HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1351 Savings and Out-of-pocket Expenses in Health Insurance
SPONSOR(S): Health & Human Services Committee, Melo
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	17 Y, 0 N	Poche	McElroy
2) Health & Human Services Committee	19 Y, 0 N, As CS	Poche	Calamas

SUMMARY ANALYSIS

Health spending in the United States has exploded in the last 50 years, totaling $74.1 billion in 1970, increasing to $1.4 trillion by 2000, then tripling in 2021 to $4.3 trillion. The United States spends more per person on health care than any other high-income country in the world and spending has continued to increase over the past few decades. Health spending per person in the U.S. was $12,914 in 2021, more than $5,000 greater than any other high-come nation.

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.

CS/HB 1351 expands health care price transparency, allowing consumers access to information necessary to make informed choices in health care. Specifically, the bill requires:

- Facilities licensed under chapter 395, including hospitals and ambulatory surgery centers, to tell a patient at the point-of-sale whether his or her cost-sharing obligations for services exceed the retail price of such services absent health insurance coverage.
- Physicians and osteopathic physicians, upon request and before or on the day services are rendered, to provide to an insurer patient CPT codes for scheduled services and the retail price in the absence of health insurance.
    - Chiropractors and podiatrists must disclose the same information at the point-of-sale.
- A health insurer, effective January 1, 2024, to apply an insured's payments to an out-of-network, nonpreferred provider to the insured's deductible and out-of-pocket maximum, if certain criteria are met.

The bill has no fiscal impact to state or local governments.

The bill provides an effective date of July 1, 2023, except as otherwise provided.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

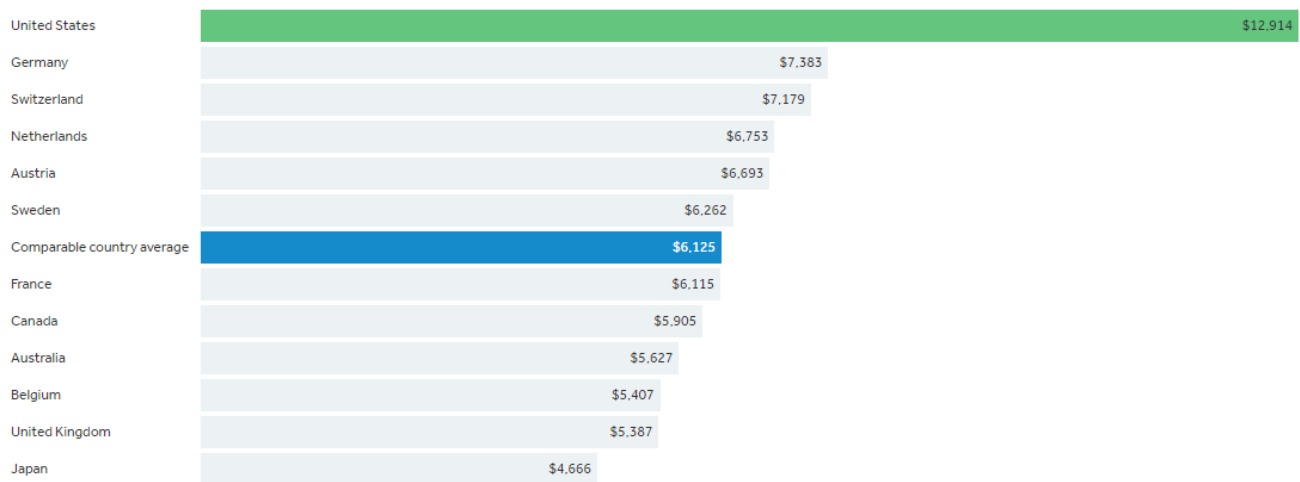
A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Spending

