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 1626
INTRODUCER:	Senator Flores
SUBJECT:	Price Transparency in Health Care Services
DATE:	February 10, 2020
REVISED:	

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

I. Summary:

SB 1626 provides that a contract between an insurer or health maintenance organization (HMO) and a health care provider may not limit the ability of the health care provider to disclose whether the cost-sharing obligation of an insured or subscriber exceeds the retail price of a covered service or to disclose the availability of a more affordable service. Further, the bill provides that an insurer or HMO may not require an insured or subscriber to pay an amount for covered service that exceeds the cash price of the service in the absence or coverage through a policy or contract of health insurer or HMO.

II. Present Situation:

Health care spending in the United States is expected to grow an average of 5.5 percent annually from 2018-2027.[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.

Federal law prescribes maximum out-of-pocket limits for cost sharing by insureds or subscribers who purchase qualified health plans.[2] The minimum annual deductible is the amount that an individual must pay for medical expenses before the plan will pay any medical costs. The maximum out of pocket cost is the total amount (deductibles, copayments, and coinsurance) an individual must pay for covered services during a plan year. A high-deductible health plan HDHP has a higher annual deductible than typical health plans offered by insurers or HMOs, and

[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 Feb. 2, 2020).

[2] For the 2020 plan year, the out-of-pocket limit for a Marketplace plan or qualified health plan is $8,200 for an individual plan and $16,400 for a family plan. *See* Health.gov, Glossary, *https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/* (last viewed Dec. 1, 2019).

a maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that an insured or subscriber must pay for covered expenses.[3]

From 2007 through 2017, enrollment in HDHPs with a health savings account (HSA) increased from 4.2 percent to 18.9 percent (and without an HSA it increased from 10.6 percent to 24.5 percent) among adults aged 18–64 with employment-based coverage, while enrollment in traditional plans decreased.[4] Enrollment in HDHPs reached 47 percent of the commercially insured, pre-Medicare population in 2018, representing a 3.3-percentage-point increase from 2017.[5]

According to the Kaiser Family Foundation, the average deductible for single coverage was $1,655 in 2019 for employer-based plans.[6] The average deductible for HDHPs was $2,486 for a single plan. Further, the Kaiser Family Foundation said the average HDHP deductible for family coverage was about $3,700 for employer-based plans in 2019.

Regulation of Health Insurers and Health Maintenance Organizations in Florida

The Office of Insurance Regulation (OIR) is responsible for the regulation of health insurers, health maintenance organizations, and other risk-bearing entities.[7] To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.[8] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[9] As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[10]

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

[3] For 2020, a high deductible health plan (HDHP) is defined as any plan with a deductible of at least $1,400 for an individual or $2,800 for a family. An HDHP's total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) may not exceed $6,900 for an individual or $13,800 for a family. *See* Health.gov, *High Deductible Plan*, https://www.healthcare.gov/high-deductible-health-plan/ (last viewed Dec. 1, 2019).
[4] Cohen RA, Zammitti EP. High-deductible health plan enrollment among adults aged 18–64 with employment-based insurance coverage. NCHS Data Brief, no 317. Hyattsville, MD: National Center for Health Statistics. 2018. at https://www.cdc.gov/nchs/products/databriefs/db317.htm (last viewed Jan. 30, 2020).
[5] Daly, R., High-Deductible Plans Surge: CDC (Aug. 29, 2018) at https://www.hfma.org/topics/news/2018/08/61762.html (last viewed Jan. 20, 2020).
[6] Kaiser Family Foundation, 2019 Employer Health Benefits Survey (Sept. 25, 2019) at https://www.kff.org/report-section/ehbs-2019-section-8-high-deductible-health-plans-with-savings-option/ (last viewed Jan. 20, 2019).
[7] 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.
[8] Section 641.21(1), F.S.
[9] Sections 624.401 and 641.49, F.S.
[10] Section 641.495, F.S.

cost-sharing responsibilities for health care services and procedures.[11] Likewise, federal law[12] requires insurance policies and contracts to provide price and coverage information to enrollees, including cost sharing and payments with respect to coverage.[13]

III. Effect of Proposed Changes:

Section 1 creates s. 627.4303, F.S., to prohibit certain provisions in contracts between health insurers and health care providers. 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 health insurer may not require an insured to pay an amount for a covered service that exceeds the retail price of the service in the absence of health insurance.

As used in this section, the term, "health insurer," means a health insurer issuing major medical coverage through an individual or group policy or a health maintenance organization issuing major medical coverage through an individual or group contract.

Section 2 provides this bill takes effect July 1, 2020.

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:

None.

[11] The Agency for Healthcare Administration, available at http://www.floridahealthfinder.gov/index.html (last viewed March 2, 2019).
[12] 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.
[13] 45 CFR Part 147 and Section 2715A Public Health Service Act.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

For individuals with high deductible health plans, the option of paying a lower cash price may prevent delays in obtaining necessary health care services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

It appears that the intent of the bill is to apply the requirements to individual, and small and large group policies, as well as HMO contracts. However, the bill does not amend s. 627.6699, F.S., relating to small employer group plans. Amending ch. 641, F.S., would provide greater clarity regarding the application of the HMO requirements.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 627.4303 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.