HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1205 Price Transparency in Health Care Services
SPONSOR(S): Health & Human Services Committee, Rodriguez, A.
TIED BILLS: **IDEN./SIM. BILLS:** SB 1626

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	14 Y, 0 N	Grabowski	Calamas
2) Insurance & Banking Subcommittee	13 Y, 0 N	Fortenberry	Cooper
3) Health & Human Services Committee	17 Y, 0 N, As CS	Grabowski	Calamas

SUMMARY ANALYSIS

The United States is experiencing significant changes in health care payment and delivery. Consumers bear a greater share of health care costs, and more participate in high deductible health plans. Clear, accurate information about the cost and quality of health care is necessary for consumers to select value-based health care.

CS/HB 1205 prohibits a health insurer or health maintenance organization (HMO) from limiting a health care provider's ability to disclose whether a patient's cost-sharing obligation under his or her health insurance exceeds the cash price for a covered service. In addition, insurers and HMOs must not prevent providers from communicating the availability of more affordable services to insured patients.

The bill also prohibits an insurer or HMO from requiring an insured patient to make a payment for a health care service that exceeds the cash price of that service in the absence of health insurance.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2020.

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. Consumers bear a greater share of health care costs, and more participate in high deductible health plans. 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 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 on 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 or the price or cost of health care has different meanings depending on who is incurring the cost.[4]

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 five Americans with private insurance is enrolled in a high deductible health plan (HDHP). 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-one 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.[5]

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,573.[6] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $2,132 in small firms, compared to $1,355 for workers in large firms.[7] Sixty-eight percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 54% in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (42% for small firms vs. 20% for large firms). The chart below 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 2009 through 2018.[8]

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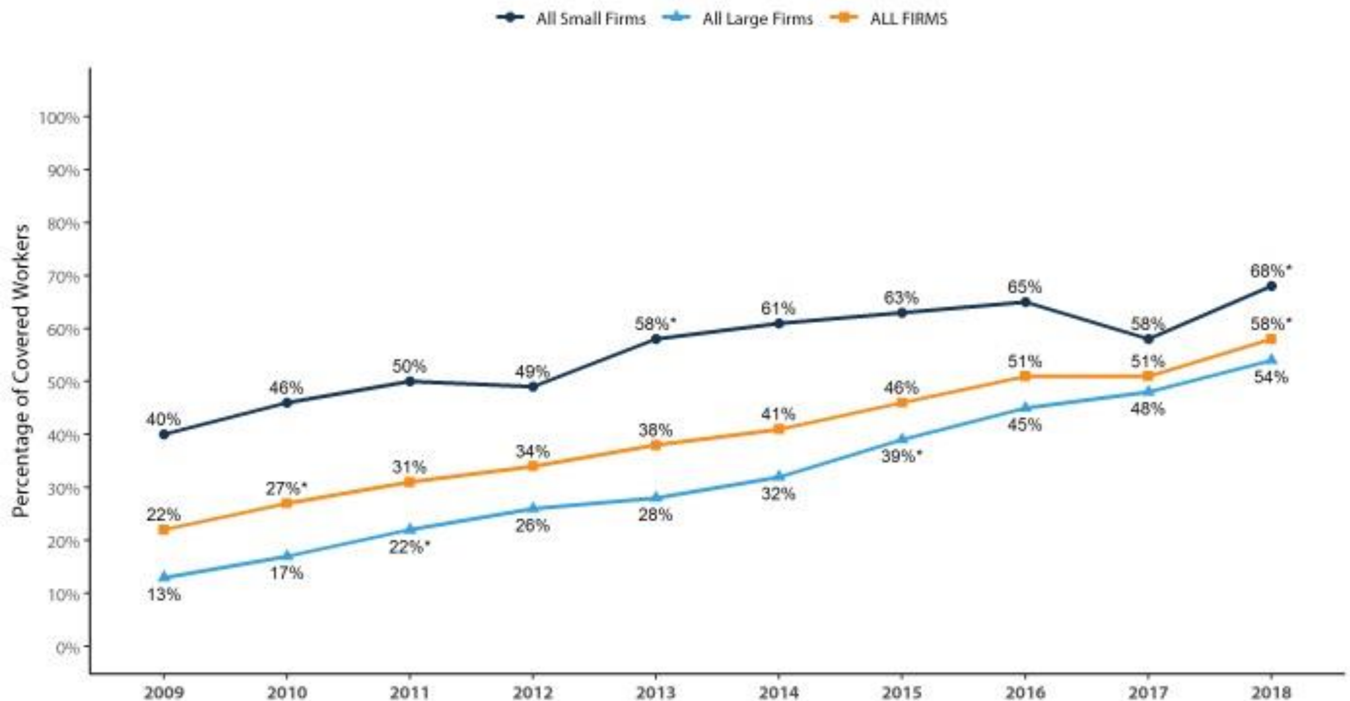
[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 2, available at http://www.gao.gov/products/GAO-11-791 (last accessed December 16, 2019).
[2] Id.
[3] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, page 2, 2014, available at https://www.hfma.org/Content.aspx?id=22305 (last accessed December 16, 2019).
[4] Id.
[5] The Henry J. Kaiser Family Foundation, *2018 Employer Health Benefits Survey*, October 3, 2018, available at http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018 (last accessed December 16, 2019).
[6] Id.
[7] Id.
[8] Id, figure 7.13.

