The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 1640
INTRODUCER:	Senator Collins
SUBJECT:	Payments for Health Care Services
DATE:	February 5, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			FP	

I. Summary:

SB 1640 creates several consumer protections relating to the collection of medical debt and creates price transparency requirements for hospitals, ambulatory surgical centers (ASC) and insurers relating to nonemergency services. In regards to the collection of hospital and ASC medical debt, the bill:

- Prohibits a hospital or ASC from engaging in extraordinary collections actions, such as certain legal or judicial processes including commencing a civil action, garnishing wages or placing a lien on property.
- Establishes a three-year statute of limitations for actions to collect medical debt, which runs from the later of the date on which the facility completes written notification of the medical debt or the date on which the facility refers the medical debt to a third-party for collection. Currently, medical debt is subject to a five-year statute of limitation.
- Exempts from attachment, garnishment or other legal process in an action on hospital medical debt:
  - A debtor's interest, not to exceed $10,000 in value, in a single motor vehicle. Currently, the exempt interest is $1,000.
  - A debtor's interest in personal property, not to exceed $10,000 in value, if the debtor does not claim or receive the benefits of a homestead exemption. Currently, the exempt interest is $1,000.

SB 1640 also includes the following price transparency requirements:

- A hospital or ASC must post standard charges for specified services on its website and establish a process for reviewing and responding to grievances from patients.
- Hospitals and ASCs must provide estimates of anticipated charges for nonemergency services and provide such estimates to the patient's health insurer.
- A health insurer, in turn, must prepare an "advanced explanation of benefits" for the patient, within a specified time frame prior to the service being provided, based on the facility's estimate.

The bill also revises the current voluntary shared savings incentive program for insurers participating in the individual market to make the program mandatory for such insurers.

The bill expands the health care providers that may participate in a direct health care agreement that is exempt from the insurance code to include a health care provider licensed under ch. 490 (practice of psychology) or ch. 491, F.S. (clinical, counseling, and psychotherapy services).

The fiscal impact of the bill, relating to the enforcement of the federal transparency requirements for hospitals and ASCs by the Agency for Health Care Administration is indeterminate. The Office of Insurance Regulation estimates that changing the shared savings program from a voluntary to mandatory program for insurers and HMOs will require an additional $193,000 salaries and benefits and $150,000 in rate to upgrade, recruit, and fill specific positions to accommodate the additional workload.

II. Present Situation:

Office of Insurance Regulation

In Florida, the Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities. To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR and comply with the requirements of the Florida Insurance Code. The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency. As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care. Rates and forms for health insurers and HMOs are subject to prior approval by the OIR.[1] Such rates may not be excessive, inadequate, or unfairly discriminatory.[2]

The federal Patient Protection and Affordable Care Act (PPACA)[3] requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the medical loss ratio (MLR).[4] It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. The PPACA requires insurers that provide coverage to small businesses and individuals to spend at least 80 percent of their premium income on health care claims and quality improvement, leaving the remaining 20 percent for administration, marketing, and profit.[5] Large group plans must spend at least 85 percent of premium dollars on medical care.[6] If an insurer fails to meet the applicable MLR standard in any given year, the issuer is required to provide a rebate to its customers.

[1] Part I, ch. 627, F.S.
[2] *Id*.
[3] Pub. L. 111-148, Mar. 23, 2010.
[4] Medical Loss Ratio | CMS (last visited Jan. 30, 2024)
[5] Medical Loss Ratio: Getting Your Money's Worth on Health Insurance | CMS (last visited Jan. 30, 2024).
[6] *Id*.

The regulations finalized in October 2020 specify that expenses by a health plan in direct support of a shared savings program must be counted as medical expenditures.[7] Thus, a health insurer or HMO providing shared savings to insureds or subscribers will receive an equivalent credit towards meeting the MLR standards established by PPACA.

Florida Shared Savings Programs[8]

In 2019, the Legislature created a voluntary shared savings program for the commercial insurance market, which allows health insurers and health maintenance organizations (HMOs) to provide financial incentives to insureds with individual policies or contracts when they obtain health care services offered by their health insurer or HMO through their shared savings list. Participation is voluntary and optional for insureds and subscribers. The shoppable health care services are lower-cost, non-emergency services for which a shared savings incentive is available for insureds under the 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.[9] Health insurers offering a shared savings incentive program must submit an annual report to the Office of Insurance Regulation (OIR) regarding the performance of the program. Currently, one insurer is participating in the voluntary program.

