HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/HB 1175	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Health & Human Services Committee; Health Care Appropriations Subcommittee; Sprowls and others	116 **Y's**	1 **N's**
COMPANION BILLS:	CS/SB 1496	**GOVERNOR'S ACTION:**	Approved

SUMMARY ANALYSIS

CS/CS/HB 1175 passed the House on March 2, 2016. The bill was amended by the Senate on March 10, 2016, and subsequently passed the House as amended on March 11, 2016.

The bill ensures greater consumer access to health care price and quality information by requiring certain heath care providers, insurers and health maintenance organizations (HMOs) to give that information to patients. The bill requires the Agency for Health Care Administration (AHCA) to contract with a vendor for an all-payer claims database (APCD), which provides an online, searchable method for consumers to compare provider price and quality, and a Florida-specific data set for price and quality research purposes. The bill requires insurers and HMOs to submit data to the APCD, under certain conditions.

The bill creates pre-treatment transparency obligations for hospitals, ambulatory surgery centers, health care practitioners providing non-emergency services in these facilities, and insurers and HMOs. Facilities must post online the average payments and payment ranges received for bundles of health care services defined by AHCA. This information must be searchable by consumers. Facilities must provide, within 7 days of a request, a written, good faith, personalized estimate of charges, including facility fees, using either bundles of health care services defined by AHCA or patient-specific information. Failure to provide the estimate results in a daily licensure fine of $1,000, up to $10,000. Facilities must inform patients of health care practitioners providing their nonemergency care in hospitals and these practitioners must provide the same type of estimate, subject to a daily fine of $500, up to $5,000. Facilities and facility practitioners must publish information on their financial assistance policies and procedures. Insurers and HMOs must create online methods for patients to estimate their out-of-pocket costs, both using the service bundles established by AHCA and based on patient-specific estimates using the personalized estimate the patient obtains from facilities and practitioners. In addition, diagnostic-imaging centers owned by a hospital but located off of the premises must publish and post charges for services pursuant to s. 395.107, F.S., which currently requires urgent care centers to do the same.

Post-treatment, facilities must provide an itemized bill within 7 days of discharge or request, whichever is later, meeting certain requirements for comprehension by a layperson, and identifying any providers who may bill separately for the care received in the facility.

Finally, the bill makes several changes to the Florida Center for Health Information and Policy Analysis, which is the health care data collection unit of AHCA. The bill changes the Center's name, and streamlines the Center's functions by eliminating obsolete language, redundant duties, and unnecessary functions.

The bill provides an appropriation for AHCA of $952,919 in recurring funds and $3,100,000 in nonrecurring funds from the Health Care Trust Fund and one full-time equivalent position with associated salary rate to implement the provisions of the bill.

The bill was approved by the Governor on April 14, 2016, ch. 2016-234, L.O.F., and will become effective on July 1, 2016.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Background

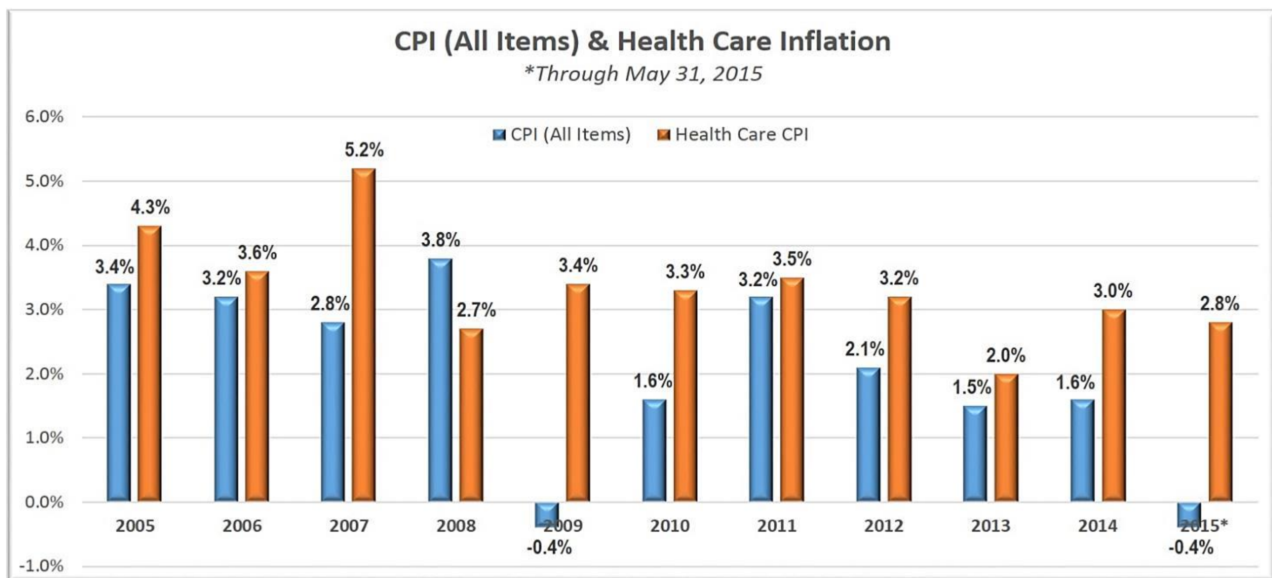
Health Care Price Transparency

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Consumers bear a greater share of health care costs, and more participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Price transparency in health care can have different definitions. The term can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[1] Price can be defined as an estimate of a consumer's complete cost on a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and identifies a consumer's out-of-pocket cost.[2] Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."[3] Indeed, the definition or the price or cost of health care has different meanings depending on who is incurring the cost.[4]

