HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 1067 Health Care Expenses
SPONSOR(S): Health & Human Services Committee, Finance & Facilities Subcommittee, Rommel
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Facilities Subcommittee	18 Y, 0 N, As CS	Grabowski	Lloyd
2) Health & Human Services Committee	20 Y, 1 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.

The bill requires hospitals and ambulatory surgical centers to post a consumer-friendly list of standard charges for at least 300 shoppable health care services on a facility website, consistent with federal rule.

Current law requires hospitals and ambulatory surgical centers to provide patients with personalized pre-treatment estimates on the costs of care, *upon patient request*. Effective July 1, 2022, the bill makes the estimate mandatory, regardless of whether a patient requests it, and requires a facility to transmit the estimate to a patient's health plan, consistent with the federal No Surprises Act of 2020. A facility that levies charges exceeding the provided estimate by more than 10% must clearly document a rationale for those increased charges in a written communication to the patient. In addition, a facility that fails to provide a patient estimate of charges at least 24 hours before furnishing treatment is prohibited from billing or collecting for those services.

The bill requires a health plan, upon receipt of a facility cost estimate, to develop an advanced explanation of benefits in accordance with the federal No Surprises Act of 2020. This requirement is effective July 1, 2022, to coincide with the facility estimate requirement.

The bill requires hospitals and ambulatory surgical centers to establish an internal grievance process for patients to dispute charges that appear on an itemized statement or bill. Additionally, the bill prohibits these facilities from taking collection actions to collect medical debt before determining whether a patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, and for 30 days after notifying a patient in writing that a collections action will commence.

Current law provides a court process for the collection of lawful debts, and makes some limited exemptions for personal property. The bill increases exemptions from attachment, garnishment, or other legal process to include a single motor vehicle and personal property of a debtor of a value up to $10,000 when debt is incurred as a result of medical services provided in a licensed hospital facility, unless the property receives the higher protection of a homestead exemption.

Lastly, the bill specifies that shared savings incentives offered by health plans are to be counted as medical expenses for rate development and rate filing purposes, consistent with recent federal regulations.

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

The bill provides an effective date of July 1, 2021, except as otherwise specified.

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 of 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. 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[5] for single coverage that must be met before most services are paid for by their health plan.[6]

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,644.[7] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $2,295 in small firms, compared to $1,418 for workers in large firms.[8] Sixty-four 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 percent in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (42 percent for small firms vs. 20 percent 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 2020.[9]

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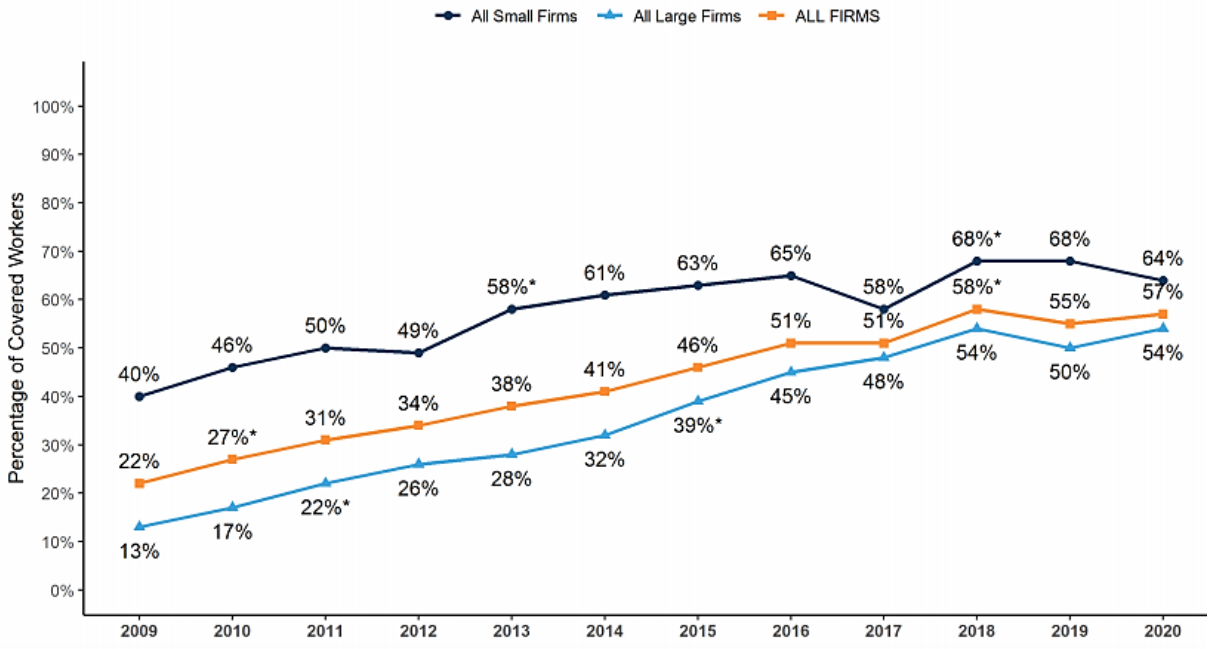
[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, pg. 2, available at http://www.gao.gov/products/GAO-11-791 (last accessed February 11, 2021).
[2] Id.
[3] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, pg. 2, 2014, available at https://www.hfma.org/content/dam/hfma/document/policies_and_practices/PDF/22279.pdf (last accessed February 11, 2021).
[4] Id.
[5] The term "general annual deductible" means a deductible which applies to both medical and pharmaceutical benefits and which must be met by the insured individual before most services are covered by the health plan.
[6] The Henry J. Kaiser Family Foundation, *2020 Employer Health Benefits Survey*, October 8, 2020, available at https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/ (last accessed February 11, 2021).
[7] Id.
[8] Id.
[9] Id, figure 7.13.

