower-cost shoppable health care service as compared to the average price of the service.
- "Shoppable health care service" includes nonemergency health services received by an insured and for which the insured may be eligible to share savings under the Program. The services include:
    - Clinical laboratory services.
    - Infusion therapy.
    - Inpatient and outpatient surgical procedures.
    - Obstetrical and gynecological services.
    - Outpatient nonsurgical diagnostic tests and procedures.
    - Physical and occupational therapy services.
    - Radiology and imaging services.

Shared Savings Incentive Program

The bill requires a health insurer to provide a method for an insured to request information on the contracted amount for shoppable health care services from a health care provider and to compare the

[57] s. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[58] S. 624.11, F.S. The Insurance Code consists of chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S.
[59] S. 624.307(4), F.S.
[60] S. 624.307(3), F.S.
[61] S. 624. 310(5), F.S.
[62] S. 624.310(5)(c), F.S.

average price among providers. Upon the request of an insured, an insurer must provide within 2 working days a good faith estimate of the contracted amount for the shoppable health care service, as well as an estimate of copayments, deductibles, and other cost-sharing responsibilities.

If, using the information from the health insurer, the insured obtains a shoppable health care service for less than the average price for the service, the bill requires the savings to be shared by the health insurer and the insured. The cash payment can be calculated as a percentage between the contracted amount and the average price, or by an alternative method approved by OIR. The bill requires the cash payment be at least 50 percent of the health insurer's saved cost as compared to the average price. If an insured elects to receive a shoppable healthcare service from an out-of-network provider for less than the average in-network price, that service must be treated as in-network for purposes of calculating the incentive payment. The bill does not require a cash incentive payment to an insured for cost savings less than $50, and incentive payments are not considered administrative expenses for purposes of rate development or filing.

The Program must be a component part of the policy, contract, or certificate of insurance provided by the health insurer, and the health insurer must notify its insureds of the Program annually and at the time of enrollment and renewal.

Reports

The bill requires a health insurer to file a description of its Program by March 1, 2018 and each year thereafter with OIR, on a form prescribed by OIR, and requires an annual report to OIR that must include the:

- Total number of incentive payments made for the calendar year;
- Shoppable health care services by category for which payments were made;
- Average amount of incentive payments;
- Total amount saved by the health insurer when compared with the average prices for each shoppable health service; and
- Total number of insured and the percentage of total insured who participated in the program.

The bill requires OIR to submit an annual report to the President of the Senate and the Speaker of the House by April 1, 2019, and each year thereafter, which summarizes the annual Program reports submitted by the health insurers.

Enforcement

The bill permits OIR to impose an administrative penalty of no more than $5,000 per violation per day against a health insurer which fails to comply with s. 627.6387, F.S. In addition, OIR is specifically authorized to suspend for 12 months or revoke the certificate of authority for a health insurer which fails to comply with the section. For health insurers that fail to meet the required filing deadline, the bill also allows OIR to order the health insurer to discontinue the issuance of policies, contracts, or certificates of insurance until the filing requirement has been fulfilled.

Finally, the bill provides OIR with rulemaking authority to implement the provisions of the bill.

The bill provides an effective date of upon becoming law.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.42351, F.S., relating to shared savings incentive program.
Section 2: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

OIR may realize an increase in workload as a result of ensuring compliance with the Program by health insurers and imposing the specific penalties for those health insurers that are not in compliance. There may be additional increased workload associated with compiling the Program reports from each health insurer and compiling the summary report for the President of the Senate and the Speaker of the House of Representatives each year.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health insurers may incur administrative costs as a result of their responsibilities under this bill; however, these costs may be offset or more than offset by the savings realized from the Program.

Insureds who participate in the Program will benefit from any compensable savings they earn.

D. FISCAL COMMENTS:

None.

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:

OIR is granted sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 22, 2017, the Health Innovation Subcommittee adopted a strike-all amendment to HB 449. The strike-all amendment:

- Removed self-insured plans from the definition of "health insurer";
- Required health insurers to include quality information for each shoppable health service and health care provider on their website;
- Removed the private cause of action as an enforcement mechanism;
- Increased the possible administrative penalty from $2,500 to $5,000 per violation, per day;
- Increased the possible amount of time an insurer's certificate of authority may be suspended from 6 months to 12 months; and
- Made non-substantive, technical changes to bill language for clarity and conciseness.

On March 7, 2017, the Insurance & Banking Subcommittee considered and adopted three amendments and reported the bill favorably as a committee substitute. The amendments:

- Moved the language from part VI of ch. 627, F.S., to part II of ch. 627, F.S., and revised the definition of "health insurer" to include insurers offering individual and group major medical insurance, except the State Group Health Insurance Program.
- Revised the reference to the plan year from "beginning on January 1, 2018" to "beginning on or after January 1, 2018."
- Provided a deadline for health insurers to file the required data with the Office of Insurance Regulation.

This analysis is drafted to the committee substitute as passed by the Insurance & Banking Subcommittee.