On January 1, 2019, the Division of State Group Insurance of the Department of Management Services instituted a voluntary shared savings program to reward insureds, subscribers, or their dependents for making informed and cost-effective decisions about health care spending.[10] The program allows participants to earn rewards by receiving rewardable healthcare services through two state vendors. Rewards are credited to a select pretax savings or spending account of the participant, and funds can be used to pay for eligible medical, dental, and vision expenses. Rewards are earned after the participant shops for a rewardable healthcare service on the website, receives the service, and the claim has been paid.[11] For fiscal year 2022-2023, total expenses for the program was $18.6 million. The program spent $9.6 million on claims, $6.3 million on administrative fees, and paid out $2.0 million in shared savings to employees.[12]

U.S. Health Care Spending

Major Payers of Health Care Spending

Highlights of the 2022 national health expenditures data[13] include:

[7] 45 CFR Part 158.
[8] Section 627.6387, 627.6648, and 641.31076, F.S.
[9] 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.
[10] Ch. 2017-70, L.O.F.
[11] MyBenefits, Shared Savings Program, available at https://www.mybenefits.myflorida.com/health/shared_savings_program (last viewed Jan. 30, 2024).
[12] State Employees Group Health Self-Insurance Trust Fund, Exhibit II, Financial Outlook by Fiscal Year (Jan. 10, 2024) HealthInsuranceOutlook.pdf (state.fl.us) (last visited Jan. 20, 2024).
[13] Centers for Medicare and Medicaid, National Health Expenditure Data https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data (last visited Jan. 31, 2024).

- Private health insurance spending grew 5.9% to $1,289.8 billion in 2022, or 29 percent of total NHE.
- Out of pocket spending grew 6.6% to $471.4 billion in 2022, or 11 percent of total NHE.
- Hospital expenditures grew 2.2% to $1,355.0 billion in 2022, slower than the 4.5% growth in 2021.
- Physician and clinical services expenditures grew 2.7% to $884.9 billion in 2022, slower growth than the 5.3% in 2021.
- Prescription drug spending increased 8.4% to $405.9 billion in 2022, faster than the 6.8% growth in 2021.
- The largest shares of total health spending were sponsored by the federal government (33 percent) and the households (28 percent). The private business share of health spending accounted for 18 percent of total health care spending, state and local governments accounted for 15 percent, and other private revenues accounted for 7 percent.

In 2020, California's personal health care spending was highest in the nation ($410.9 billion), representing 12.2 percent of total U.S. personal health care spending. Comparing historical state rankings through 2020, California consistently had the highest level of total personal health care spending, together with the highest total population in the nation. Other large states, New York, Texas, Florida, and Pennsylvania, also were among the states with the highest total personal health care spending. [14] In 2020, the average per enrollee cost of private health insurance in Florida was $5.057. In comparison, the per capita personal health care spending ranged from $7,522 in Utah to $14,007 in New York.[15] The national average for per capita spending was $10,191.[16]

U.S. Health Outcomes

Although the United States spends more of its gross domestic product on health care than any other country, the U.S. has the highest rate of infant deaths as well as the highest rate of preventable deaths.[17] Many experts suggest that these longstanding, widespread problems stem in part from the misaligned incentives built into the traditional, fee-for-service payment model.[18] Under fee-for-service, health care providers, such as physicians and hospitals, are paid for each service they provide, resulting rewards for greater utilization or volume, they are paid more if they deliver more services, even if they don't achieve desired results.

Value-Based Payment Models

In response to concerns about rising medical costs, greater utilization of services, and quality of outcomes, many insurers and HMOs have implemented value-based health care payment models (e.g., bundled payments) with providers, which aim to change that dynamic, so physicians earn more for delivering health care that helps patients have better outcomes, while also keeping costs down, thereby reducing costs and inefficiencies in the health care system.

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[14] National Health Expenditures Fact Sheet, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet (last visited Jan. 20, 2024).
[15] State Health Expenditure Accounts by State of Residence Highlights https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/res-highlights.pdf (last visited Jan. 20, 2024).
[16] *Id.*
[17] Value-Based Care: What It Is, and Why It's Needed | Commonwealth Fund (Feb. 7, 2023).
[18] *Id.*

Medical Debt

Medical debt, or personal debt incurred from unpaid medical bills, is a leading cause of bankruptcy in the United States. Two-thirds of medical debts are the result of a one-time or short-term medical expense arising from an acute medical need.[19] Many medical collections on consumer credit reports are low-dollar accounts. Data from the CFPB's Consumer Credit Panel show that in 2020, the median medical collection was $310, the mean medical collection was $773, and 62 percent of medical collections were under $490.[20] In Florida, approximately 14.3 percent of the population has medical debt in collection.[21] The median amount of medical debt in collections is $915.[22] The percentage of persons without health insurance coverage is 12.1 percent.[23] Medical debt is the most common collection information reported on consumer credit records.[24]

The Urban Institute analysis found that, as of December 2020, among people who had at least one medical collection on their credit record, the median person owed a total of $797 in medical debt.[25] Additionally, some medical debts are not included on credit records but may be captured in surveys.