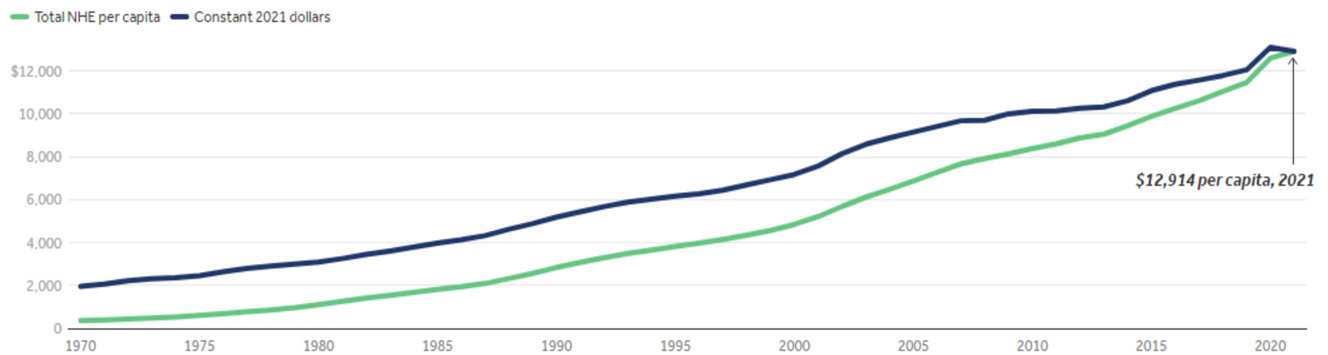
Health spending in the United States has exploded in the last 50 years, totaling $74.1 billion in 1970, increasing to $1.4 trillion by 2000, then tripling in 2021 to $4.3 trillion.[1]

The United States spends more per person on health care than any other high-income country in the world and spending has continued to increase over the past few decades. Health spending per person in the U.S. was $12,914 in 2021, more than $5,000 greater than any other high-come nation.[2]



The following chart illustrates the rate of growth in total national health expenditures per capita from 1970 to 2021[3]:

[1] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How has U.S. spending on healthcare changed over time?*, February 7, 2023, available at https://healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/ (last viewed on March 31, 2023).
[2] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How does health spending in the U.S. compare to other countries?*, February 9, 2023, available at https://healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ (last viewed on March 31, 2023). The average amount spent on health per person in comparable countries – $6,125 – is less than half of what the U.S. spends.
[3] Supra, FN 1.



Health care prices are a primary driver of health care spending. Between 1970 and 2019, total U.S. health care spending grew from 6.9 percent of GDP to 17.7 percent of GDP.[4] The Organization for Economic Cooperation Development estimated that total spending in 2019 in member countries averaged 8.8 percent of GDP, compared with 16.8 percent in the U.S.[5] One study found that U.S. commercial health spending per enrollee increased by 21.8% between 2015 and 2019.[6] The rising prices of health care services accounted for approximately two-thirds of that growth, with prices for prescription drugs, provider services (physical examinations, screenings and procedures) and inpatient and outpatient care rising by 18.3%.[7] At the same time, increased service quantity accounted for nearly one-fifth of overall spending growth, as per capita use increased by only 3.6 percent.[8]

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.[9] 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.[10] 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

[4] Health Affairs, Research Brief – Considering Health Spending, *The Role of Prices in Excess US Health Spending*, June 9, 2022, available at https://www.healthaffairs.org/do/10.1377/hpb20220506.381195/full/> (citing the Centers for Medicare and Medicaid Services statistics at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected) (last viewed on March 31, 2023).
[5] Id.
[6] Health Care Cost Institute, *2019 Health Care Cost and Utilization Report*, pg. 2, available at https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf.
[7] Id.
[8] Supra, FN 4.
[9] 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.
[10] Id.

other care purchasers to identify, compare, and choose providers that offer the desired level of value."[11] Indeed, the definition of the price or cost of health care has different meanings depending on who is incurring the cost.[12]

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-eight percent of covered workers have a general annual deductible[13] for single coverage that must be met before most services are paid for by their health plan.[14]

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,763.[15] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $2,543 in small firms, compared to $1,493 for workers in large firms.[16] Sixty-one percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 56 percent in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (49 percent for small firms vs. 25 percent for large firms).

National Price Transparency Studies

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

- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.
- Expand state-based all-payer health claims databases, 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.[17]

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.[18]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[19]
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.[20]

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[11] 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.
[12] Id.
[13] 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.
[14] The Henry J. Kaiser Family Foundation, *2022 Employer Health Benefits Survey*, October 27, 2022, available at https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/ (last viewed on March 31, 2023).
[15] Id.
[16] Id.
[17] 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.
[18] Id., pg. 1.
[19] 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/.

The individuals who compared prices stated that such research affected their health care choices and saved them money.[21] 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 higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[22] 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.[23] 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.[24]

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).[25] 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.[26] 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.