The annual increase in health care costs has outpaced inflation in every year for the past seven years, except 2008. The following chart shows the increase in costs each year from 2007 through 2014, adjusted and compared against the consumer price index, which is the measure of inflation of the cost of goods and services.[5]

[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, page 2, available at http://www.gao.gov/products/GAO-11-791.
[2] Id.
[3] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, page 2, 2014, available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=22279.
[4] Id.
[5] Patton, M., *U.S. Health Care Costs Rise Faster Than Inflation*, June 29, 2015, available at http://www.forbes.com/sites/mikepatton/2015/06/29/u-s-health-case-costs-rise-faster-than-inflation/ (last viewed March 14, 2016).



Further, PriceWaterhouse Cooper's Health Research Institute projects health care costs to rise 6.5 percent in 2016.[6]

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, more than one in five Americans with private insurance is enrolled in a high deductible health plan (HDHP). Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. Eighty-one percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan.[7]

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,318.[8] The average annual deductible is similar to last year ($1,217), but has increased from $917 in 2010.[9] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $1,836 in small firms, compared to $1,105 for workers in large firms.[10] Sixty-three percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 39% in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (36% for small firms vs. 12% for large firms)

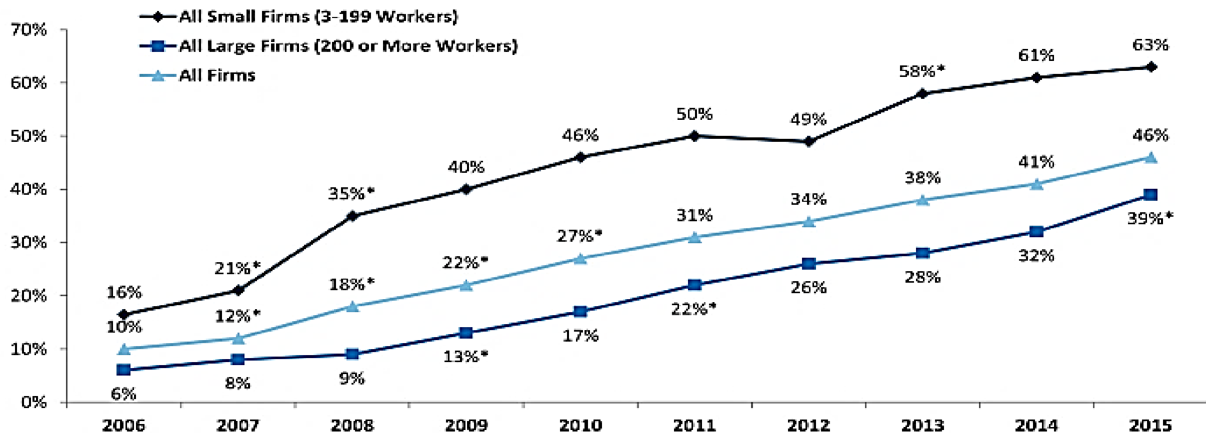
Looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 55% in 2006 to 70% in 2010 to 81% in 2015. If we look at the change in deductible amounts for all covered workers (assigning a zero value to workers in plans with no deductible), we can look at the impact of both trends together. Using this approach, the average deductible for all covered workers in 2015 is $1,077, up 67% from $646 in 2010 and 255% from $303 in 2006.

From 2010 to 2015, the average premium increase for covered workers with family coverage increased 27%, while wages have only increased 10%.[11] Furthermore, 63 percent of covered workers employed by a firm of 3 to 199 employees are in a plan with a deductible of $1,000 or more, while 39 percent of

[6] PwC, Health Research Institute, *Behind the Numbers, 2016*, available at http://www.pwc.com/us/en/health-industries/behind-the-numbers.html (last viewed March 14, 2016).
[7] The Henry J. Kaiser Family Foundation, *2015 Employer Health Benefits Survey*, September 22, 2015, page 4, available at http://files.kff.org/attachment/report-2015-employer-health-benefits-survey.
[8] Id.
[9] Id.
[10] Id.
[11] Id.

covered workers employed by a firm with 200 or more employee are in such a plan, more than three times the average in 2006.[12] In fact, the average annual deductible in 2015 is $1,217, up from $917 in 2010.[13] The chart below shows the percent of workers enrolled in employer-sponsored insurance with an annual deductible of $1,000 or more for single coverage by employer size for 2006 through 2015.[14]

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2015



* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

According to the 2014 Mercer National Survey of Employer-Sponsored Health Plans, 48 percent of employers with 500 or more employees currently offer consumer-driven health plans (CDHPs), up from 39 percent in 2013, while 72 percent of jumbo employers, those with 20,000 or more employees, offer CDHPs, up from 63 percent the previous year.[15] Further, more employers plan on offering CHDPs in 2017. The chart below tracks the increase in CDHP offerings over the last five years.[16]

FIGURE 4
Sharp increase in offerings of consumer-directed health plans
Percent of employers offering/likely to offer CDHP, by employer size

Number of employees	2010	2011	2012	2013	2014	Very likely to offer in 2017
All employers (10+ employees)	17%	20%	22%	23%	27%	36%
All large employers (500+ employees)	23%	32%	36%	39%	48%	66%
Jumbo employers (20,000 + employees)	51%	48%	59%	63%	72%	88%

[12] Id.
[13] Id.
[14] Supra, FN 7, Exhibit G.
[15] Mercer, Newsroom, *Modest Health Benefit Cost Growth Continues as Consumerism Kicks Into High Gear*, November 19, 2014, available at http://www.mercer.com/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html (last viewed March 14, 2016).
[16] Id. Mercer National Survey of Employer Sponsored Health Plans.