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, 2009-2020



* 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, 2018-2020; 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 83% in 2020. 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 $1,364, up 53% from $883 in 2013 and 212% from $433 in 2008.

From 2015 to 2020, the average premium for covered workers with family coverage increased 22%, while inflation totals just 10% over the same period.[10] The dramatic increases in the costs of health care 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.

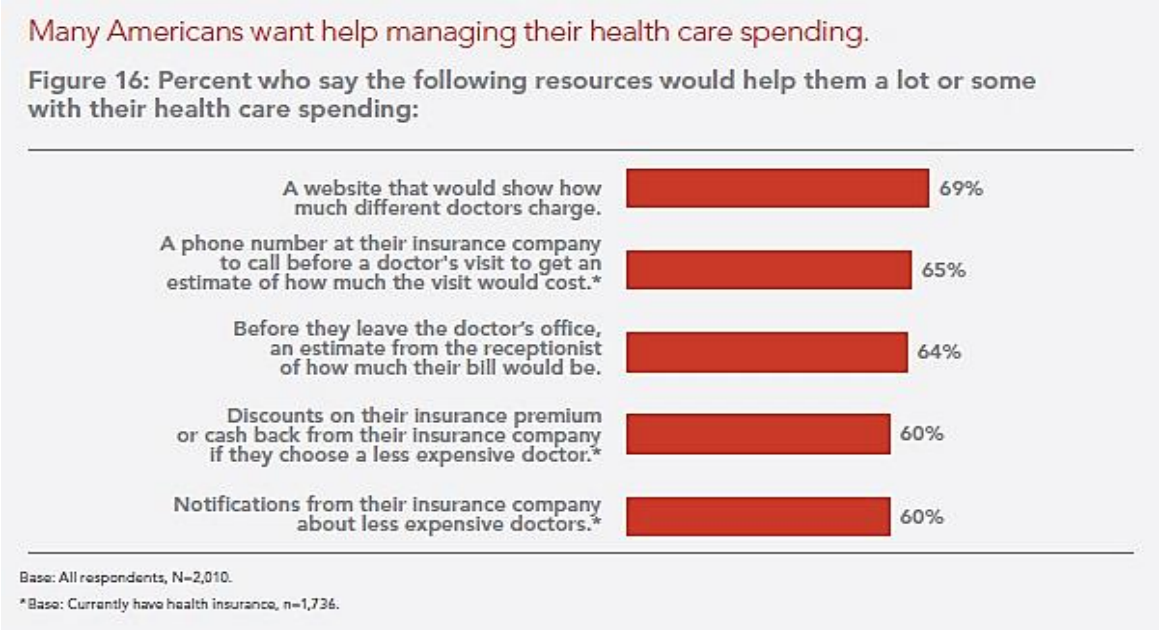
- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.

[10] Id.