Medical Debt Collection Process in Florida

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 monetary 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.[26] Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[27]

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[19] Hamel, Liz et al. "The Burden of Medical Debt: January 2016 Results from the Kaiser Family Foundation/New York Times Medical Bills Survey." Kaiser Family Foundation. January 2016. The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey (kff.org) (last visited Jan. 20, 2024).
[20] Medical Debt Burden in the United States (consumerfinance.gov). (last visited Jan. 28, 2024).
[21] Debt in America: State-Level Medical Debt | Urban Data Catalog (Sep. 14, 2023) and Debt in America: An Interactive Map; Technical Appendix (urban-data-catalog.s3.amazonaws.com) (last visited Jan. 28, 2024).
[22] *Id.*
[23] *Id.*
[24] Furey, Michael and Ryan Kelly. "Market Snapshot: Third-Party Debt Collections Tradeline Reporting." Consumer Financial Protection Bureau. July 18, 2019. https://files.consumerfinance.gov/f/documents/201907_cfpb_thirdparty-debt-collections_report.pdf. (last visited Jan. 25, 2024).
[25] Debt in America: An Interactive Map (urban.org) (last visited Jan. 24, 2024).
[26] Art. X, s. 4(a), Fla. Const.
[27] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.

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;[28] proceeds from life insurance policies;[29] wages or unemployment compensation payments due certain deceased employees;[30] disability income benefits;[31] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[32] $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.[33]

Bankruptcy is a means by which a person's assets are liquidated in order to pay that person's debts under court supervision. The U.S. Constitution gives Congress the right to uniformly govern bankruptcy law.[34] 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.[35] 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.[36] 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.[37]

Federal and Other State Laws Governing Medical Debt Collections

The Consumer Financial Protection Bureau's (CFPB) debt collection final rule, which revised Regulation F, the rule implementing the Fair Debt Collection Practices Act (FDCPA), took effect November 30, 2021. The FDCPA and Regulation F, apply to "debt collectors,"[38] as that term is defined in the statute, including, in general, debt collectors collecting medical debts. Generally the FDCPA and Regulation F do not apply to medical service providers or their employees who attempt to collect debts owed to the provider. The FDCPA and Regulation F prohibit, among other things, using "unfair or unconscionable means to collect or attempt to collect any debt."

Among other changes, the final rule prohibits "debt parking," also known as passive or delayed collections. This is the practice of furnishing collection information about a debt to a consumer

[28] Section 222.11, F.S.
[29] Section 222.13, F.S.
[30] Section 222.15, F.S.
[31] Section 222.18, F.S.
[32] Section 222.22, F.S.
[33] Section 222.25, F.S.
[34] Art. 1, s. 8, cl. 4, U.S. Const.
[35] 11 U.S.C. s. 522.
[36] 11 U.S.C. s. 522(b).
[37] Section 222.20, F.S.
[38] Under the FDCPA, a debt collector is "any person who uses any instrumentality of interstate commerce or the mails in any business the principal purpose of which is the collection of any debts, or who regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due another." The FDCPA additionally provides certain exemptions from this definition.

reporting company before communicating with the consumer about the debt.[39]210 This practice was previously employed by some medical debt collectors, who would report a debt to a consumer reporting company, then wait for the debtor to notice the reported debt when, for example, applying for credit. Regulation F addresses the practice of "debt parking" by requiring a debt collector to take certain actions intended to convey information about the debt to the debtor before furnishing information about that debt to a consumer reporting company.

The FDCPA and Regulation F also require debt collectors, including medical debt collectors, to provide certain information about the debt to consumers at or near the outset of collections. Regulation F requires debt collectors to include, as part of this information, an itemization of the current amount of the debt. This itemization may help individuals recognize and understand medical debts in collection.

State Laws Relating to Financial Assistance for Patients with Medical Bills

Some hospitals and managed care organizations have financial assistance programs that aim to reduce financial burdens for low-income patients. Under the federal Affordable Care Act (ACA), nonprofit hospitals are required to offer financial assistance to patients.[40] Certain states also require hospitals to offer programs to help patients with medical bills. Eligibility for these programs varies. Several states—including California, Connecticut, Illinois, Maine, Maryland, Nevada, New Jersey, New York, Rhode Island, and Washington—require discounted or free care for people with low incomes.[41] Certain states extend these protections to those with moderate incomes, as well. In most states, the mandates apply to all hospitals, but in some states, mandates cover only nonprofit, publicly funded, rural, or critical-access hospitals.

State Laws and Consumer Protection Related to Medical Debt Collection

Further, states such as Maryland, Nevada, New Mexico,[42] California, and Washington have enacted legislation providing expanded protections relating to disclosures, delayed credit reporting, and debt collection, as described below:

- Washington (law effective July 28, 2019). Prohibits health care providers and facilities from selling or assigning medical debt until at least 120 days after the initial billing statement. Prohibits certain practices with respect to medical debt, including the reporting of adverse information to consumer credit reporting agencies or credit bureaus until at least 180 days after the original obligation was received by the licensee for collection or by assignment; and, if the claim involves hospital debt, failure to include certain information regarding charity care or collection during the pendency of an application for charity care about which the licensee has received notice.[43]

[39] FTC Stops Debt Collector's Alleged "Debt Parking" Scheme, Requires it to Delete Debts it Placed on Consumers' Credit Reports (Nov. 30, 2020). https://www.ftc.gov/news-events/news/press-releases/2020/11/ftc-stops-debt-collectors-alleged-debt-parking-scheme-requires-it-delete-debts-it-placed-consumers (last visited Jan. 29, 2024).
[40] 26 U.S.C. s. 501(r).
[41] Medical Debt Burden in the United States (consumerfinance.gov) (last visited Jan. 29, 2024).
[42] SB0071JUS2 (nmlegis.gov) New Mexico Legislature. (last visited Jan. 29, 2024).
[43] 1531-S HBR FBR 19.pdf (wa.gov) Washington House. (last visited Jan. 28, 2024).