These trends, coupled with overall increases in health care expenditures, mean consumers now spend $329.8 billion out-of-pocket annually.[17] Out-of-pocket medical spending by adults with employer-sponsored health insurance rose from $793 per capita in 2013 to $810 per capita in 2014.[18] Such spending accounted for 16.3 percent of total per capita health care expenditures in 2014.[19]

National Price Transparency Studies

There are 28 states with active health price transparency or price disclosure legislation.[20] Legislation ranges from requiring facilities and other providers to report prices to state agencies to requiring providers to notify patients and prospective patients of prices of the most common procedures.

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

- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.
- Expand state-based all-payer health claims databases (APCDs), which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[21]

The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the next 10 years.[22]

As Americans shoulder more health care costs, research suggests that they are looking for more and better price information.[23]

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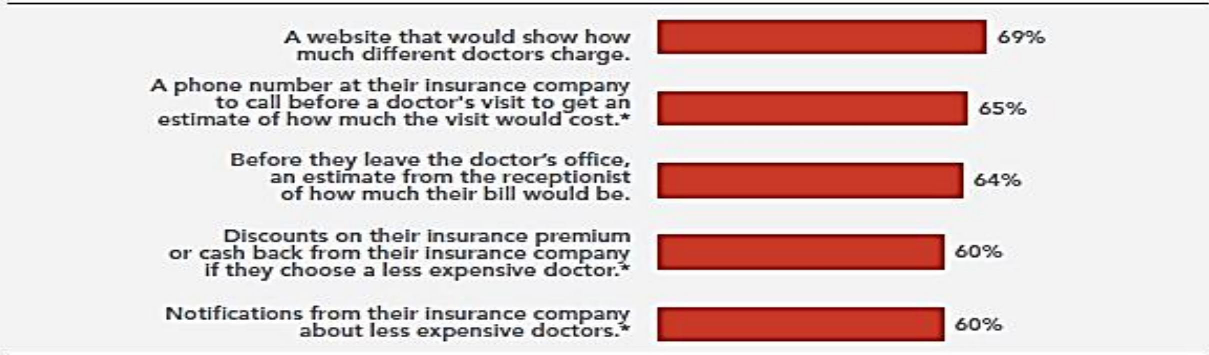
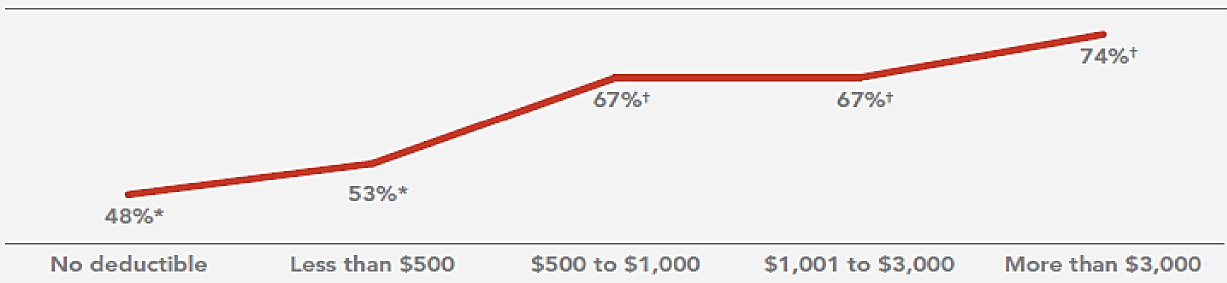
[17] U.S. Dept. of Health and Human Services, Centers for Medicaid and Medicare Services, *National Health Expenditure Data Fact Sheet-Historical National Health Expenditures, 2014*, available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.htm (last viewed March 14, 2016).
[18] Health Care Cost Institute, *2014 Health Care Cost and Utilization Report*, October 2015, page 5, available at http://www.healthcostinstitute.org/2014-health-care-cost-and-utilization-report (last viewed March 14, 2016).
[19] Id.
[20] Pallardy, C., *10 Things to Know About Price Transparency*, Becker's ASCReview, August 25, 2015, available at http://www.beckersasc.com/asc-coding-billing-and-collections/10-things-to-know-about-price-transparency.html (last viewed March 14, 2016).
[21] White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, available at: http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf.
[22] Id., pg. 1.
[23] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at http://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf.