- Expand state-based all-payer health claims databases, 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.[11]

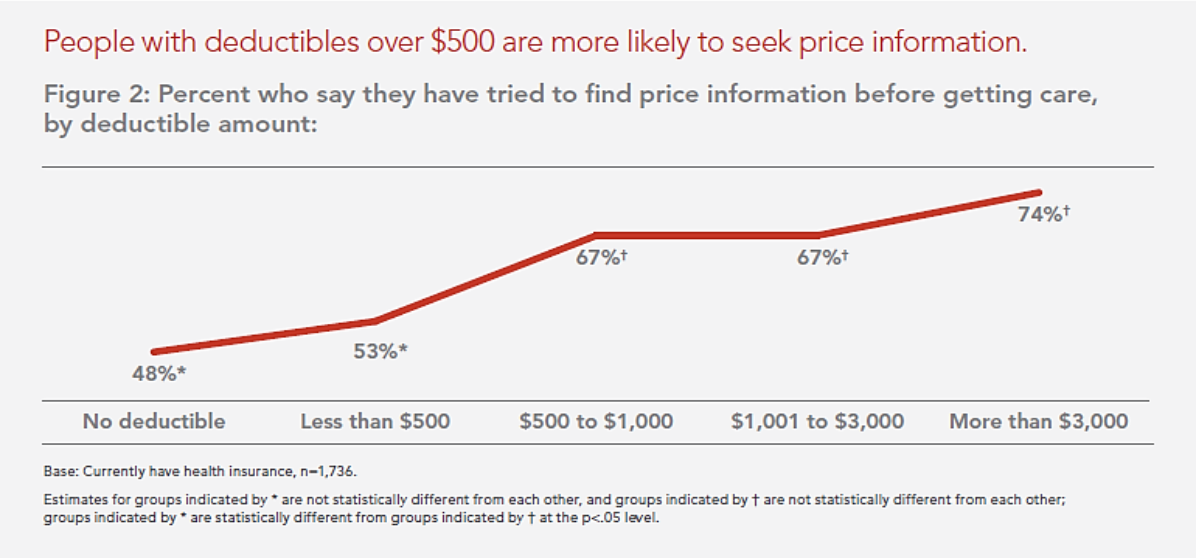
The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[12]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[13]



One study in 2014, which included a survey of more than 2,000 adults from across the country, 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.[14] 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.[15]

[11] 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 February 11, 2021).
[12] Id., pg. 1.
[13] 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/reports/how-much-will-it-cost-how-americans-use-prices-in-health-care/ (last accessed February 11, 2021).
[14] Id., pg. 3.
[15] Id., pg. 13.



The individuals who compared prices stated that such research affected their health care choices and saved them money.[16] In addition, the study found that most Americans do not equate price with quality of care. Seventy-one percent do not believe higher price reflects a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[17] 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.[18] 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.[19]

Florida 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).[20] 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.[21] 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.

[16] Id., pg. 4.
[17] Supra note 14.
[18] 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 February 11, 2021).
[19] 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.
[20] 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.
[21] S. 381.026(3), F.S.

A patient has the right to request certain financial information from health care providers and facilities.[22] 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.[23] Estimates must be written in language "comprehensible to an ordinary layperson."[24] 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.[25] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[26]

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 Florida Patient's Bill of Rights and Responsibilities 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 licensed facility must place a notice in its reception area that financial information related to that facility is available on the website of the Agency for Health Care Administration (AHCA).
- 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 Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[27]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[28] to publish a schedule of charges for the medical services offered to patients.[29] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[30] 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.[31] 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.[32]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[33] This applies to 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 schedule requirements for urgent care centers are the same as those

[22] S. 381.026(4)(c), F.S.
[23] S. 381.026(4)(c)3., F.S.
[24] Id.
[25] Id.
[26] S. 381.026(4)(c)5., F.S.
[27] S. 381.0261, F.S.
[28] 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.
[29] S. 381.026(4)(c)3., F.S.
[30] Id.
[31] Id.
[32] S. 381.026(4)(c)4., F.S.
[33] S. 395.107(1), F.S.

established for primary care providers.[34] The schedule must 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. 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).[35]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[36] must 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[37] 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 estimate as required may be fined $500 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 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.

Current law also directs these health care facilities 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 actually provided.[38] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[39] Hospitals and other facilities post a link to this site - https://pricing.floridahealthfinder.gov/ - to comply with the price transparency requirements. The cost information is searchable, and based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[40]

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.[41]

Shared Savings Programs

[34] S. 395.107(2), F.S.
[35] S. 395.107(6), F.S.
[36] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.
[37] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention and resource intensity. For more information, see https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf.
[38] S. 395.301, F.S.
[39] S. 408.05(3)(c), F.S.
[40] Id.
[41] S. 456.0575(2), F.S.

In 2019, the Legislature adopted the Patient Savings Act,[42] which allows 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 with the insured, as a result of the insured's choice. The Act authorized implementation of these incentive programs for plan years beginning January 1, 2020.