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2009-2018



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

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 59% in 2008 to 78% in 2013 to 85% in 2018. If we look at the change in deductible amounts for all covered workers (assigning a zero value to workers in plans with no deductible), we can look at the impact of both trends together. Using this approach, the average deductible for all covered workers in 2018 is $1,350, up 53% from $883 in 2013 and 212% from $433 in 2008.

From 2013 to 2018, the average premium for covered workers with family coverage increased 20%, while wages have only increased 12%.[9] The dramatic increases in the costs of healthcare in recent years have focused significant attention on the need for greater communication and transparency to inform individual health care choices.

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.

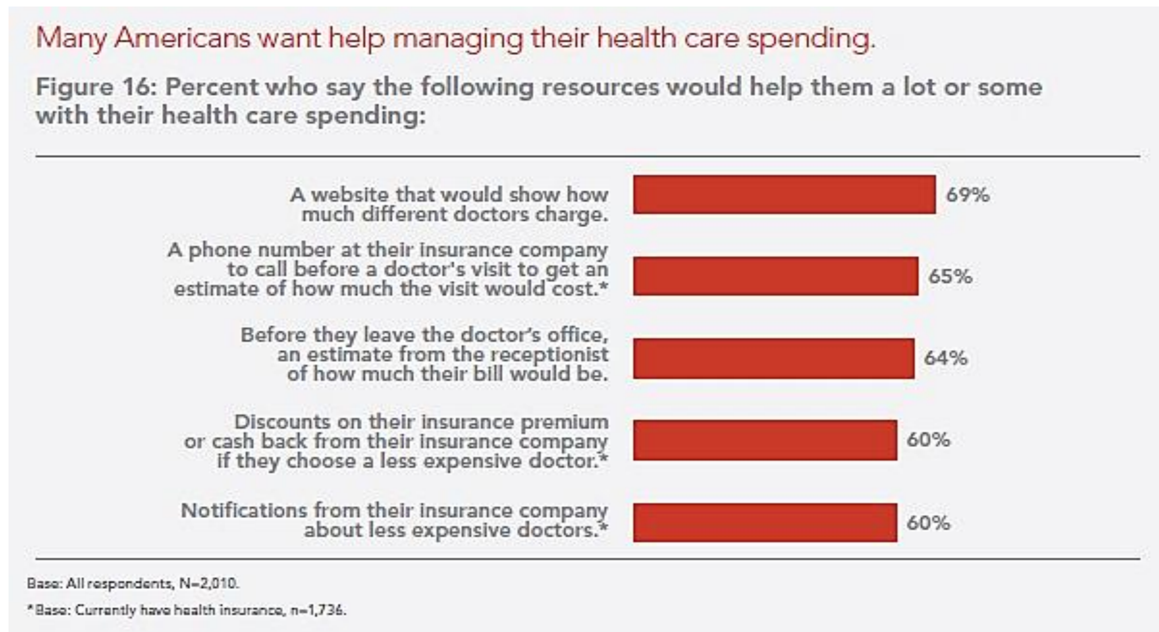
- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.

[9] Id.

