A bill to be entitled

An act relating to savings and out-of-pocket expenses in health insurance; amending ss. 627.6387, 627.6648, and 641.31076, F.S.; revising the definition of the term "shoppable health care service"; requiring, rather than authorizing, individual health insurers, group health insurers, and health maintenance organizations, respectively, to offer shared savings incentive programs; revising the minimum amount of shared savings incentives; amending s. 627.6471, F.S.; conforming provisions to changes made by the act; requiring individual health insurers to apply payments for services by nonpreferred providers toward insureds' annual deductibles and out-of-pocket limits under certain circumstances; creating s. 627.65613, F.S.; defining the term "preferred provider"; requiring group health insurers to apply payments for services by nonpreferred providers toward insureds' annual deductibles and out-of-pocket limits under certain circumstances; amending s. 641.31, F.S.; requiring health maintenance organizations to apply payments for services by out-of-network providers toward subscribers' annual deductibles and out-of-pocket limits under certain circumstances; defining the terms "in-network provider" and "out-of-network

provider"; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (e) of subsection (2) and subsection (3) of section 627.6387, Florida Statutes, are amended to read:

627.6387 Shared savings incentive program.—

(2) As used in this section, the term:

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. The items and services listed in Table 1—500 Items and

Services List as published in Volume 85, No. 219 of the Federal Register, pages 72182-72190 (2020).

11.~~10.~~ Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(m).

(3) A health insurer shall ~~may~~ offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. In offering a shared savings incentive program, a health insurer ~~that offers a shared savings incentive program~~ must:

(a) Establish the program as a component part of the policy or certificate of insurance provided by the health insurer and notify the insureds and the office at least 30 days before program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify an insured annually and at the time of renewal, and an applicant for insurance at the time of enrollment, of the availability of the shared savings incentive program and the procedure to participate in the program.

(d) Publish on a web page easily accessible to insureds

and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the difference in cost compared to the second-lowest cost in-network amount paid for that service in the rating area ~~savings generated by the insured's participation in any shared savings incentive offered by the health insurer~~. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent.

(f) Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of insureds who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health insurer.

Section 2. Subsection (7) of section 627.6471, Florida Statutes, is renumbered as subsection (8), subsection (4) is amended, and a new subsection (7) is added to that section, to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(4) Except as otherwise provided in subsection (7), any policy that provides schedules of payments for services provided by preferred providers that differ from the schedules of payments for services provided by nonpreferred providers is subject to the following limitations:

(a) The amount of any annual deductible per covered person or per family for treatment in a facility that is not a preferred provider may not exceed four times the amount of a corresponding annual deductible for treatment in a facility that is a preferred provider.

(b) If the policy has no deductible for treatment in a preferred provider facility, the deductible for treatment

received in a facility that is not a preferred provider facility may not exceed $500 per covered person per visit.

(c) The amount of any annual deductible per covered person or per family for treatment, other than inpatient treatment, by a provider that is not a preferred provider may not exceed four times the amount of a corresponding annual deductible for treatment, other than inpatient treatment, by a preferred provider.

(d) If the policy has no deductible for treatment by a preferred provider, the annual deductible for treatment received from a provider which is not a preferred provider shall not exceed $500 per covered person.

(e) The percentage amount of any coinsurance to be paid by an insured to a provider that is not a preferred provider may not exceed by more than 50 percentage points the percentage amount of any coinsurance payment to be paid to a preferred provider.

(f) The amount of any deductible and payment of coinsurance paid by the insured must be applied to the reduced charge negotiated between the insurer and the preferred provider.

(g) Notwithstanding the limitations of deductibles and coinsurance provisions in this section, an insurer may require the insured to pay a reasonable copayment per visit for inpatient or outpatient services.

(h) If any service or treatment is not within the scope of services provided by the network of preferred providers, but is within the scope of services or treatment covered by the policy, the service or treatment shall be reimbursed at a rate not less than 10 percentage points lower than the percentage rate paid to preferred providers. The reimbursement rate must be applied to the usual and customary charges in the area.

(7) Notwithstanding any other provision of law, any insurer issuing a policy of health insurance in this state shall apply the payment for a service rendered to an insured by a nonpreferred provider toward the insured's annual deductible and out-of-pocket limitation as if the service had been rendered by a preferred provider if all of the following apply:

(a) The insured requests that the insurer apply the payment for the service rendered to the insured by the nonpreferred provider toward the insured's annual deductible and out-of-pocket limitation.

(b) The service rendered to the insured by the nonpreferred provider is a service within the scope of services covered under the insured's policy.

(c) The amount that the nonpreferred provider charged the insured for the service is the same or less than:

1. The lowest cost that the insured's preferred provider network charges for the service in the relevant rating area; or

2. The 25th percentile of the statewide average amount for

the service based on the data reported on the Florida Health Price Finder website.

Section 3. Section 627.65613, Florida Statutes, is created to read:

627.65613 Nonpreferred provider services; deductibles and out-of-pocket limitations.—

(1) As used in this section, the term "preferred provider" means any licensed health care provider, including, but not limited to, an optometrist, a podiatric physician, and a chiropractic physician, with whom the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment.