The law permits an issuer of individual and group health insurance policies, as well as a health maintenance organization (HMO), to establish a program. An established program may offer a shared savings incentive payment to an insured who receives treatment from a comprehensive list of more than 25 individual entities or groups that provide a health care service; this includes hospitals, physicians, nursing homes, pharmacies, and others.[43]

Health insurers who choose to offer a program must develop a website outlining the range of "shoppable health care services"[44] available to insureds. This website must provide insureds with an inventory of participating health care providers and an accounting of the shared savings incentives available for each shoppable service. The law provides a list of nonemergency services that qualify as "shoppable health care services". These include, but are not limited to:

- 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.
- Prescription drugs.
- Services provided through telehealth.

A program must be a component part of the policy, contract, or certificate of insurance provided by each participating health insurer, and the insurer must notify its insureds of the program annually and at the time of enrollment and renewal.[45]

Shared Savings Incentives

Florida law defines a "shared savings incentive" as an optional financial incentive that may be paid to an insured for choosing certain shoppable health care services under a program. When an insured obtains a shoppable health care service for less than the average price for the service, any savings generated will be shared by the health insurer and the insured. An insured is entitled to a financial incentive that is no less than 25 percent of the savings that accrue to the insurer as a result of the insured's participation.

A program may financially reward insureds who use shoppable health care services in several different forms. Insureds may receive financial incentives in the form of premium reductions, or deposits into a flexible spending account, health savings account, or health reimbursement account.[46]

Federal Price Transparency Laws and Regulations

Congress and federal regulatory agencies recently took steps to improve the quantity and quality of health care cost information available to patients.

[42] Ch. 2019-100, L.O.F.
[43] Ss. 627.6387, 627.6648, and 641.31076, F.S. The State Employee Group Program, which provides health care benefits to state employees, also offers a shared savings program, described in s. 110.12303, F.S.
[44] The term "shoppable health care services" generally refers to medical services that can be scheduled in advance. Florida law specifies a list of services that qualify for this designation, see Id.
[45] Supra note 43.
[46] Id.

Hospital Facility Transparency

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations[47] changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, CMS also established new requirements for hospitals to publish standard charges for a wide range of health care services offered by such facilities. Specifically, the regulations require hospitals to make public both a machine-readable file of standard charges and a consumer-friendly presentation of prices for at least 300 shoppable health care services. The regulations became effective on January 1, 2021.[48]

The regulations define a shoppable service as one that can be scheduled in advance, effectively giving patients the opportunity to select the venue in which to receive the service. This is a more expansive designation of shoppable services than currently exists in Florida law. For each shoppable service, a hospital must disclose several pricing benchmarks to include:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This information should provide a patient with both a reasonable point estimate of the charge for a shoppable service, and also a range in which the actual charge can be expected to fall.

The penalty for facility noncompliance under the federal regulations is a maximum fine of $300 per day.[49] Very early indications suggest that there are varying levels of compliance with the new rules among hospital facilities.[50]

Health Insurer Transparency

On October 29, 2020, the federal Departments of Health and Human Services, Labor, and Treasury finalized regulations[51] imposing new transparency requirements on issuers of individual and group health insurance plans.

Estimates

Central to the new regulations is a requirement for health plans to provide an estimate of an insured's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurance plans must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs *before* receiving health care to encourage shopping and price competition amongst providers.[52]

Each health plan will be required to establish an online shopping tool that will allow insureds to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-

[47] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public, 84 FR 65524 (November 27, 2019)(codified at 45 CFR Part 180).
[48] Id.
[49] Supra note 47.
[50] ADVI, "Implementation of Newly Enacted Hospital Price Transparency," available at https://advi.com/analysis/Hospital_Transparency_-_ADVI_Summary.pdf (last accessed February 12, 2021).
[51] Transparency in Coverage, 85 FR 73158 (November 12, 2020)(codified at 29 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 147, and 45 CFR Part 158).
[52] Trump Administration Finalizes Transparency Rule for Health Insurers," Health Affairs Blog, November 1, 2020. Available at https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last accessed February 12, 2021).

pocket cost for 500 of the most shoppable items and services. This requirement is scheduled to take effect on January 1, 2023. Beginning in 2024, health plans will need to provide personalized cost-sharing information to patients across the full range of covered health care services.[53]

Medical Loss Ratio

The regulations also clarify the treatment of shared savings expenses under medical loss ratio (MLR) calculations required by the Patient Protection and Affordable Care Act (PPACA). MLR refers to the percentage of insurance premium payments that are actually spent on medical claims by an insurer. In general, MLR requirements are intended to promote efficiency among insurers.[54] The PPACA established minimum MLR requirements for group and individual health insurance plans.[55] Under the PPACA, large group plans must dedicate at least 85 percent of premium payments to medical claims, while small group and individual market plans must dedicate at least 80 percent of premium payments to medical claims.[56] Further, the law requires a health plan that does not meet these standards to provide annual rebates to individuals enrolled in the plan.[57]

The regulations finalized in October 2020 specify that expenses by a health plan in direct support of a shared savings program shall be counted as medical expenditures.[58] Thus, a health plan providing shared savings to members will receive an equivalent credit towards meeting the MLR standards established by PPACA. In theory, this policy should provide an additional incentive for insurers who have not already done so to adopt shared savings programs.