- 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.[10]

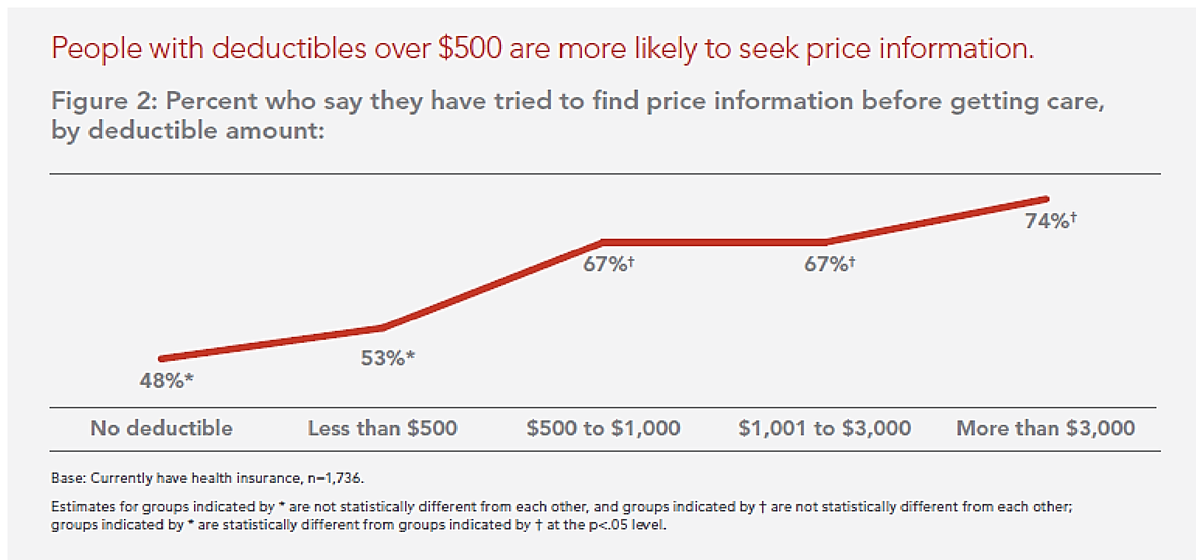
The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[11]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[12]



[10] 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 (last accessed December 16, 2019).
[11] Id., pg. 1.
[12] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, pg. 34, available at https://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf (last accessed December 16, 2019).

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.[13] The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.[14]



The individuals who compared prices stated that such research affected their health care choices and saved them money.[15] In addition, the study found that most Americans do not equate price with quality of care. Seventy one percent do not believe higher prices impart a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[16] Consumers enrolled in high-deductible and consumer-directed health plans are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. Accordingly, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price transparency tool.[17] 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.[18]

Price Transparency in Florida Law

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).[19] 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.[20]

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[13] Id., pg. 3.
[14] Id., pg. 13.
[15] Id., pg. 4.
[16] Supra note 12.
[17] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, pg. 4, available at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126 (last accessed December 16, 2019).
[18] 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.
[19] 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.
[20] S. 381.026(3), F.S.

Under s. 381.026(4)(c), F.S., a patient has the right to request certain financial information from health care providers and facilities.[21] 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.[22] Estimates must be written in language "comprehensible to an ordinary layperson".[23] 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.[24] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[25]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[26] to publish a schedule of charges for the medical services offered to patients.[27] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[28] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size.[29] 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.[30] The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[31]

In addition, current licensure law requires all practitioners regulated by the Department of Health or its boards to provide an estimate for nonemergency services provided in a hospital or ambulatory surgical center, if the patient requests it. This provision is an enforceable licensure standard, and failure to provide the estimate is subject to a daily fine of $500 until the estimate is provided.[32]

Health Care Facilities

Under s. 395.301(1)(b)1., F.S., a health care facility[33] must provide, within 7 days of a request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's or prospective patient's condition. The facility is not required to adjust the estimate for any potential insurance coverage.[34] The facility must inform the patient or prospective patient of the option to contact his or her insurer or Health maintenance organization (HMO) to obtain additional information regarding cost-sharing.[35] Upon request, the facility must also notify the patient or prospective patient of any revision to the estimate.[36] Failure to timely provide the estimate as requested will result in a daily fine of $1,000 until the estimate is provided, with a total fine not to exceed $10,000.[37]

Pursuant to s. 395.301(1)(d)1., F.S., upon request and at discharges or release from a facility, the facility must provide a patient or the patient's survivor or legal guardian, an itemized bill or statement detailing the charges or expensed incurred by the patient.