- Maryland (law effective January 1, 2021). Specifies the method for calculating family income to be used to consider free or reduced-cost medic\al care under a certain hospital financial assistance policy; and prohibits a hospital from charging interest or fees on certain debts incurred by certain patients.[44]
- California (law effective January 1, 2022). Prohibits a hospital from selling patient debt to a debt buyer, unless specified conditions are met, including that the hospital has found the patient ineligible for financial assistance or the patient has not responded to attempts to bill or offer financial assistance for 180 days. Requires that uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level be eligible for charity care or discount payments from a hospital, and authorizes a hospital to grant eligibility for charity care or discount payments to patients with incomes over 400 percent of the federal poverty level. Prohibits debt collection before 180 days after the initial billing.[45]
- Nevada (law effective July 1, 2021). Requires a collection agency to notify a debtor 60 days before taking any action to collect a medical debt; providing certain protections to a medical debtor who initiates contact with or makes a voluntary payment to a collection agency; prohibiting certain practices relating to the collection of medical debt; prohibiting the waiver of certain protections provided to medical debtors.[46]

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).[47] 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.[48] 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.[49] 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.[50] Estimates must be written in language "comprehensible to an ordinary layperson."[51] 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

[44] Legislation - SB0514 (maryland.gov) Maryland General Assembly. (last visited Jan. 22, 2024).
[45] Bill Text - AB-1020 Health care debt and fair billing. California Legislative Information. (last visited Jan. 22, 2024).
[46] SB248 Text (state.nv.us) Nevada Legislature. (last visited Jan. 28, 2024)
[47] Section 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[48] Section 381.026(3), F.S.
[49] Section 381.026(4)(c), F.S.
[50] Section 381.026(4)(c)3., F.S.
[51] *Id.*

warrant.[52] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[53]

Currently, under the financial information and disclosure provisions in the Patient's Bill of Rights:

- 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 the AHCA may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[54]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[55] to publish a schedule of charges for the medical services offered to patients.[56] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[57] 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.[58] 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 two-year period.[59]

[52] *Id.*
[53] Section 381.026(4)(c)5., F.S.
[54] Section 381.0261, F.S.
[55] Section 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.
[56] Section 381.026(4)(c)3., F.S.
[57] *Id.*
[58] *Id.*
[59] Section 381.026(4)(c)4., F.S.

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[60] 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.[61] 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.[62]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[63] must provide, within seven 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[64] 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 seven 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.[65] Under s. 408.05, F.S., the AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[66]

[60] Section 395.107(1), F.S.
[61] Section 395.107(2), F.S.
[62] Section 395.107(6), F.S.
[63] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.
[64] 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.
[65] Section 395.301, F.S.
[66] Section 408.05(3)(c), F.S.

Hospitals and other facilities post a link to this site – known as Florida Health Finder – to comply with the price transparency requirements. The cost information is searchable, 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.[67]

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.[68]

Federal Transparency Requirements - Hospitals

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations[69] changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, the federal 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.[70]

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 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.[71]

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[67] *Id.*
[68] Section 456.0575(2), F.S.
[69] 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).
[70] *Id.*
[71] 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).

Federal Oversight and Enforcement Relating to Price Transparency Requirements for Hospitals

The federal hospital transparency requirements were effective January 1, 2021. To be fully compliant, a hospital must have a complete machine-readable standard charge file; and either a consumer friendly 300 shoppable services list; or an online price estimator tool. 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.[72] 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.[73] Another review of more than 6,400 hospitals in 2022 indicated widespread non-compliance with the federal transparency rule in that more than 63 percent of hospitals were estimated to be non-compliant.[74] According to that review, only 38 percent of Florida hospitals were in compliance.[75]

In response to compliance concerns, the Centers for Medicare and Medicaid Services (CMS) has increased the number of comprehensive reviews conducted from 30-40 per month to over 200 comprehensive reviews per month.[76] As of April 2023, CMS has issued more than 730 warning notices and 269 requests for corrective action plans (CAPs). The CMS has imposed CMPs on six hospitals for noncompliance and the CMPS on an additional eight hospitals, including a Florida hospital, are under review or appeal, which are posted and made publicly available on the CMS website. As part of the monitoring and enforcement efforts, CMS[77] is updating the enforcement process, with respect to areas that do not require rulemaking, with the following changes:

- **Requiring CAP completion deadline.** CMS will continue to require hospitals that are out of compliance with the hospital price transparency regulation to submit a CAP within 45 days from when CMS issues the CAP request. CMS will also now require hospitals to be in full compliance with the hospital price transparency regulation within 90 days from when CMS issues the CAP request, rather than allowing hospitals to propose a completion date for CMS approval which can vary. This change will standardize and streamline the timeframe and promote compliance at earlier dates.
- **Imposing CMPs earlier and automatically**. Currently, CMS does not impose automatic CMPs for failure to submit a requested CAP or failure to come into compliance within 90 days from when a CAP request is issued. CMS will now automatically impose a CMP on hospitals that fail to submit a CAP at the end of the 45-day CAP submission deadline. Before imposing the CMP, CMS will re-review the hospital's files to determine whether any of the violations cited in the CAP request continue to exist and, if violations are found, impose a CMP. For hospitals that submit a CAP by the 45-day CAP submission deadline but fail to comply with the terms of that CAP by the end of the 90-day deadline, CMS will re-review

[72] 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 visited Jan. 31, 2024).
[73] *Id.*
[74] 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 visited Jan. 31, 2024).
[75] *Id., p.* 4.
[76] Hospital Price Transparency Enforcement Updates | CMS (Apr. 26, 2023) (last visited Jan. 17, 2024).
[77] *Hospital Price Transparency Enforcement Updates | CMS* (last visited Jan. 17, 2024).

the hospital's files to determine whether any of the violations cited in the CAP request continue to exist and, if so, impose an automatic CMP.

- **Streamlining the compliance process.** For hospitals that have not made any attempt to satisfy the requirements (i.e., those that have not posted any machine-readable file or shoppable services list/price estimator tool), CMS will no longer issue a warning notice to the hospital and will instead immediately request that the hospital submit a CAP. Currently, CMS does not issue CAP requests without first issuing a warning notice.

The CMS notes that these enforcement updates will shorten the average time by which hospitals must come into compliance with the hospital price transparency requirements after a deficiency is identified to no more than 180 days, or 90 days for cases with no warning notice, and will complement future efforts.[78]

Federal Transparency in Coverage Requirements – Insurers and HMOs

On October 29, 2020, the federal departments of Health and Human Services, Labor, and Treasury finalized Transparency in Coverage regulations[79] imposing new transparency requirements on issuers of individual and group health insurance plans.

Central to the new regulations is a requirement for insurers and HMOs 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 insurers and HMOs 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 services, to encourage shopping and price competition among providers.[80]

Federal Oversight and Enforcement of Transparency in Coverage Requirements

The Transparency in Coverage Final Rules (TiC Rules) require non-grandfathered group health insurers and HMOs offering non-grandfathered group and individual health insurance coverage to make cost-sharing information available to insureds and subscribers through an internet-based self-service tool and in paper form, upon request.[81] This information must be made available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the Departments[82] in Table 1 of the preamble

[78] *Id.*
[79] 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).
[80] Health Affairs Blog, *Trump Administration Finalizes Transparency Rule for Health Insurers, November 1, 2020, available at* https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last visited Jan. 23, 2024).
[81] 26 CFR 54.9815-2715A2(b); 29 CFR 2590.715-2715A2(b); and 45 CFR 147.211(b). The Consolidated Appropriations Act, 2021 imposed a largely duplicative requirement, and added a requirement that price comparison guidance also be provided by telephone, upon request. See also FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), Q3, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf, and FAQs about Affordable Care Act Implementation Part 61 (cms.gov) (Sep 27, 2024) (last visited Jan.19, 2024).
[82] Department of Treasury, Department of Labor, and Department of Health and Human Services.

to the TiC Rules,[83] and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.[84]

The insurer or HMO must make available to an insured or subscriber upon request cost-sharing information for a discrete covered item or service by billing code or descriptive term, and generally must furnish it according to the insured's or subscriber's request.[85] Further, the TiC Rules require an insurer or subscriber to provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider, according to the insured's or subscriber's request, permitting the individual to specify the information necessary for the insurer or HMO to provide meaningful cost-sharing liability information.[86]

For plans and issuers that are subject to CMS's enforcement authority and do not comply, CMS may take several enforcement actions, including: requiring corrective actions or imposing a civil money penalty up to $100 per day, adjusted annually under 45 CFR part 102, for each violation and for each individual affected by the violation.[87]

The Federal "No Surprises" Act

On December 27, 2020, Congress enacted the No Surprises Act as part of the Consolidated Appropriations Act of 2021.[88] 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 federal departments of Health and Human Services, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.[89]

Federal No Surprises Act Requirements Relating to Estimates – Facilities

The No Surprises Act requires a health insurer or health maintenance organization (HMO) to generate an "advanced explanation of benefits" (AEOB) that combines information on charges provided by a hospital facility with patient-specific cost information provided by a policy or contract. 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 insurer (if the patient is insured) or individual (if the patient is uninsured).[90]

Federal No Surprises Act Requirements of Health Insurers and HMOs

[83] 85 FR 72158, 72182-90 (Nov. 12, 2020).
[84] 26 CFR 54.9815-2715A2(c)(1); 29 CFR 2590.715-2715A2(c)(1); and 45 CFR 147.211(c)(1).
[85] In responding to an insured's or subscriber's request, the group health plan or health insurer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. 26 CFR 54.9815-2715A2(b)(2)(ii); 29 CFR 2590.715-2715A2(b)(2)(ii); and 45 CFR 147.211(b)(2)(ii).
[86] 26 CFR 54.9815-2715A2(b)(1); 29 CFR 2590.715-2715A2(b)(1); and 45 CFR 147.211(b)(1).
[87] 45 CFR part 150, subpart B and C.
[88] Public Law 116-260. The No Surprises Act is found in Division BB of the Act.
[89] *Id.*
[90] Public Law 116-260, Division BB, Section 112.