One study in 2014, which conducted a nationally representative survey of more than 2,000 adults, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[24] The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.[25]



The individuals who compared prices stated that such research impacted their health care choices and saved them money.[26] In addition, the study found that most Americans do not equate price with quality of care. Seventy one percent do not believe higher price impart a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[27] Because of the high level of cost-sharing associated with CDHPs, these consumers are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. In fact, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price

[24] Id., pg. 3.
[25] Id., pg. 13.
[26] Id., pg. 4.
[27] Supra, FN 23.

transparency tool.[28] Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.[29]

Additional research has found the use of price transparency tools to be associated with lower total claims payments for common medical services and procedures.[30] A recent study sought the measure the impact of consumer access to health care price data on the cost of three of the most common health services- laboratory tests, advanced imaging services, and clinician office visits.[31] Medical claims from 2010 to 2013 of more than 500,000 patients insured in the U.S. by 18 employers who provided a health care price transparency platform were reviewed to determine the total claims payment for the three services.[32]

Researchers accessed the price transparency platform to determine which claims were associated with a prior search of the platform. In the study sample, 6 percent of lab test claims, 7 percent of advanced imaging claims, and nearly 27 percent of clinician office visit claims were associated with a search.[33] Prior to accessing the price transparency platform, searchers had higher claim payments than non-searchers for each of the services. After using the price transparency platform, searchers paid nearly 14 percent less for lab test services, 13 percent less for advanced imaging services, and 1 percent less for doctor office visits than non-searchers.[34] The study concluded that patient access to pricing information before obtaining clinical services may result in lower overall payments made for clinical care.[35]

Florida Efforts in Health Care Price Transparency

Florida Patient's Bill of Rights and Responsibilities

In 1991, s. 381.026, F.S., enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[36] 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.[37] 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.

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[28] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, page 4, available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126.

[29] Hibbard, JH, et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, Health Affairs 2012; 31(3): 560-568.

[30] Whaley, C., Schneider Chafen, J., et al., *Association Between Availability of Health Service Prices and Payments for These Services*, Journal of the American Medical Association. 2014;312(16): 1670-1676.

[31] Id.

[32] Id.

[33] Id.

[34] Id.

[35] Id.

[36] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.; The Florida Patient's Bill of Rights and Responsibilities is intended to promote better communication and eliminate misunderstandings between the patient and health care provider or health care facility. The rights of patients include standards related to individual dignity; information about the provider, facility, diagnosis, treatments, risks, etc.; financial information and disclosure; access to health care; experimental research; and patient's knowledge of rights and responsibilities. Patient responsibilities include giving the provider accurate and complete information regarding the patient's health, comprehending the course of treatment and following the treatment plan, keeping appointments, fulfilling financial obligations, and following the facility's rules and regulations affecting patient care and conduct.

[37] S. 381.026(3), F.S.

Under s. 381.026(4)(c), F.S., a patient has the right to request certain financial information from health care providers and facilities.[38] 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.[39] Estimates must be written in language "comprehensible to an ordinary layperson."[40] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[41] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[42]

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

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility.
- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Florida Patient's Bill of Rights and Responsibilities does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the Agency's website.
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[43]

In 2011, the Legislature passed HB 935,[44] which amended the Patient's Bill of Rights to authorize, but not require, primary care providers[45] to publish a schedule of charges for the medical services offered to patients.[46] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[47] 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.[48] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single 2-year period.[49]

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[38] S. 381.026(4)(c), F.S.
[39] S. 381.026(4)(c)3., F.S.
[40] Id.
[41] Id.
[42] S. 381.026(4)(c)5., F.S.
[43] S. 381.0261, F.S.
[44] Ch. 2011-122, Laws of Fla.
[45] S. 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[46] S. 381.026(4)(c)3., F.S.
[47] Id.
[48] Id.
[49] S. 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.[50] The schedule requirements are the same as those established for primary care providers.[51] 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).[52]

In 2012, the Legislature passed HB 787,[53] which built upon the transparency requirements established by HB 935. The law amended the definition of "urgent care center" to include 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 in the definitions.

The law requires a schedule of charges for medical services posted by an urgent care center to 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. The law also requires the text of the schedule of medical charges to fill at least 12 square feet of the total 15 square feet area of the posted schedule, and allows use of an electronic device for the posting. The device must measure at least three square feet in size and be accessible to all consumers during business hours.

Health Care Facilities

Under s. 395.301, F.S., a health care facility[54] is required to provide, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group 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 is required to notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

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[50] S. 395.107(1), F.S.
[51] S. 395.107(2), F.S.
[52] In 2012, the Legislature considered, but did not pass, HB 1329. The bill required ambulatory surgical centers and diagnostic-imaging centers to comply with the provisions of s. 395.107, F.S., established by HB 935 in 2011, and required physicians to publish, in writing, a schedule of medical charges. The bill would have imposed a fine of $1,000, per day, on an urgent care center, ambulatory surgical center, or diagnostic-imaging center that fails to post the schedule of medical charges. The failure of a practitioner to publish and distribute a schedule of medical charges subjected the practitioner to discipline under the applicable practice act and s. 456.072, F.S. Lastly, the bill addressed balance billing by requiring health insurers, hospitals, and medical providers to disclose contractual relationships among the parties and to disclose, in advance of the provision of medical care or services, whether or not the patient will be balance billed as a result of the contractual relationship, or lack thereof, among the insurer, hospital, and medical provider. Failure to provide disclosure to the insured as required by this provision of the bill resulted in a $500 fine, per occurrence, to be imposed by the AHCA.
[53] SS. 1-3, Ch. 2012-160, Laws of Fla.
[54] The term "health care facilities" refers to hospital, ambulatory surgical centers, and mobile surgical centers, all of which are licensed under part I of Chapter 395, F.S.

