The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1560
INTRODUCER:	Senator Flores
SUBJECT:	Price Transparency in Contracts
DATE:	March 29, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			HP	
3.			RC	

I. Summary:

SB 1560 provides that a contract between an insurer and a health care provider may not limit the ability of a health care provider to disclose whether an insured's cost-sharing obligation exceeds the retail price of a covered service or to disclose the availability of a more affordable service. Further, the bill provides that a contract between an insurer and a health care provider must prohibit the insurer from requiring an insured's cost-sharing obligation for a covered service exceeding the retail price of a service provided by the health care provider.

The bill may provide consumers with greater affordability options for obtaining health care services.

II. Present Situation:

Health care spending in the United States is expected to grow an average of 5.5 percent annually from 2018-2027, reaching nearly $6.0 trillion by 2027.[1] Consumers are becoming responsible for a growing proportion of this spending, as demonstrated in the increased use of high deductible health plans, and other forms of cost sharing. Since 2012, the percentage of workers covered by a plan with a deductible of $1,000 or greater has grown from 34 to 51 percent.[2]

Price transparency and quality transparency enable consumers to obtain more value out of the health care system. Greater awareness and access by consumers to pricing information before obtaining health care services may result in lower overall payments for health care services and higher quality providers. A recent study concluded that the use of private price transparency

[1] Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Projections 2018-2027, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf (last viewed March 2, 2019).

[2] North Carolina Medical Journal, 79. 1.34.

platforms was associated with lower claims payments for common medical services. [3] According to a 2017 survey, 98 percent of health plans around the country indicated that they have cost calculator tools, but only 2 percent of policyholders or subscribers use them.[4] Financial incentives may encourage consumer to access price information. Incentives may include reductions in premiums, cash payments, or lower out-of-pocket costs for their members if they select low-price, high quality providers.

Regulation of Health Insurance

The Office of Insurance Regulation is responsible for the regulation of insurers and other risk-bearing entities.[5] Rates and forms of individual and small group policies and contracts are subject to prior approval.

Section 627.6385, F.S., requires health insurers writing individual policies to make available on their website a method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities for health care services and procedures.[6] Insurers are required to provide a hyperlink to health information, including service bundles and quality of care information, developed by the Agency for Health Care Administration. Likewise, the federal Patient Protection and Affordable Care Act[7] requires insurance policies and contracts to provide price and coverage information to enrollees, including cost sharing and payments with respect to out-of-network coverage.[8]

Florida Patient's Bill of Rights and Responsibilities

The Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights) establishes the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[9] 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.

[3] JAMA. 2014:312(16):1670-1676.
[4] Catalyst for Payment Reform Survey available at http://www.catalyzepaymentreform.org/wp-content/uploads/2017/04/National-Scorecard.png (last viewed March 2, 2019).
[5] Section 20.121, F.S. The Financial Services Commission, composed of the Governor, Attorney General, Commissioner of Agriculture, and the Chief Financial Officer, are the agency head for purposes of rulemaking.
[6] The Agency for Healthcare Administration, available at http://www.floridahealthfinder.gov/index.html (last viewed March 2, 2019).
[7] Patient Protection and Affordable Care Act, Public Law 111–148, was enacted on March 23, 2010; and amended by the Health Care and Education Reconciliation Act, Public Law 111–152, was enacted on March 30, 2010.
[8] 45 CFR Part 147 and Section 2715A Public Health Service Act.
[9] S. 381.026(3), F.S.

Section 381.026(4)(c), F.S., provides that a patient has the right to request certain financial information from health care providers and facilities.[10] 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.[11] The provision of a 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.[12]

The Patient's Bill of Rights allows, primary care providers[13] to publish a schedule of charges for the medical services offered to patients, but requires the primary care provider to post the schedule in a conspicuous place in the reception area of the provider's office. The schedule must include price information for at least the 50 services most frequently provided by the primary care provider.[14]

The law requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[15] This applies to any entity that holds itself out to the 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 schedule requirements for urgent care centers are the same as those established for primary care providers.[16]

Health Care Provider and Facility Price Transparency

Section 395.301, F.S., requires a health care facility[17] to provide, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the required estimate is subject to a $500 fine for each instance of the facility's failure to provide the requested information.