Under the No Surprises Act, once the "good faith estimate" has been shared with a patient's health insurer or HMO, then the insurer or HMO must then develop the AEOB. This personalized cost estimate must include the following:

- An indication of whether the facility participates in the patient's insurer's or HMO's 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 insurer or HMO;
- 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 policy or contract;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (e.g., 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.[91]

Deferral of Federal Enforcement Related to the Good Faith Estimates and the AEOBs for Insured Individuals[92]

The Department of Health and Human Services issued regulations implementing Public Health Services Act (PHS Act) s. 2799B-6 related to good faith estimates for uninsured or self-pay individuals in interim final rulemaking that was published in the Federal Register on October 7, 2021, but deferred enforcement of the portion of PHS Act s. 2799B-6 related to good faith estimates for insured individuals who are seeking to have a claim submitted to insurer or HMO for scheduled items or services.[93] In the preamble to that rule (and as stated in guidance issued by the Departments), the Departments also deferred enforcement of Code section 9816(f), ERISA section 716(f), and PHS Act section 2799A–1(f) related to the requirement that plans and issuers provide an AEOB.[94]

The decision to defer enforcement in October 2021 was made in response to stakeholder requests that the Departments first establish standards for the data transfer from providers and facilities to plans and issuers, and give plans, issuers, providers, and facilities enough time to build the infrastructure necessary to support the transfers. The Departments agreed that compliance with

[91] Public Law 116-260, Division BB, Section 111.
[92] 87 FR 56905.
[93] Requirements Related to Surprise Billing; Part II, 86 FR 55980, 55983 (October 7, 2021), available at *https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii*. (last visited Jan. 24, 2024).
[94] FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (August 20, 2021), Q6, available at *https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf*. (last visited Jan. 29, 2024).

these sections was likely not possible by January 1, 2022, and indicated an intent to undertake notice and comment rulemaking in the future to implement these provisions, including establishing appropriate data transfer standards. In September 2022, issued a Request for Information relating to the AEOB and the GFE for covered individuals. In the September 2022 Request for Information, noticed in the Federal Register, it was stated that HHS is deferring enforcement of the requirement that providers and facilities must provide a GFE to plans and issuers for covered individuals enrolled in a health plan or coverage and seeking to have a claim submitted for scheduled (or requested) items or services to their plan or coverage, and the Departments are deferring enforcement of the requirement that plans and issuers must provide these covered individuals with an AEOB until the notice and comment rulemaking, including the establishment of appropriate data transfer standards is accomplished.

III. Effect of Proposed Changes:

Medical Debt Protections for Consumers

SB 1640 amends and creates several sections of law in order to establish new protections for consumers who owe medical debt to a hospital or ambulatory surgical center (ASC).

Section 1 amends s. 95.11, F.S., to establish that the statute of limitations for an action to collect medical debt for services rendered by a hospital or ASC licensed under ch. 395, F.S., is three years, running from the date on which the facility completes written notification of the medical debt or the date on which the facility refers the medical debt to a third-party for collection, whichever is later. Medical debt is currently subject to a five-year statute of limitations under s. 95.11(2)(b), F.S.

Section 2 creates s. 222.26, F.S., to exempt from attachment, garnishment or other legal process in an action on hospital medical debt:

- A debtor's interest, not to exceed $10,000 in value, in a single motor vehicle. Currently, the exempt interest is $1,000.
- A debtor's interest in personal property, not to exceed $10,000 in value, if the debtor does not claim or receive the benefits of a homestead exemption. Currently, the exempt interest is $1,000.

Section 4 creates s. 395.3011, F.S., to prohibit a hospital or ASC from engaging in certain billing and collection activities relating to medical debt. The bill defines "extraordinary collection actions" to mean any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care covered under the facility's financial assistance policy:

- Selling the individual's debt to another party.
- Reporting adverse information about the individual to consumer credit reporting agencies.
- Deferring, denying, or requiring a payment before providing medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the facility's financial assistance policy.
- Actions that require a legal or judicial process, including, but not limited to:
  - Placing a lien on the individual's property;
  - Foreclosing on the individual's real property;

- Attaching or seizing the individual's bank account or any other personal property;
- Commencing a civil action against the individual;
- Causing the individual's arrest; or
- Garnishing the individual's wages.

The bill prohibits a hospital or ASC from engaging in an extraordinary collection action to obtain payment for services in the following circumstances:

- Before the facility has made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy for the care provided and, if eligible, before a decision is made by the facility on the patient's application for such financial assistance;
- Before the facility has provided the individual with an itemized statement or bill;
- During an ongoing grievance process as described in s. 395.301(6), F.S., or an ongoing appeal of a claim adjudication;
- Before billing any applicable insurer or HMO and allowing the insurer or HMO to adjudicate a claim;
- For 30 days after notifying the patient in writing, by certified mail, or by other traceable delivery method, that a collection action will commence absent additional action by the patient; or
- While the individual:
  - Negotiates in good faith the final amount of a bill for services rendered; or
  - Complies with all terms of a payment plan with the facility.