Health Care Quality Transparency

Most Americans believe that the health care they receive is the best available, but the evidence shows otherwise.[55] Although the U.S. spends more than $3 trillion a year on health care,[56] 17.4 percent of the gross national product,[57] research shows that the quality of health care in America is, at best, imperfect, and, at worst, deeply flawed.[58] Issues with health care quality fall into three categories:

- Underuse. Many patients do not receive medically necessary care.
- Misuse. Each year, more than 100,000 Americans get the wrong care and are injured as a result. More than 1.5 million medication errors are made each year.
- Overuse. Many patients receive care that is not needed or for which there is an equally effective alternative that costs less money or causes fewer side effects.

Research indicates that quality of care in the U.S. is uneven. For example, Americans receive appropriate, evidence-based care when they need it only 55 percent of the time.[59] Similarly, more than 400,000 people die each year as a result of preventable hospital errors in the U.S.[60], and more than 75,000 people died in 2011 from an infection obtained while in the hospital.[61]

There are hundreds of health care quality measures developed, maintained, and evaluated for relevancy and accuracy by many different organizations, including the federal Agency for Healthcare Research and Quality, the National Quality Forum, and the National Committee for Quality Assurance. In general, health quality measures can be sorted into four categories:[62]

- **Structure measures**- assess the aspects of the health care setting, including facility, personnel, and policies related to the delivery of care.
  - Example- What is the nurse-to-patient ratio in a neonatal intensive care unit?
- **Process measures**- determine if the services provided to patients are consistent with routine clinical care.
  - Example- Does a doctor recommend prostate-specific antigen testing for his male patients at average risk for prostate cancer beginning at age 50?
- **Outcome measures**- evaluate patient health as a result of care received.
  - Example- What is the infection rate of patients undergoing cardiac surgery at a hospital?
- **Patient experience measures**- provide feedback on patients' experiences with the care received.
  - Example- Do patients recommend their doctor to others following a procedure?

Data on health care quality measures come from a number of sources. Some of the most common sources include:

- Health insurance claims and other administrative documents;

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[55] National Committee for Quality Assurance, *The Essential Guide to Health Quality*, page 6, available at http://www.ncqa.org/Portals/0/Publications/Resource/%20Library/NCQA_Primer_web.pdf (last viewed March 14, 2016).
[56] The Henry J. Kaiser Foundation, Peterson-Kaiser Health System Tracker, *Health Spending Explorer-U.S. Health Expenditures 1960-2014*, available at http://www.healthsystemtracker.org/interactive/health-spending-explorer/?display=U.S.%2520%2524%2520Billions&service=Hospitals%252CPhysicians%2520%2526%2520Clinics%252CPrescriptions%2520Drug (last viewed February 13, 2016).
[57] The World Bank, *Data-United States*, available at http://data.worldbank.org/country/united-states (last viewed March 14, 2016).
[58] Supra, FN 55.
[59] McGlynn, E.A., Asch, S.M., et al., *The quality of health care delivered to adults in the United States*, New England Journal of Medicine, 348(26): 2635-45, June 2, 2003.
[60] James, J., *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, Journal of Patient Safety, 9(3): 122-128 (September 2013).
[61] Centers for Disease Control, *Healthcare-associated infections (HAI), Data and Statistics-HAI Prevalence Survey*, available at http://www.cdc.gov/HAI/surveillance/index.html (last viewed March 14, 2016).
[62] U.S. Government Accountability Office, *Health Care Transparency-Actions Needed to Improve Cost and Quality Information for Consumers*, October 2014, pgs. 6-7 (citing quality measure categories established by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality's National Quality Measures Clearinghouse, available at http://qualitymeasures.ahrq.gov/tutorial/varieties.aspx).

- Disease registries, such as those maintained by the Agency for Toxic Substances and Disease Registry[63] in the Centers for Disease Control and national disease-specific registries, like the National Amyotrophic Lateral Sclerosis (ALS) Registry[64] and the Kaiser Permanente Autoimmune Disorder Registry[65];
- Medical records; and
- Qualitative data, including information from patient surveys, interviews, and focus groups.[66]

Standardized healthcare performance measures are used by a range of healthcare stakeholders for a variety of purposes. Measures help clinicians, hospitals, and other providers understand whether the care they provide their patients is optimal and appropriate, and if not, where to focus their efforts to improve. Public and private payers also use measures for feedback and benchmarking purposes, public reporting, and incentive-based payment. Lastly, measures are an essential part of making the cost and quality of healthcare more transparent to all, particularly for those who receive care or help make care decisions for loved ones. The Institute of Medicine's six domains of quality—safe, effective, patient-centered, timely, efficient, and equitable—are one way to organize the information.[67] Studies have found patients find effectiveness, safety, and patient-centeredness to be most meaningful in their consideration of health care options.[68]

As more and more health care consumers shop for their health care, value becomes more important than price alone. Determining value means comparing the cost of care with information on the quality or benefit of the service. Presenting health care price information without accompanying quality information leads consumers to assume that high-priced care is high quality care.[69] In fact, there is no evidence of a correlation between cost and quality in health care.[70]