The "No Surprises Act"

On December 27, 2020, Congress enacted the No Surprises Act as part of the Consolidated Appropriations Act of 2021.[59] The No Surprises Act includes a wide-range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of care. Most sections of the Act go into effect on January 1, 2022, and the Departments of Health and Human Services, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.[60]

Estimates - Facilities

In the realm of price transparency, the No Surprises Act establishes the concept of an "advanced explanation of benefits" that combines information on charges provided by a hospital facility with patient-specific cost information supplied by a health insurance plan. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a "good faith estimate" of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured).[61]

Estimates – Health Plans

Once the "good faith estimate" has been shared with a patient's health plan, the plan must then develop a more detailed and "advanced explanation of benefits". This personalized cost estimate must include the following:

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[53] Supra note 51.
[54] "Explaining Health Care Reform: Medical Loss Ratio (MLR)", Henry J Kaiser Family Foundation, February 29, 2012. Available at https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ (last accessed February 12, 2021).
[55] PPACA s. 1001; 42 U.S.C. 300gg-18.
[56] Supra note 51.
[57] Id.
[58] 45 CFR Part 158.
[59] PL 116-260. The No Surprises Act is found in Division BB of the Act.
[60] Id.
[61] PL 116-260, Division BB, Section 112.

- An indication of whether the facility participates in the patient's health plan network. If the facility is non-participating, information on how the patient can receive services from a participating provider;
- The good-faith estimate prepared by the hospital facility based on billing/diagnostic codes;
- A good-faith estimate of the amount to be covered by the health plan;
- A good-faith estimate of the amount of the patient's out-of-pocket costs;
- A good-faith estimate of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's health plan;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (i.e., medical necessity determinations, prior authorization, step therapy, etc.); and,
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.[62]

Furthermore, the Act directs the Secretary of Health and Human Services (HHS) to establish by January 1, 2022, a "patient-provider dispute resolution process" to resolve any disputes concerning bills received by uninsured individuals that substantially differ from a provider's good faith estimate provided prior to the service being rendered.[63]

The new requirements placed on hospitals and health plans by the No Surprises Act are cumulatively intended to provide patients with increased certainty about the total and out-of-pocket costs associated with health care services. In turn, patients may be more equipped to seek out cost-effective care and avoid unforeseen costs that can lead to financial strain.