Also pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and

[10] Section 381.026(4)(c), F.S.
[11] Section 381.026(4)(c)3., F.S.
[12] *Id.*
[13] Section 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.
[14] *Id*.
[15] Section 395.107(1), F.S.
[16] Section 395.107(2), F.S.
[17] The term, "health care facilities," refers to hospital, ambulatory surgical centers, and mobile surgical centers, all of which are licensed under part I of ch. 395, F.S.

including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Health care facilities are required to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services provided.[18] The Agency for Health Care Administration contracts with a vendor to collect and publish this cost information to consumers on an internet site.[19] Hospitals and other facilities are required to post a link to this internet site to comply with the price transparency requirements.[20] The cost information is searchable, and based on descriptive bundles of commonly performed procedures and services. At a minimum, the information must provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[21] The law also establishes the right of a patient to request a personalized estimate on the costs of care from health care practitioners who provide services in a licensed hospital facility or ambulatory surgical center.[22]

III. Effect of Proposed Changes:

Section 1 creates s. 627.4303, F.S., to provide that a contract between a health insurer and a health care provider may not limit a provider's ability to disclose whether a patient's cost-sharing obligation exceeds the retail price for a covered service or to disclose the availability of a more affordable service. Further, a contract between a health insurer and health care provider must prohibit the insurer from requiring the insured to pay an amount for a service that exceeds the retail price of the service in the absence of health insurance.

As used in this section, the term, "health insurance," has the same meaning as provided in s. 627.4301, F.S. Section 627.4301, F.S., defines the term, "health insurer," to mean an authorized insurer offering health insurance as defined in s. 624.603, F.S., a self-insured plan as defined in s. 624.031, F.S., a multiple-employer welfare arrangement as defined in s. 624.437, F.S., a prepaid limited health service organization as defined in s. 636.003, F.S., a health maintenance organization as defined in s. 641.19, F.S., a prepaid health clinic as defined in s. 641.402, F.S., a fraternal benefit society as defined in s. 632.601, F.S., or any health care arrangement whereby risk is assumed. Section 624.603, F.S., defines the term, "health insurance," also known as "disability insurance," as insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto.[23]

Section 2 provides this bill takes effect July 1, 2019.

---

[18] S. 395.301, F.S.
[19] S. 408.05(3)(c), F.S.
[20] See Agency for Health Care Administration, https://pricing.floridahealthfinder.gov/ (last viewed Mar. 3, 2019).
[21] *Id*.
[22] S. 456.0575(2), F.S.
[23] Section 624.603, F.S., also provides that health insurance does not include workers' compensation coverages, except as provided in s. 624.406(4). F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

The bill does not address whether the provisions apply prospectively to future contracts between a person and an insurer or an HMO or to contracts in existence on the effective date of the bill. However, s. 624.21, F.S., provides that any amendment to the Insurance Code[24] will be deemed to operate prospectively where no contrary intent is specified.

Article I, section 10 of the State Constitution provides:

> **Prohibited laws.—**No bill of attainder, ex post facto law or law impairing the obligation of contracts shall be passed.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will allow a health care provider to discuss freely information to an insured that may reduce an insured's out-of-pocket costs if that information was previously prohibited by contract.

The bill may cause health care providers to incur indeterminate, additional administrative costs to ensure that pricing information is available to insureds during an appointment or at the time of payment.

[24] *See* s. 624.01, F.S. ("Chapters 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the 'Florida Insurance Code.'")

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The bill provides that a contract between a health insurer and a health care provider must prohibit the insurer from requiring an insured to pay an amount for services that exceeds the retail price of the service in the absence of health insurance. It appears that this contractual prohibition should be placed in the contract between the insurer and the insured since it relates to the contractual duties and obligations between the insurer and insured.

The bill addresses contractual provisions, rather than the actions of insurers, which limits the OIR's enforcement authority to determining whether contracts between health insurers and health care providers violate the statute. If the bill prohibited insurers from taking certain actions, it would allow the OIR to oversee the market conduct of insurers and would also prohibit contractual provisions requiring such actions as insurers may not enter into contracts requiring violations of the Insurance Code.

It is unclear what the term, "retail price," means, as well as how often it would be determined. The bill appears to be referring to the amount a consumer would pay in the absence of insurance coverage.

VII. Related Issues:

The broad definition of the terms, "health insurer" and "health insurance," provided in the bill may result in the application of the bill's contractual requirements on health insurers that write insurance products that are not major medical or comprehensive coverage, such as excepted benefit, limited benefit, indemnity benefit, and supplemental benefit policies. It is unclear if the contractual prohibitions would apply to a prepaid health clinic since a prepaid health clinic contract is a contract entered into with a subscriber or group of subscribers to provide basic services.[25]

VIII. Statutes Affected:

This bill creates section627.4303 of the Florida Statutes.

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.

[25] Section 641.402, F.S.