Showing cost and quality information together helps consumers clearly see variation among providers.[71] Further, it helps consumers understand that high costs do not necessarily mean high quality—high-quality care is available without paying the highest price.[72] One way to accomplish this would be to present comparative quality and cost information on one, consumer-friendly website, using several specific measures or scores so multiple metrics can be compared at the same time.[73]

All-Payer Claims Database (APCD)

An APCD is a computer database, usually created by state mandate, which includes data derived from medical, pharmacy, and dental claims, with eligibility and provider files from private and public payers such as commercial insurance carriers, Medicaid, and Medicare.[74] There are both mandatory and voluntary APCDs, however the majority of APCDs established in the last 10 years are mandatory

[63] For more information, visit www.atsdr.cdc.gov/.
[64] For more information, visit https://wwwn.cdc.gov/ALS/Default.aspx.
[65] For more information, visit https://www.dor.kaiser.org/external/DORExternal/aidr/index.aspx.
[66] Supra, FN 62, pg. 11.
[67] Institute of Medicine, *Report: Crossing the Quality Chasm: A New Health System for the 21st Century*, March 1, 2001, available at http://ion.nationalacademies.org/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf (last viewed March 14, 2016).
[68] Hibbard, JH, Greene, J, Daniel D., *What is Quality Anyway? Performance Reports That Clearly Communicate to Consumers the Meaning of Quality Care*, Med. Care Res. Rev., 67(3): 275-293 (2010).
[69] Supra, FN 23, pg. 5.
[70] Carman, KL, Maurer M., et al., *Evidence That Consumers Are Skeptical About Evidence-Based Health Care*, Health Affairs, 29(7): 1400-1406 (2010).
[71] American Institute of Research, The Robert Wood Johnson Foundation, *How to Report Cost Data to Promote High-Quality, Affordable Choices: Findings from Consumer Testing*, February 2014, available at http://www.rwjf.org/content/dam/farm/reports/issue_brief/2014/rwjf410706 (last viewed March 14, 2016).
[72] Id.
[73] Id.
[74] APCD Council*, All Payer Claims Databases: An Overview*, presentation before the Select Committee on Affordable Healthcare Access, January 11, 2016, slide 3 (on file with Health and Human Services Committee staff).

reporting initiatives.[75] Information contained in claims data reported to an APCD includes:

- Encrypted social security numbers;
- Patient demographics, such as date of birth, gender, residence, and relationship to subscriber or insured;
- Type of product, such as HMO, POS, or indemnity;
- Diagnosis codes;
- Procedure codes;
- NDC codes;
- Revenue codes;
- Service dates;
- Service provider, including name, tax identification number, payer identification number, specialty code, city, state, and zip code;
- Prescribing physician;
- Plan charges & payments;
- Member cost-sharing responsibilities, such as co-payments, coinsurance, and deductible; and
- Facility type.[76]

Information that is normally not included in claims data reported to an APCD includes:

- Services provided to uninsured
- Denied claims;
- Workers' compensation claims;
- Test results from lab work, imaging, etc.;
- Premium information;
- Capitation fees; and
- Administrative fees.[77]

Twenty states have implemented an APCD, designed to do various things. Most states developed and operate the APCD.[78] Other states were involved in the initial planning stages of the APCD, but delegated day-to-day operations of the database to private not-for-profit entity.[79] Two states, California and Washington, have private, voluntary reporting initiatives. Some of the purposes for which APCDs are being used include:[80]

- Understanding overall and categorical costs for care;[81]
- Creating tools for consumers to determine health care costs and quality;[82]
- Determining the variation in health care costs across states;[83]
- Establishing benchmarks for health care purchasers;[84] and
- Evaluating the medical home model.[85]

The cost of developing, operating and maintaining an APCD varies greatly across states. For example, Colorado has spent $6.7 million since 2010 on its APCD, and estimates $2.7 million in annual operations costs. Kansas projects an operations cost of $1.2 million to $1.4 million over a 5-year period. Other states have incurred lower costs for operating an APCD. Tennessee has annual APCD

[75] Robert Wood Johnson Foundation, APCD Council, *The Basics of All-Payer Claims Databases, A Primer for States*, January 2014, page 2, available at https://www.apcdcouncil.org/file/31/download?token=b7qtlhRQ (last viewed March 14, 2016).
[76] Jo Porter, APCD Council, *State Innovations in the Use of APCD Data*, presentation at the National Association of State Health Plans Conference, October 19-21, 2015, slide 5 (on file with Health and Human Services Committee staff).
[77] Id., slide 6.
[78] Id., slide 10; Kansas, Maine, Massachusetts, Maryland, Minnesota, New Hampshire, Oregon, Tennessee, Utah, Vermont, W. Virginia, Rhode Island, Connecticut, New York, and Washington.
[79] Id.; Colorado, Virginia, Arkansas, and Washington (still in implementation).
[80] Id., slide 16.
[81] Colorado, New Hampshire, Maine, Vermont, Utah, Massachusetts, and Maryland.
[82] Massachusetts, New Hampshire, and Maine.
[83] Colorado, Maine, New Hampshire, and Vermont.
[84] New Hampshire.
[85] Vermont and New Hampshire.

operating costs of $500,000. Utah uses $615,000 in General Revenue funds and $185,000 in federal matching funds each year to fund its APCD. West Virginia has operated its APCD, since 2010, on a total of $200,000. Reported state APCD funding, for a state with 1.3 million to 1.5 million covered lives, ranges from $350,000 to establish a basic data system to $1 million to $2 million for a more robust data system.[86] Start-up costs may range from $600,000 to $2 million, depending on the complexity of the APCD platform.[87]

States have also seen wide variation in the amount of time it takes to establish an operating APCD. Some states, like California, Colorado, New Hampshire, and Oregon, took less than one year to two years to have a functional database. Other states, like Kansas and Rhode Island, required four years to have an operational APCD. Still other states, like Connecticut and New York, passed authorizing legislation in 2011 and 2012, respectively, but are still in the implementation process.