Medical Debt

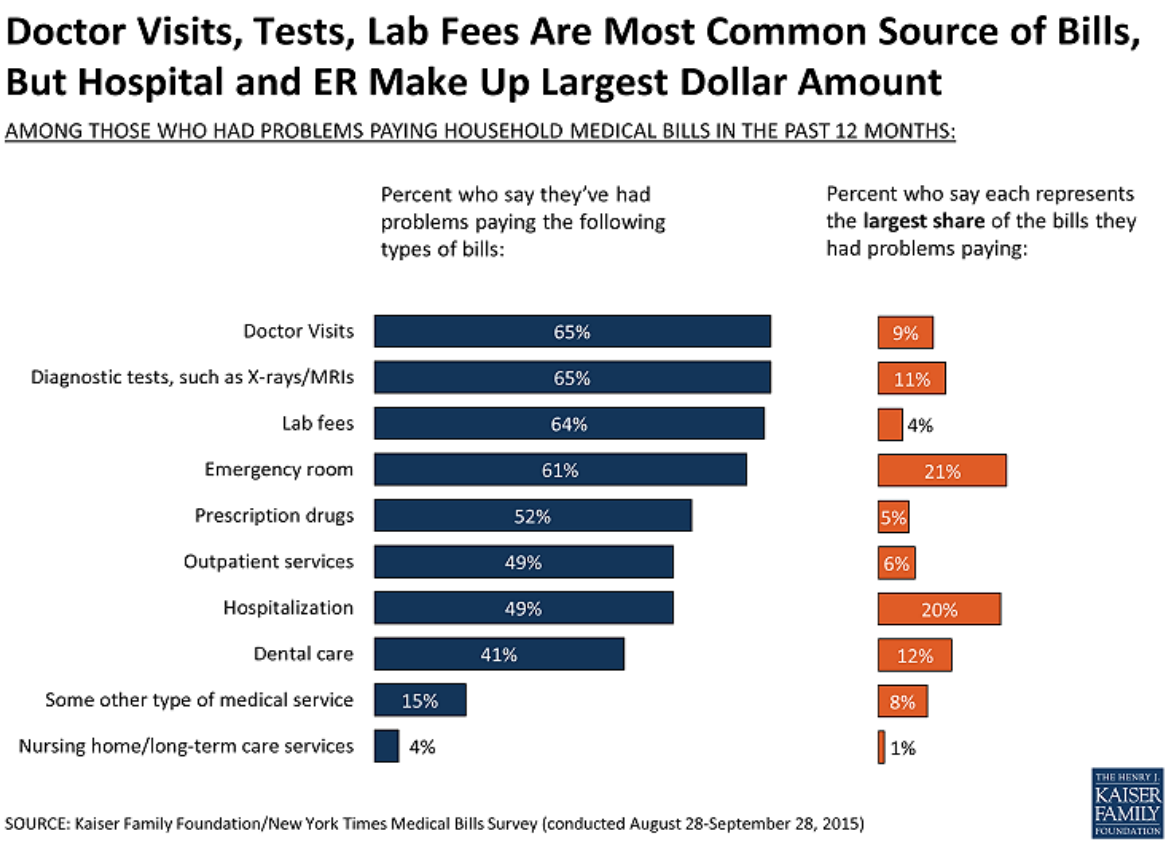
Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. A 2007 study suggested that illness and medical bills contributed to 62.1% of all personal bankruptcies filed in the U.S. during that year.[64] A more recent analysis, which considered only the impact of hospital charges, found that 4% of U.S. bankruptcies among non-elderly adults resulted from hospitalizations.[65]

Even when medical costs do not result in personal bankruptcy, they often weigh heavily on the financial health of patients and their families. According to the Kaiser Family Foundation, about a quarter of U.S. adults ages 18-64 say they or someone in their household had problems paying or an inability to pay medical bills in the past 12 months.[66] About three in ten survey respondents reported medical debt of $5,000 or more, with 13 percent of respondents indicating medical debt in excess of $10,000. Even patients with lower amounts of medical debt reported that the outstanding bills led to financial distress, in light of other financial commitments and/or limited income.[67]

Among those who reported problems paying medical bills, 66 percent said the bills were the result of a one-time or short-term medical expense such as a hospital stay or an accident, while 33 percent cited bills for treatment of chronic conditions that have accumulated over time. Respondents to the Kaiser survey reported a wide range of illnesses and injuries that led to an accumulation of medical debt. The largest share (36 percent) named a specific disease, symptom, or condition like heart disease or gastrointestinal problems, followed by issues related to chronic pain or injuries (16 percent), accidents and broken bones (15 percent), surgery (10 percent), dental issues (10 percent), and infections like

[62] PL 116-260, Division BB, Section 111.
[63] Supra note 59.
[64] David U. Himmelstein, et al. "Medical Bankruptcy in the United States, 2007: Results of a National Study." *American Journal of Medicine* 2009; 122: 741-6. Available at https://www.amjmed.com/article/S0002-9343(09)00404-5/abstract (last accessed February 11, 2021).
[65] Carlos Dobkin, et al. "Myth and Measurement: The Case of Medical Bankruptcies." *New England Journal of Medicine* 2018; 378:1076-1078. Available at https://www.nejm.org/doi/full/10.1056/NEJMp1716604 (last accessed February 11, 2021).
[66] The Henry J. Kaiser Family Foundation, "The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey." January 5, 2016. Available at https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/ (last accessed February 11, 2021).
[67] Id.

pneumonia and flu (9 percent).[68] The following illustration provides additional detail on the type of medical services that led to an accumulation of medical debt.[69]



Medical Debt Collection Process

Current law provides a court process for the collection of lawful debts, including medical debts. A creditor may sue a debtor and, if the creditor prevails, the creditor may receive a final judgment awarding money damages. If the debtor does not voluntarily pay the judgment, the creditor has several legal means to collect on the debt, including:

- Wage garnishment.
- Garnishment of money in a bank account.
- Directing the sheriff to seize assets, sell them, and give the proceeds to the creditor.