Prescription Drug Transparency

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[21] S. 381.026(4)(c), F.S.
[22] S. 381.026(4)(c)3., F.S.
[23] Id.
[24] Id.
[25] S. 381.026(4)(c)5., F.S.
[26] 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.
[27] S. 381.026(4)(c)3., F.S.
[28] Id.
[29] Id.
[30] S. 381.026(4)(c)4., F.S.
[31] S. 395.107(1), F.S.
[32] S. 456.0575(2), F.S.
[33] The term "health care facilities" refers to hospital, ambulatory surgical centers, and mobile surgical centers, all of which are licensed under ch. 395, part I, F.S.
[34] S. 395.301(1)(b)1., F.S.
[35] Id.
[36] Id.
[37] Id.

In 2018, the Legislature approved statutory changes to ensure that pharmacists can freely communicate pricing information to patients.[38] Those changes were aimed at pharmacy benefit managers (PBMs), which are entities that provide services related to the acquisition and distribution of prescription drugs. PBMs enter into contracts with both health plans and pharmacies. PBMs negotiate with drug manufacturers, on behalf of health plans, in an effort to purchase drugs at reduced prices or with the promise of additional rebates. This negotiation process often involves the development of drug formularies, which are tiered drug lists that incentivize the use of some drugs over others.[39] PBMs simultaneously negotiate with pharmacies to establish reimbursements for dispensing prescription drugs to patients.

Current Florida law requires contracts between pharmacy benefit managers (PBMs) and insurers or HMOs to include a prohibition on PBM practices that may limit the ability of a pharmacy or pharmacist to communicate with patients. Each contract must prohibit a PBM from restricting the ability of a pharmacy or pharmacist to disclose to a patient whether his or her cost sharing obligation under an insurance benefit exceeds the retail price of a drug, and whether a more affordable alternative drug may be available.[40]

Congress also passed two complementary laws in 2018 aimed at improving drug price transparency for insured patients.[41] The laws prohibit all private health insurers and all Medicare plans covering prescription drugs from limiting the ability of pharmacies and pharmacists to provide patients with relevant price information on the drugs they purchase. Under the laws, no PBM or insurer may prevent a pharmacist from informing a patient about any difference in the cost of a drug under that patient's insurance versus the cash price of the drug.

Both the federal laws and Florida law apply only to price information shared in the context of prescription drug coverage. Current law does not otherwise prohibit any limits on price transparency that may exist in contracts between health plans and service providers, such as physicians and clinics.

Effect of Proposed Changes

CS/HB 1205 prohibits a health insurer or HMO from limiting a health care provider's ability to disclose whether a patient's cost-sharing obligation under his or her health insurance exceeds the cash price for a covered service.[42] The bill expands existing law protecting the communication rights of pharmacies and pharmacists to include all providers of health care services. In addition, an insurer or HMO may not prevent a provider from communicating the availability of more affordable services to an insured patient.

The bill also prohibits an insurer or HMO from requiring an insured patient to make a payment for a health care service that exceeds the cash price of that service in the absence of health insurance.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.4303, F.S.; relating to price transparency in contracts between health insurers and health care providers.
Section 2: Amends s. 627.6699, F.S.; relating to employee health care access act.

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[38] Ch. 2018-91, Laws of Fla.
[39] Academy of Managed Care Pharmacy (AMCP). *Formulary Management*. Available at https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/formulary-management (last accessed January 2, 2020). *See also* Pharmaceutical Care Management Association (PCMA). *Pharmacy Contracting & Reimbursement*. Available at https://www.pcmanet.org/policy-issues/pharmacy-contracting-reimbursement/ (last accessed January 2, 2020).
[40] Ss. 627. 64741, 627.6572, and 641.314, F.S.
[41] Public Laws 115-162 and 115-263.
[42] While cash price is not a defined term, in the healthcare context it generally refers to the price that a health care provider would charge a patient who does not have health insurance.

Section 3: Creates s. 641.516, F.S.; relating to price transparency in health care services.
Section 4: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

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:

The bill neither authorizes nor requires administrative rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 12, 2020, the Health and Human Services Committee adopted a strike-all amendment to the bill which specified that the bill's provisions apply to all state-regulated health plans. This includes individual health insurance policies, small and large group policies, and HMO coverage contracts.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.