States fund APCDs in a variety of ways.[88] Public APCDs are funded, at least in part, through general appropriations or fee assessments. States have also received grant funding to support the initial phases of APCD development. Some states have been able to use the federal grants to develop their APCD. More recently, states have been successful in securing federal rate review grants, and use part of that funding for APCD development, operation, and maintenance.[89] New Hampshire's APCD is used by its Medicaid program and leverages funding from Medicaid to support it.[90] Many states expect to use data product sales to fund, at least in part, the operation of APCDs into the future. Due to the APCD costs experienced by states, it appears that data sales revenue will not be sufficient to wholly fund operation and maintenance of APCDs over the long term, and other core revenue streams will be necessary to fully fund these databases.[91]

Health Insurer Regulation

The Florida Office of Insurance Regulation (OIR) regulates the business of insurance in the state, in accordance with the Florida Insurance Code (Code). The Life and Health Unit (Unit) of OIR provides financial oversight of health insurers, health maintenance organizations, and other regulated entities providing health care coverage pursuant to various chapters of the Code:

Chapter 624, F.S. – Insurance Code: Administration and General Provisions
Chapter 626, F.S. – Insurance Field Representatives and Operations
Chapter 627, F.S. – Insurance Rates and Contracts
Chapter 631, F.S. – Insurer Insolvency; Guaranty of Payment
Chapter 632, F.S. – Fraternal Benefit Societies
Chapter 636, F.S. – Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations
Chapter 641, F.S. – Health Care Service Programs
Chapter 651, F.S. – Continuing Care Contracts

OIR insurance regulatory activities include licensing, rate and form approval, market conduct review, issuing certificates of authority, ensuring solvency, and administrative supervision. The following chart shows the type and number of each entity in the state:[92]

[86] Multiple telephone conferences between APCD Council staff and Select Committee staff, Fall 2015.
[87] Id.
[88] Supra, FN 75, pg. 5.
[89] Id.
[90] Id.
[91] Id.
[92] Email correspondence from OIR staff dated November 12, 2015 (on file with Health and Human Services Committee staff).

Authority Category	Authorities
Health Insurers	442
Third Party Administrators	299
Continuing Care Retirement Communities	63
Discount Medical Plan Organizations	42
Health Maintenance Organizations	35
Fraternal Benefit Societies	36
Prepaid Limited Health Service Organizations/Prepaid Health Clinics	27

Florida Center for Health Information and Policy Analysis

Organization and Function

The Florida Center for Health Information and Policy Analysis (the Florida Center) provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.[93] The Florida Center is housed within AHCA[94] and is funded through appropriations in the General Appropriations Act, through grants, gifts, and other payments, and through fees charged for services.[95] Offices within the Florida Center, which serve different functions,[96] are:

- Data Collection and Quality Assurance, which collects patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units), comprehensive rehabilitation hospitals, ambulatory surgical centers and emergency departments.[97]
- Risk Management and Patient Safety, which conducts in-depth analyses of reported incidents to determine what happened and how the facility responded to the incident.[98]
- Data Dissemination and Communication, which maintains AHCA's health information website,[99] provides technical assistance to data users, and creates consumer brochures and other publications.[100]
- Health Information Exchange and Policy Analysis, which monitors innovations in health information technology, informatics, and the exchange of health information and provides a clearinghouse of technical resources on health information exchange, electronic prescribing, privacy and security, and other relevant issues.[101]

The Florida Center identifies existing health-related data and collects data for use in the information system. The information collected by the Florida Center must include:

- The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality;

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[93] S. 408.05(1), F.S.
[94] S. 408.05(1), F.S.
[95] S. 408.05(7), F.S.
[96] Agency for Health Care Administration, *Florida Center for Health Information and Policy Analysis*, available at: http://ahca.myflorida.com/SCHS/index.shtml (last viewed March 14, 2016).
[97] Agency for Health Care Administration, *Office of Data Collection & Quality Assurance*, available at: http://ahca.myflorida.com/schs/DataCollection/DataCollection.shtml (last viewed March 14, 2016).
[98] Agency for Health Care Administration, *Office of Risk Management and Patient Safety*, available at: http://ahca.myflorida.com/schs/RiskMgtPubSafety/RiskManagement.shtml (last viewed March 14, 2016).
[99] www.FloridaHealthFinder.gov
[100] Agency for Health Care Administration, *Office of Data Dissemination and Communication*, available at: http://ahca.myflorida.com/schs/DataD/DataD.shtml (last viewed March 14, 2016).
[101] Agency for Health Care Administration, *Office of Health Information Exchange and Policy Analysis*, available at: http://ahca.myflorida.com/schs/HIE/HIE.shtml (last viewed March 14, 2016).