In order to protect debtors from being destitute, current law provides that certain property is exempt from being taken by a creditor. The Florida Constitution provides that the debtor's homestead and $1,000 of personal property is exempt.[70] Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[71]

In addition to the protection from creditors contained in the Florida Constitution, chapter 222, F.S., protects other personal property from certain claims of creditors and legal process: garnishment of wages for a head of family;[72] proceeds from life insurance policies;[73] wages or unemployment compensation payments due certain deceased employees;[74] disability income benefits;[75] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane

[68] Id.
[69] Id, Figure 4.
[70] Art. X, s. 4(a), Fla. Const.
[71] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.
[72] S. 222.11, F.S.
[73] S. 222.13, F.S.
[74] S. 222.15, F.S.
[75] S. 222.18, F.S.

savings accounts;[76] $1,000 interest in a motor vehicle; professionally prescribed health aids; certain refunds or credits from financial institutions; and $4,000 interest in personal property, if the debtor does not claim or receive the benefits of a homestead exemption under the State Constitution.[77]

Bankruptcy is a means by which a person's assets are liquidated in order to pay the person's debts under court supervision. The United States Constitution gives Congress the right to uniformly govern bankruptcy law.[78] Bankruptcy courts are operated by the federal government. A debtor (the bankrupt person) is not required to give up all of his or her assets in bankruptcy. Certain property is deemed "exempt" from the bankruptcy case, and may be kept by the debtor without being subject to creditor claims. The Bankruptcy Code provides for exempt property in a bankruptcy case.[79] In general, a debtor may choose to utilize the exempt property listing in state law or the exempt property of the Bankruptcy Code. However, federal law allows a state to opt-out of the federal law and thereby insist that debtors only utilize state law exemptions.[80] Florida, like most states, has made the opt-out election to prohibit the use of the federal exemptions and require that debtors may only use state law exemptions.[81]

Effect of Proposed Changes

The bill increases patient access to health care cost information. The various provisions apply to hospitals, ambulatory surgical centers, health insurers, and HMOs. The bill brings provisions from recent federal law and regulation into the Florida Statutes; in doing so, the bill requires compliance by facilities and insurers as a condition of state licensure, thus ensuring that these provisions will be fully adopted and adequately enforced in Florida.[82]

Shoppable Services

The bill requires each licensed hospital and ambulatory surgical center to post a consumer-friendly list of standard charges for at least 300 shoppable health care services on a facility website. A facility that provides less than 300 distinct services will be required to post standard charges for each service it does provide.

The bill requires facilities to post pricing information for shoppable services in accordance with the definition of “standard charges” established in federal rule.[83] This information extends beyond the traditional concept of charges to include negotiated and actual prices paid for selected services. For each shoppable service, a hospital must disclose the following pricing benchmarks:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This bill is intended to mirror the shoppable services requirement included in the hospital facility transparency regulations finalized by the CMS in 2019. The bill requires facilities to disclose the relevant cost information as a condition of state licensure, which should result in uniform compliance among facilities.

Shared Savings Programs

[76] S. 222.22, F.S.
[77] S. 222.25, F.S.
[78] Art. 1, s. 8, cl. 4, U.S. Const.
[79] 11 U.S.C. s. 522.
[80] 11 U.S.C. s. 522(b).
[81] S. 222.20, F.S.
[82] See Ss. 395.003, 395.301, 408.802, 624.401, 641.22, F.S.
[83] Supra note 47.

The bill clarifies that insurer payment for shared savings incentives shall be counted as medical expenses for rate development and rate filing purposes.[84] This change aligns Florida law with the federal regulations that became final in 2020.[85]

Billing Estimates

Effective July 1, 2022, the bill requires that all patients receive cost-of-care information prior to receiving scheduled, nonemergency treatment in hospitals and ambulatory surgical centers, and from physicians providing services in those facilities.

At present, licensed facilities are required to provide a customized estimate of "reasonably anticipated charges" to a patient for treatment of the patient's specific condition, *upon request of the patient*. The bill makes these personalized estimates mandatory, rather than dependent on patient requests. A facility must submit the estimate of charges to a patient's health plan at least 3 business days before a service is to be furnished, according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after the service is scheduled;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after a service is scheduled.

By requiring facilities to provide a good-faith estimate of charges to each patient in advance of treatment, the bill mirrors the requirements of the federal No Surprises Act. Compliance with the Act is required on January 1, 2022, but the bill allows facilities additional time to comply by providing a July 1, 2022 effective date for this change.

The bill prohibits a facility from billing the patient or the patient's health plan or collecting charges from any source for the treatment provided if the estimate is not furnished to the patient at least 24 hours prior to the treatment.