A patient has the right to request certain financial information from health care providers and facilities.[27] 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.[28] Estimates must be written in language "comprehensible to an ordinary layperson."[29] 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.[30] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[31]

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.

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[20] Id., pg. 3.
[21] Id., pg. 4.
[22] Supra, FN 14.
[23] 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.
[24] 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.
[25] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[26] S. 381.026(3), F.S.
[27] S. 381.026(4)(c), F.S.
[28] S. 381.026(4)(c)3., F.S.
[29] Id.
[30] Id.
[31] S. 381.026(4)(c)5., F.S.

- 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.[32]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[33] to publish a schedule of charges for the medical services offered to patients.[34] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[35] 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.[36] 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.[37]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[38] 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 established for primary care providers.[39] 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).[40]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[41] 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

[32] S. 381.0261, F.S.
[33] 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.
[34] S. 381.026(4)(c)3., F.S.
[35] Id.
[36] Id.
[37] S. 381.026(4)(c)4., F.S.
[38] S. 395.107(1), F.S.
[39] S. 395.107(2), F.S.
[40] S. 395.107(6), F.S.
[41] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.

average charges for that diagnosis related group[42] 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.[43] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[44] 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.[45]

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.[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.

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]

[42] 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.
[43] S. 395.301, F.S.
[44] S. 408.05(3)(c), F.S.
[45] Id.
[46] S. 456.0575(2), F.S.
[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.

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]

The Federal No Surprises Act

On December 27, 2020, Congress enacted the No Surprises Act as part of the Consolidated Appropriations Act of 2021.[51] 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.[52]

Many hospitals do not comply with the federal transparency requirement. A 2021 review of more than 3,500 hospitals found that 55 percent of hospitals were not compliant with the rule and had not posted price information for commercial plans or had not posted any prices at all.[53] Further, an August 2022 review of 2,000 hospitals found that 16 percent with all transparency requirements.[54] Nearly 84 percent of hospitals failed to post machine-readable files containing standard charges, and roughly 78 percent of hospitals did not provide a consumer-friendly shoppable services display.[55] Another review of more than 6,400 hospitals showed wide-spread non-compliance with the federal transparency rule- more than 63 percent of hospitals are not complying.[56] According to that review, only 38 percent of Florida hospitals are in compliance.[57]

Health Insurance

Health insurance is the insurance of human beings against bodily injury or disablement by accident or sickness, including the expenses associated with such injury, disablement, or sickness.[58] Individuals purchase health insurance coverage for the purpose of managing anticipated expenses related to

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[49] Supra, FN 42.
[50] ADVI, "*Implementation of Newly Enacted Hospital Price Transparency*," available at https://advi.com/analysis/Hospital_Transparency_-_ADVI_Summary.pdf.
[51] PL 116-260. The No Surprises Act is found in Division BB of the Act.
[52] Id.
[53] John Xuefeng Jiang, et al., *Factors associated with compliance to the hospital price transparency final rule: A national landscape study*, Journal of General Internal Medicine (2021), available at https://link.springer.com/article/10.1007/s11606-021-07237-y (last viewed on March 31, 2023).
[54] Patients' Rights Advocates, *Third semi-annual hospital transparency compliance report, 2022*, available at https://www.patientrightsadvocates.org/august-semi-annual-compliance-report-2022.
[55] Id.
[56] Foundation for Government Accountability, *How America's Hospitals Are Hiding the Cost of Health Care*, pg. 3, August 2022, available at https://www.TheFGA.org/paper/americas-hospitals-are-hiding-the-cost-of-health-care. (last viewed on March 31, 2023). Only two hospitals to date have been fined for noncompliance with the transparency rule, both of which are in Georgia's Northside Hospital System.
[57] Id., pg. 4.
[58] S. 624.603, F.S.

health or protecting themselves from unexpected medical bills or large health care costs. How much the insurance covers – and how much the policyholder pays via copays, deductibles, and coinsurance – depends on the details of the policy itself, with specific rules and regulations that apply to some plans. Managed care is the most common delivery system for medical care today by health insurers.[59]

Managed care systems combine the delivery and financing of health care services by limiting the choice of doctors and hospitals.[60] In return for this limited choice, however, medical care is less costly due to the managed care network's ability to control health care services. Some common forms of managed care are preferred provider organizations[61] (PPO) and health maintenance organizations[62] (HMO).