Section 3 amends s. 395.301, F.S., to require each hospital and ASC to establish an internal process for reviewing and responding to grievances from patients. The process must allow a patient to dispute charges that appear on the patient's itemized statement or bill and the facility must prominently post on its website and print on each itemized statement or bill, in bold print, the instructions for initiating, and the direct contact information required to initiate, a grievance. The facility must respond to a patient's grievance within seven business days after the patient formally files the grievance.

Price Transparency Provisions Relating to Hospitals and ASCs

Section 3 amends s. 395.301, F.S., to require a hospital or an ASC to post on its website a consumer-friendly list of standard charges for at least 300 shoppable health care services. If the facility posts less than 300 services, it must include each service it provides. The bill defines:

- "Shoppable health care service" to mean a service that can be scheduled by a health care consumer in advance. The term includes, but is not limited to, the services described in s. 627.6387(2)(e), F.S.,[95] and any services defined in regulations or guidance issued by the U.S. Department of Health and Human Services.

[95] These services include clinical laboratory services, infusion therapy, inpatient and outpatient surgical procedures, obstetrical and gynecological services, inpatient and outpatient nonsurgical diagnostic tests and procedures, physical and occupational therapy services, radiology and imaging services, prescription drugs, services provided through telehealth, and 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).

- "Standard charge" to mean the same as that term is defined in regulations or guidance issued by the U.S. Department of Health and Human Services for purposes of hospital price transparency.

The bill also amends provisions requiring a hospital or ASC to provide a good faith estimate for nonemergency medical services to a patient. The bill requires this estimate to be provided to the patient or prospective patient upon scheduling the medical service, rather than within seven days of receiving the request for the service as under current law, and also requires the facility to provide the estimate to the patient's health insurer[96] and to the patient at least three business days before the service but no more than one business day after the service is scheduled, or three business days after the service is scheduled if the service is scheduled at least ten days in advance.

The bill removes current-law provisions that require the facility to take action to educate the public that such estimates are available upon request and that specify that the estimate does not preclude the actual charges from exceeding the estimate.

Advanced Explanation of Benefits Required of Insurers and HMOs

Section 6 creates s. 627.445, F.S., to require a health insurer to prepare an "advanced explanation of benefits" (AEOB) after receiving an estimate from a hospital or ASC. The bill defines "health insurer" as a health insurer issuing individual or group coverage or a HMO issuing coverage through an individual or a group contract. The AEOB must be provided to the patient no later than one business day after the insurer receives the estimate or no later than three business days for services scheduled at least ten business days in advance. At a minimum, the AEOB must include detailed coverage and cost-sharing information pursuant to the federal No Surprises Act.

Disclosure of Discounted Cash Prices

Section 7 creates s. 627.447, F.S., to provide that an insurer may not prohibit a provider from disclosing to an insured the option to pay the provider's discounted cash price for services. The term, "discounted cash price," means:

- With respect to a hospital facility, the term has the same meaning as provided in 45 C.F.R. s. 180.20. The term does not include the amount charged to an individual pursuant to a facility's financial assistance policy.
- With respect to a provider that is not a hospital, the term means the charge that is applied to an individual who paid for a health care service without filing an insurance claim.

Shared Savings Incentive Program (Sections 8-10)

[96] As defined in s. 627.445(1), F.S.

These sections amend ss. 627.6387, 627.6648, and 641.31076, F.S. to specify that a health insurer or health maintenance organization must count a shared saving incentive program as a medical expense for rate development and rate filing purposes.[97]

The program is revised to provide that it is mandatory for an insurer writing individual policies.

The program remains voluntary and optional for insureds.

Direct Health Care Agreements

Section 5 amends s. 624.27, F.S., to expand the definition of health care provider that may participate in a direct health care agreement that is exempt from the insurance code to include a health care provider licensed under ch. 490 (practice of psychology) or ch. 491, F.S. (clinical, counseling, and psychotherapy services). Currently, physicians licensed under chapter 458, osteopaths licensed under chapter 459, chiropractors licensed under chapter 460, podiatric physicians licensed under chapter 461, nurses and certified nursing assistants licensed under chapter 464, or dentists licensed under chapter 466, or a health care group practice, who provides health care services to patients are authorized to participate in direct health care agreements. Direct health care agreements are contracts between providers and a patient that are exempt from the insurance code if the agreement is in writing, discloses the scope of the services, duration of the agreement, monthly fees, and any fees for health care services not covered by the monthly fee. Further, the agreement must offer a refund to the patient of monthly fees paid in advance if the provider ceases to offer the services for any reason.

Conforming Changes (Sections 11-15)

The bill amends ss. 475.01, 475.611, 768.28, and 787.061, F.S., to make conforming cross-reference changes.