The bill also makes the mandatory estimate binding on the facility. The amount ultimately charged by the facility may not exceed the estimate by more than 10%, unless unforeseen circumstances dictate that the charges be higher. If the charges exceed this threshold, the facility must clearly document the rationale for the higher charges to the patient.

Advanced Explanation of Benefits

Effective July 1, 2022, the bill requires health plans to issue an advance explanation of benefits statement when a covered patient schedules a service in a hospital or ambulatory surgical center. This requirement builds on the facility charges estimate provision in the bill. Once a facility notifies a health plan that a patient has scheduled a medical service, the health plan must prepare a personalized estimate of costs for the patient in accordance with the federal No Surprises Act. A health plan must provide an advanced explanation of benefits to the patient according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after receiving the estimate of charges from the facility;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after receiving the estimate of charges from the facility.

Health insurers and HMOs are required to be in compliance with the federal Act on January 1, 2022, but the bill allows these entities additional time to comply with the Florida law by providing a July 1, 2022 effective date for this change.

Medical Debt Collection

[84] Current law indicates that a shared savings incentive offered by a health plan is "not an administrative expenses for rate development or rate filing purposes," but does not affirmatively categorize the expense. See Ss. 627.6387, 627.6648, and 641.31076, F.S.
[85] Supra note 51.

The bill requires each hospital and ambulatory surgical center to establish an internal grievance process allowing a patient to dispute any charges that appear on an itemized statement or bill. When a patient initiates a grievance, the facility must then provide an initial response to that patient within 7 business days.

The bill prohibits these facilities from engaging in any "extraordinary collection actions" against a patient prior to determining whether that patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, and for 30 days after notifying a patient in writing that a collections action will commence. For purposes of the provision, "extraordinary collection action" means any action that requires a legal or judicial process, including:

- Placing a lien on an individual's property;
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or any other personal property;
- Commencing a civil action against an individual;
- Causing an individual's arrest; or,
- Garnishing an individual's wages.

The bill also establishes a new set of debt collection exemptions in chapter 222, F.S. that apply explicitly to debt incurred as a result of medical services provided in hospitals, ambulatory surgical centers, or urgent care centers. Under current law, this type of medical debt is subject to the uniform exemptions that apply to all types of debt and are described above. The bill increases the ceiling on the debt collection exemptions, when the debt results from services provided in a hospital facility or ambulatory surgical center, as follows:

- To $10,000 interest in a single motor vehicle (versus the current law exemption of $1,000);
- To $10,000 interest in personal property, provided that a debtor does not claim the homestead exemption under s. 4, Art. X of the state constitution (versus the current law exemption of $4,000).

The bill provides an effective date of July 1, 2021, except as otherwise specified throughout.

B. SECTION DIRECTORY:

Section 1: Creates s. 222.26, F.S.; related to additional exemptions from legal processes concerning medical debt.
Section 2: Amends s. 395.301, F.S.; relating to price transparency; itemized patient statement or bill; patient admission status notification.
Section 3: Effective July 1, 2022, amends s. 395.301, F.S.; relating to price transparency; itemized patient statement or bill; patient admission status notification.
Section 4: Creates s. 395.3011, F.S.; related to billing and collection activities.
Section 5: Effective July 1, 2022, creates s. 627.445, F.S.; relating to advanced explanation of benefits.
Section 6: Amends s. 627.6387, F.S.; relating to shared savings incentive program.
Section 7: Amends s. 627.6648, F.S.; relating to shared savings incentive program.
Section 8: Amends s. 641.31076, F.S.; relating to shared savings incentive program.
Section 9: Provides an effective date of July 1, 2021, except as otherwise expressly provided.

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:

The bill may increase costs for facilities licensed under chapter 395, F.S., by requiring them to issue cost estimates for all non-emergency patients. Facilities may forego revenues due to the bill's binding patient cost estimates, and the bill's limits on the use of extraordinary collection activities.

Additionally, the increased dollar limit on personal property exemptions under chapter 222, F.S., may reduce revenues for medical service providers or their collection agents.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Current law provides AHCA with sufficient rule-making authority to execute the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 21, 2021, the Finance & Facilities Subcommittee adopted an amendment to the bill. The amendment restores current law language to clarify that required facility estimates are applicable to nonemergency scheduled services, rather than all scheduled services.

On April 14, 2021, the Health & Human Services Committee adopted an amendment to the bill. The amendment:

- Clarifies that the debt collection exemptions established by the bill apply only when a legal action seeks to collect a medical debt, and not to other types of debt.
- Defines the term “standard charges” consistent with federal rules issued by the federal Department of Health & Human Services for purposes of hospital price transparency.

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