(2) Notwithstanding any other provision of law, any insurer issuing a policy of health insurance in this state shall apply the payment for a service rendered to an insured by a nonpreferred provider toward the insured's annual deductible and out-of-pocket limitation as if the service had been rendered by a preferred provider if all of the following apply:

(a) The insured requests that the insurer apply the payment for the service rendered to the insured by the nonpreferred provider toward the insured's annual deductible and out-of-pocket limitation.

(b) The service rendered to the insured by the nonpreferred provider is a service within the scope of services covered under the insured's policy.

(c) The amount that the nonpreferred provider charged the insured for the service is the same or less than:

1. The lowest cost that the insured's preferred provider network charges for the service in the relevant rating area; or

2. The 25th percentile of the statewide average amount for the service based on the data reported on the Florida Health Price Finder website.

Section 4. Paragraph (e) of subsection (2) and subsection (3) of section 627.6648, Florida Statutes, are amended to read:

627.6648 Shared savings incentive program.—

(2) As used in this section, the term:

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. The items and services listed in Table 1—500 Items and Services List as published in Volume 85, No. 219 of the Federal Register, pages 72182-72190 (2020).

11.~~10.~~ Any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(m).

(3) A health insurer shall ~~may~~ offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. In offering a shared savings incentive program, a health insurer ~~that offers a shared savings incentive program~~ must:

(a) Establish the program as a component part of the policy or certificate of insurance provided by the health insurer and notify the insureds and the office at least 30 days before program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify an insured annually and at the time of renewal, and an applicant for insurance at the time of enrollment, of the

availability of the shared savings incentive program and the procedure to participate in the program.

(d) Publish on a web page easily accessible to insureds and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the difference in cost compared to the second-lowest cost in-network amount paid for that service in the rating area ~~savings generated by the insured's participation in any shared savings incentive offered by the health insurer~~. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, or reward the insured directly with cash or a cash equivalent.

(f) Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of insureds who participated in the program during the plan year and the number of instances of

participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health insurer.

Section 5. Subsection (2) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(2)(a) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(b) Notwithstanding any other provision of law, a health

maintenance organization entering into a contract in this state with a subscriber shall apply the payment for a service rendered to the subscriber by an out-of-network provider toward the subscriber's annual deductible and out-of-pocket limitation as if the service had been rendered by an in-network provider if all of the following apply:

1. The subscriber requests that the health maintenance organization apply the payment for the service rendered to the subscriber by the out-of-network provider toward the subscriber's annual deductible and out of-pocket limitation.

2. The service rendered to the subscriber by the out-of-network provider is a service within the scope of services covered under the subscriber's contract.

3. The amount that the out-of-network provider charged the subscriber for the service is the same or less than:

a. The lowest cost that the subscriber's provider network charges for the service in the relevant rating area; or

b. The 25th percentile of the statewide average amount for the service based on the data reported on the Florida Health Price Finder website.

As used in this paragraph, the term "in-network provider" means a health care provider that is in the health maintenance organization's provider network, and the term "out-of-network provider" means a health care provider that is not in the health

maintenance organization's provider network.

Section 6. Paragraph (e) of subsection (2) and subsection (3) of section 641.31076, Florida Statutes, are amended to read:

641.31076 Shared savings incentive program.—

(2) As used in this section, the term:

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for subscribers under a health maintenance organization's shared savings incentive program. Shoppable health care services may be provided within or outside this state and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

10. The items and services listed in Table 1—500 Items and Services List as published in Volume 85, No. 219 of the Federal Register, pages 72182-72190 (2020).

11.~~10.~~ Any additional services published by the Agency for

Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(m).

(3) A health maintenance organization shall ~~may~~ offer a shared savings incentive program to provide incentives to a subscriber when the subscriber obtains a shoppable health care service from the health maintenance organization's shared savings list. A subscriber may not be required to participate in a shared savings incentive program. In offering a shared savings incentive program, a health maintenance organization that offers a shared savings incentive program must:

(a) Establish the program as a component part of the contract of coverage provided by the health maintenance organization and notify the subscribers and the office at least 30 days before program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify a subscriber annually and at the time of renewal, and an applicant for coverage at the time of enrollment, of the availability of the shared savings incentive program and the procedure to participate in the program.

(d) Publish on a web page easily accessible to subscribers and to applicants for coverage a list of shoppable health care services and health care providers and the shared savings

incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the difference in cost compared to the second-lowest cost in-network amount paid for that service in the rating area ~~savings generated by the subscriber's participation in any shared savings incentive offered by the health maintenance organization~~. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health maintenance organization and approved by the office.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the subscriber's account as a return or reduction in premium, or credit the shared savings incentive amount to the subscriber's flexible spending account, health savings account, or health reimbursement account, or reward the subscriber directly with cash or a cash equivalent.

(f) Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of subscribers who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive

payments made to subscribers participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health maintenance organization.

Section 7. This act shall take effect July 1, 2023.