Effective Date (Section 16)

The bill provides an effective date of October 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[97] 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).

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Article II, Section 3, of the Florida Constitution has been interpreted by Florida courts to prohibit the Legislature from delegating its legislative power to others. Under this non-delegation principle, Florida courts have held that the Legislature may enact laws that adopt federal statutes or other federal regulations in existence and in effect at the time the Legislature acts; however, if the Legislature incorporates into a Florida statute a future federal act or regulation, courts have held that such incorporation constitutes an unconstitutional delegation of legislative power.

However, when a statute incorporates a federal law or regulation by reference, in order to avoid holding the subject statute unconstitutional, Florida courts generally interpret the statute as incorporating only the federal law or regulation in effect on the date of the Legislature's action to enact the Florida law, reasoning that the Legislature is presumed to have intended to enact a valid and constitutional law.

Lines 166-171 of the bill define the terms "shoppable health care service" and "standard charge" with reference to how those terms are defined in "regulations or guidance issued by the United States Department of Health and Human Services." Considering that the bill does not specify that it is referring to such definitions as they exist at a specific date prior to the enactment of the bill, these references may be considered an unauthorized delegation of legislative powers if interpreted to make reference to future revisions of those definitions in federal law and may be interpreted to maintain the meaning of how those federal definitions stand on the date the bill becomes effective instead of incorporating such future revisions.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 1640 may have an indeterminate positive fiscal impact on consumers of health care services at hospitals and ASCs by providing additional price information prior to the consumer obtaining a health care service and through protecting the consumer against certain debt collection practices for medical debt.

The bill may have an indeterminate negative fiscal impact on hospitals, ASCs, health insurers, and HMOs related to complying with the new state requirements in the bill and on hospitals and ASCs that may not be able to collect on medical debt that they may have collected prior to the passage of the bill.

C. Government Sector Impact:

The Office of the State Courts Administrator

The Office of the State Courts Administrator reports that the State Courts System receives $195 in filing fees for each civil proceeding, and those funds are deposited into the State Courts Revenue Trust Fund (SCRTF). To the extent that the number of such proceedings will be reduced by the bill's prohibition against hospitals and ASCs pursuing "extraordinary collection activities," combined with the bill's other limitations related to the collection of medical debt, the bill will negatively impact deposits into the SCRTF. The extent of this impact is indeterminate.[98]

Agency for Health Care Administration (Agency)

The fiscal impact on Agency is indeterminate at this time. The bill increases the regulation of hospitals and ASCs, both of which are currently licensed and regulated by the Agency.

Office of Insurance Regulation[99]

The OIR provides a fiscal impact related to implementing a mandatory shared savings program for insurers and HMOs to offer insureds and subscribers. Implementation of the bill would require all health insurers, and HMOs to file new forms and annually thereafter file forms with the office for review as part of the contract, and submit annual rate filings for review. Since only one insurer currently offers this type of program, this would require additional work and training for OIR staff. To ensure the products are thoroughly reviewed and readily available in the market, OIR would need $150,000 in rate and $193,000 in Salaries and Benefits to upgrade, recruit, and fill specific positions to accommodate the workload.

VI. Technical Deficiencies:

Lines 182-184 of the bill require a hospital or ambulatory surgical center (ASC) to provide the good faith estimate to a patient "upon scheduling a medical service." However, lines 191-192 require the facility to provide the estimate to the patient "no later than one business day after the service is scheduled" (or three business days in certain scenarios). As such, it is unclear when a facility is required to provide the estimate to the patient or whether the facility must provide the estimate to the patient twice.

[98] Office of the State Courts Administrator, *2024 Judicial Impact Statement: SB 1640* (Jan. 24, 2024) (on file with the Senate Committee on Banking and Insurance).
[99] Office of Insurance Regulation, 2024 SB 1640 Analysis. On file with Senate Banking and Insurance Committee.

VII. Related Issues:

Line 190 requires the good faith estimate to be provided by the hospital or ambulatory surgical center (ASC) to the health insurer and to the patient "at least 3 business days before a service is to be furnished." It may be impossible for a facility to meet this deadline if a service is to be furnished less than three days after it is scheduled and may preclude services from being furnished less than three days after they are scheduled.

The change to the statute of limitations to collect medical debt may result in fewer actions being barred by the statute of limitations as hospitals and ASCs could determine when the statute of limitations begins to run by delaying written notice of the debt or transfer medical debt to collection agencies.[100]

Many insurers and HMOs have implemented value-based value based purchasing or alternative payment methodologies that are tied to certain insurer-specific quality improvement or outcome strategies. Often such payment methodologies bundle services. It is unclear whether the information relating to the shared savings program includes outcome measures that a consumer may use to also evaluate the quality of care delivered by a provider.

VIII. Statutes Affected:

This bill amends sections 95.11, 395.301, 624.27, 627.447, 627.6387, 627.6648, 641.31076, 475.01, 475.611, 517.191, 768.28, and 787.061 of the Florida Statutes.
This bill creates sections 226.26, 395.3011, and 627.446, of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[100] Supra at 98.