Health insurance provides a safety net for a serious injury or illness. All major medical health insurance plans cap in-network out-of-pocket costs, a combination of copays, deductibles, and coinsurance, at no more than an amount determined by the Centers for Medicaid and Medicare Services (CMS) each year. For 2022, it's $8,700 for a single person; $17,400 for a family.[63]

Types of Health Insurance

There are several different types of health insurance in the U.S., including public coverage (Medicare, Medicaid, Children's Health Insurance Program, Indian Health Services, and Veterans Administration coverage) and private coverage. Private healthcare coverage can be provided by an employer or purchased in the individual/family market. Members of the armed services and their families are covered under Tricare, and people employed by the federal government are covered under Federal Employees Health Benefits Program.

Regulation of Health Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.[64] The Agency for Health Care Administration (AHCA) regulates the quality of care by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from AHCA.[65] As part of AHCA's certification process, an HMO must provide information to demonstrate that it can provide quality of care consistent with the prevailing standards of care.[66] All persons who transact insurance in the state must comply with the Insurance Code (Code).[67] OIR has the power to collect, propose, publish, and disseminate any information relating to the subject matter of the Code,[68] and may investigate any matter relating to insurance.[69]

Health Insurance Cost-Sharing

The term "cost-sharing" refers to how health plan costs are shared between insurers and insureds. Generally, costs are shared in two main ways:

- **Premium contributions.** The employer pays a portion of the premium and the remainder is deducted from employees' paychecks. Most insurers require employers to contribute at least half of the premium cost for covered employees.
- **Cost-sharing at the time of service.** Cost-sharing at the time a service is provided may take the form of copayments, or a fixed amount paid at the time of obtaining services; co-insurance,

[59] Florida Department of Financial Services, *Health Insurance and Health Maintenance Organizations – A Guide for Consumers*, http://www.myfloridacfo.com/Division/Consumers/understandingCoverage/Guides/documents/HealthGuide.pdf
[60] Id.
[61] S. 627.6471, F.S.
[62] Part I of chapter 641, F.S.
[63] Healthcare.gov, *Out-of-pocket maximum/limits*, available at https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.
[64] S. 20.121(3)(a), F.S.
[65] S. 641.21(1), F.S.
[66] S. 641.495, F.S.
[67] S. 624.11, F.S.
[68] S. 624.307(4), F.S.
[69] S. 624.307(3), F.S.

or a percent of the charge for services that is typically billed after services are received; and deductibles, or a flat amount that must be paid before insurance benefits kick in.

Types of Cost-sharing

Types of cost-sharing in health insurance plans include:

- **Premium Contribution**. A health insurance premium is the total amount that must be paid in advance in order obtain coverage for a particular level of services. Usually health insurance premiums are billed and paid on a monthly basis. Employers typically require employees to share the cost of the plan premium. Most insurers require the employer to cover at least half of the premium cost for employees. Employers are free to require employees to cover some or all of the premium cost for dependents, such as a spouse or children.
- **Copayments.** A copayment or "copay" is a flat fee that the patient pays at the time of service. After the insured pays the copay, the health plan usually pays 100 percent of the balance on eligible services. Eligible services are those services that the plan includes in its coverage. The fee usually ranges between $10 and $40. Copayments are common in HMO products and are often characteristic of PPO plans as well.
- **Coinsurance.** Insureds must pay a portion of the services they receive under a health plan. This payment is called "coinsurance" and is usually a small percentage of the service cost after the plan pays benefits. If the plan pays 70 percent of the cost, the patient pays 30 percent of the cost. If the plan pays 90 percent, the patient pays 10 percent, and so forth. Coinsurance is common for PPO products and less common in HMOs.
- **Deductible.** The deductible is the amount an insured pays before the plan pays anything. Deductibles generally apply per person per calendar year. Under PPOs with coinsurance, a deductible usually applies to all services, including laboratory tests, hospital stays and doctor's office visits. Some plans, however, waive the deductible for office visits. Most HMOs do not have general deductibles, but may have a service-specific deductible for inpatient hospitalization or for brand-name prescription drugs. Generally, the higher the deductible, the lower the premium. Some plans with particularly high deductibles are known as "high-deductible" plans. While these plans may have significantly lower premiums, insureds are exposed to high out-of-pocket costs.
- **Out-of-Pocket Maximum.** Once out-of-pocket expenses per insured reach a defined limit in a single calendar year, the plan will pay 100 percent of eligible charges for the rest of the calendar year. The definition of out-of-pocket maximum will differ depending on your insurance carrier. Some carriers exclude specific costs or increase the maximum for care provided by out-of-network providers. Out-of-pocket cap levels typically are in the range of $1,000 to $5,000 per person.

