A bill to be entitled

An act relating to savings and out-of-pocket expenses in health insurance; amending ss. 395.107, 395.301, 458.323, 459.012, 460.41, and 461.009, F.S.; requiring certain licensed facilities and physicians to provide specific pricing and cost-obligation information to patients; amending s. 627.6471, F.S.; requiring a health insurer, effective on a specified date, to apply the payment for a service that a nonpreferred provider provided to an insured toward the insured's deductible and out-of-pocket maximum as if the service had been provided by a preferred provider, if specific conditions are met; providing effective dates.

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

Section 1. Subsection (3) of section 395.107, Florida Statutes, is amended to read:

395.107 Facilities; publishing and posting schedule of charges; penalties; cost-sharing obligation information.—

(3)(a) The schedule of charges must describe the medical services in language comprehensible to a layperson. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card.

(b) The schedule must be posted in a conspicuous place in

the reception area and must include, but is not limited to, the 50 services most frequently provided. The schedule may group services by three price levels, listing services in each price level. The posting may be a sign, which must be at least 15 square feet in size, or may be through an electronic messaging board.

(c) If a facility is affiliated with a licensed hospital under this chapter, the schedule must include text that notifies the insured patients whether the charges for medical services received at the center will be the same as, or more than, charges for medical services received at the affiliated hospital.

(d) The text notifying the patient of the schedule of charges shall be in a font size equal to or greater than the font size used for prices and must be in a contrasting color. The text that notifies the insured patients whether the charges for medical services received at the center will be the same as, or more than, charges for medical services received at the affiliated hospital shall be included in all media and Internet advertisements for the center and in language comprehensible to a layperson.

(e) At the point of sale, each center shall disclose to the patient whether his or her cost-sharing obligation exceeds the retail price of services in the absence of health insurance coverage.

Section 2. Subsection (7) is added to section 395.301, Florida Statutes, to read:

395.301 Price transparency; itemized patient statement or bill; patient admission status notification.—

(7) A licensed facility shall disclose to a patient or a prospective patient whether his or her cost-sharing responsibilities exceed the retail price of services in the absence of health insurance coverage.

Section 3. Section 458.323, Florida Statutes, is amended to read:

458.323 Itemized patient billing.—

(1) Whenever a physician licensed under this chapter renders professional services to a patient, the physician is required, upon request, to submit to the patient, the patient's insurer, or the administrative agency for any federal or state health program under which the patient is entitled to benefits an itemized statement of the specific services rendered and the charge for each, no later than the physician's next regular billing cycle which follows the fifth day after the rendering of professional services. A physician may not condition the furnishing of an itemized statement upon prior payment of the bill.

(2) Upon request, and on or before the day of services being rendered, a physician shall provide an insured patient with information regarding the applicable Current Procedural

Terminology (CPT) codes for the scheduled services and the physician's retail price in the absence of health insurance coverage for the scheduled services.

Section 4. Section 459.012, Florida Statutes, is amended to read:

459.012 Itemized patient statement.—

(1) Whenever an osteopathic physician licensed under this chapter renders professional services to a patient, the osteopathic physician is required, upon request, to submit to the patient, the patient's insurer, or the administrative agency for any federal or state health program under which the patient is entitled to benefits an itemized statement of the specific services rendered and the charge for each, no later than the osteopathic physician's next regular billing cycle which follows the fifth day after the rendering of professional services. An osteopathic physician may not condition the furnishing of an itemized statement upon prior payment of the bill.

(2) Whenever the itemized statement is submitted to the patient's insurer or the administrative agency, a copy of the itemized statement shall simultaneously be provided to the patient. Such copy of the itemized statement which is sent to the patient shall, in boldfaced letters, state that: "THIS IS A DUPLICATE COPY OF A STATEMENT SUBMITTED TO YOUR INSURER OR OTHER AGENCY."

(3) Upon request, and on or before the day of services

being rendered, an osteopathic physician shall provide an insured patient with information regarding the applicable Current Procedural Terminology (CPT) codes for the scheduled services and the physician's retail price in the absence of health insurance coverage for the scheduled services.

Section 5. Section 460.41, Florida Statutes, is amended to read:

460.41 Itemized patient billing; cost-sharing obligation information.—

(1) Whenever a chiropractic physician licensed under this chapter renders professional services to a patient, the chiropractic physician shall submit to the patient, to the patient's insurer, or to the administrative agency for any federal or state health program under which the patient is entitled to benefits an itemized statement of the specific services rendered and the charge for each, no later than the chiropractic physician's next regular billing cycle which follows the fifth day after the rendering of professional services. A chiropractic physician may not condition the furnishing of an itemized statement upon prior payment of the bill.

(2) At the point of sale, a chiropractic physician shall disclose to a patient whether his or her cost-sharing obligation exceeds the retail price of professional services in the absence of health insurance coverage.

Section 6. Section 461.009, Florida Statutes, is amended to read:

461.009 Itemized patient billing; cost-sharing obligation information.—

(1) Whenever a podiatric physician licensed under this chapter renders professional services to a patient, the podiatric physician is required, upon request, to submit to the patient, to the patient's insurer, or to the administrative agency for any federal or state health program under which the patient is entitled to benefits, an itemized statement of the specific services rendered and the charge for each, no later than the podiatric physician's next regular billing cycle which follows the fifth day after the rendering of professional services. A podiatric physician may not condition the furnishing of an itemized statement upon prior payment of the bill.

(2) At the point of sale, a podiatric physician shall disclose to the patient whether his or her cost-sharing obligation exceeds the retail price of professional services in the absence of health insurance coverage.

Section 7. Effective January 1, 2024, subsection (7) of section 627.6471, Florida Statutes, is renumbered as subsection (8), subsection (4) is amended, 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 rendered ~~provided~~ by preferred providers that differ from the schedules of payments for services rendered ~~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 rendered ~~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) An insurer issuing a health insurance policy in this state must apply the payment for a service that a nonpreferred provider rendered to an insured toward the insured's deductible and out-of-pocket maximum 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 the nonpreferred provider rendered to the insured toward the insured's deductible and out-of-pocket maximum.

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

(c) The amount 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 data reported on the Agency for Health Care Administration's Internet-based platform under s. 408.05(3)(c).

Section 8. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2023.