Preferred Providers vs. Out-of-Network Providers

Most health plans have a list of doctors, hospitals, and other providers that have agreed to participate in the plan's network. Providers in the network have a contract with a health plan to care for its members at a certain cost. A member of the plan will generally pay less for medical services when they use one of the providers on this list. If a plan member sees a doctor or uses a hospital that does not participate with the health plan, the member is going out-of-network and will usually have to pay more for out-of-network care. Some plans will not cover any amount of out-of-network care, while others cover a percentage of care.

In-network providers have a contract with an insurer that limits the amount of money the provider may charge individuals who are covered under the contracted insurance company. The agreed-upon contract rate includes both the patient and insurer shares and may be based on certain assumptions regarding the volume of patients that will use that provider's services. The portion of the contracted rate a patient pays is determined by his or her policy.

Out-of-network providers are providers who have not agreed to accept a contracted rate with a patient's insurance company. If a patient chooses to seek treatment outside of his or her network, insurance companies typically require the patient to pay a larger deductible, copayment and coinsurance amount.

Effect of Proposed Changes

CS/HB 1351 requires facilities licensed under chapter 395, including hospitals, ambulatory surgery centers, and urgent care centers, to tell a patient at the point-of-sale whether his or her cost-sharing obligations for services exceed the retail price of such services absent health insurance coverage. The bill also requires physicians and osteopathic physicians, upon request and before or on the day services are rendered, to provide to an insured patient the CPT codes for scheduled services and the retail price in the absence of health insurance coverage. Chiropractors and podiatrists must disclose the same information to insured patients at the point-of-sale.

The bill also requires an individual health insurer, beginning on January 1, 2024, to apply an insured's or payments to an out-of-network, nonpreferred provider to the insured's deductible and out-of-pocket maximum under the policy if:

- The insured asks for such payments to be applied in that manner;
- The service provided by the out-of-network, nonpreferred provider would have been covered under the policy if it was completed by a preferred provider; and
- The amount charged for the service was the same or less than:
    - The average amount charged by the insurer's provider network; or
    - The service's statewide average amount paid based on data reported to the Florida Health Price Finder website.

The bill will likely allow insureds to reach their deductible and out-of-pocket maximums under a health insurance policy more quickly, lowering out-of-pocket payments for the remainder of each year the maximums are reached. This may require insurers to cover a greater amount of services than under current law, and may prompt changes in network contracting to reflect shifting care volume and use patterns.

Except as otherwise provided, the bill provides an effective date of July 1, 2023.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.107, F.S., relating to facilities; publishing and posting schedule of charges; penalties.
Section 2: Amends s. 395.301, F.S., relating to price transparency; itemized patient statement or bill; patient admission status notification.
Section 3: Amends s. 458.323, F.S., relating to itemized patient billing.
Section 4: Amends s. 459.012, F.S., relating to itemized patient statement.
Section 5: Amends s. 460.41, F.S., relating to itemized patient billing.
Section 6: Amends s. 461.009, F.S., relating to itemized patient billing.
Section 7: Amends 627.6471, F.S., relating to contracts for reduced rates of payment; limitations; coinsurance and deductibles.
Section 8: Except as otherwise expressly provided in the bill, provides an effective date of July 1, 2023.

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. The bill does not impact municipal or county governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On April 18, 2023, the Health and Human Services Committee adopted one strike-all amendment and reported the bill favorably as a committee substitute. The strike-all amendment required:

- Facilities licensed under chapter 395, including hospitals and ambulatory surgery centers, to tell a patient at the point-of-sale whether his or her cost-sharing obligations for services exceed the retail price of such services absent health insurance coverage.
- Physicians and osteopathic physicians, upon request and before or on the day services are rendered, to provide to an insurer patient CPT codes for scheduled services and the retail price in the absence of health insurance.
- Chiropractors and podiatrists to disclose the same information at the point-of-sale.

- A health insurer, effective January 1, 2024, to apply an insured's payments to an out-of-network, nonpreferred provider to the insured's deductible and out-of-pocket maximum, if certain criteria are met.

The analysis is drafted to the amended bill as passed by the Health and Human Services Committee.