- The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state;
- Environmental, social, and other health hazards;
- Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status;
- Health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute, long-term care and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities;
- Utilization of health care by type of provider;
- Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care;
- Family formation, growth, and dissolution;
- The extent of public and private health insurance coverage in this state; and
- The quality of care provided by various health care providers.[102]

The Florida Center electronically collects patient data from every Florida licensed inpatient hospital, ambulatory surgery center (ASC), emergency department, and comprehensive rehabilitation hospital on a quarterly basis. The data is validated for accuracy and maintained in three major databases: the hospital inpatient database, the ambulatory surgery database, and the emergency department database.[103]

- **The hospital inpatient database** contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data.[104] This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.[105]
- **The ambulatory surgery database** contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories.[106] Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.[107]
- **The emergency department database** collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.[108]

In addition to these databases, the Office of Risk Management and Patient Safety collects adverse incident reports from health care providers including, hospitals, ambulatory surgical centers, nursing homes, and assisted living facilities.[109]

[102] S. 408.05(2), F.S.
[103] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, *2014 Annual Report*, p. 2, available at: https://floridahealthfinderstore.blob.core.windows.net/documents/researchers/documents/FC%20Annual%20Report%202014%20Final%20w%20cover%20-%202_16_15.pdf.
[104] Id., pg. 3.
[105] Id., pg. 4.
[106] Id., pgs. 3-4.
[107] Id., pg. 4.
[108] Id., pgs. 4-5.
[109] Id.

Reporting

The Florida Center is required to publish and make available the following reports:

- Member satisfaction surveys;
- Publications providing health statistics on topical health policy issues;
- Publications that provide health status profiles of people in Florida;
- Various topical health statistics publications;
- Results of special health surveys, health care research, and health care evaluations required under s. 408.05, F.S.; and
- An annual report on the Florida Center's activities.[110]

The Florida Center must also provide indexing, abstracting, translation, publication and other services leading to a more effective and timely dissemination of health care statistics. The Florida Center is responsible for conducting a variety of special studies and surveys to expand the health care information and statistics available for policy analyses.[111]

Public Access to Data

The Office of Data Dissemination and Communication, within the Florida Center, makes data collected available to the public in three ways: by updating and maintaining the AHCA's health information website at www.FloridaHealthFinder.gov, by issuing standard and ad hoc reports, and by responding to requests for de-identified data.[112]

The Florida Center maintains www.FloridaHealthFinder.gov, which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public which allow easy access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida. The website also provides tools to researchers and professionals which allow specialized data queries, but requires users to have some knowledge of medical coding and terminology.[113] Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.[114]

The Center disseminates three standard reports which detail hospital fiscal data including a prior year report, an audited financial statement, and a hospital financial data report. Also, ad hoc reports may be requested for customers looking for very specific information not included on a standard report or for customers who do not wish to purchase an entire data set to obtain information. One example of an ad hoc report would be a request for the average length of stay of patients admitted to a hospital with diabetes as a principle or secondary diagnosis.[115] The Center charges a set fee for standard reports[116] and a variable fee based on the extensiveness of an ad hoc report.[117]

The Center also sells hospital inpatient, ambulatory surgery, and emergency department data to the general public in a non-confidential format. However, the requester must sign a limited set data use agreement which binds the requester to only using the data in a way specified in the agreement.

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[110] S. 408.05(5), F.S.
[111] Id.
[112] Supra, FN 103, pgs. 6-9.
[113] Id., pg. 9.
[114] Id., pgs. 9-13.
[115] Id., pgs.8-9.
[116] The price list for purchasing data from the Center is available at http://floridahealthfinderstore.blob.core.windows.net/documents/researchers/OrderData/documents/PRICE%20LIST%20Dec2014.pdf (last viewed March 14, 2016).
[117] Supra, FN 107, pg. 7.

Information not available in these limited data sets include: patient ID number, medical record number, social security number, dates of admission and discharge, visit beginning and end dates, age in days, payer, date of birth, and procedure dates.[118]

The Florida Center is required to provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and complied by the Florida Center.[119]

Florida Center Administration

AHCA is required to complete a number of responsibilities related to the information system, in order to produce comparable and uniform health information and statistics for the development of policy recommendations.[120] These responsibilities are listed in statute and include the following:

- Undertake research, development, and evaluation regarding the information system for the purpose of creating comparable health information.
- Coordinate the activities of state agencies involved in the design and implementation of the information system and review the statistical activities of state agencies to ensure that they are consistent with the information system.
- Develop written agreements with local, state, and federal agencies to share health-care-related data.
- Establish by rule the types of data collected, compiled, processed, used, or shared.
- Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data.
- Establish advisory standards to ensure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations.
- Prescribe standards for the publication of health-care-related data, which ensure the reporting of accurate, valid, reliable, complete, and comparable data.
- Prescribe standards for the maintenance and preservation of the Florida Center's data.
- Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests.
- Develop and implement a long-range plan for making available health care quality measures and financial data that will allow consumers to compare health care services.
- Administer, manage, and monitor grants to not-for-profit organizations, regional health information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or training projects to advance the development of a health information network.
- Initiate, oversee, manage, and evaluate the integration of healthcare data from each state agency that collects, stores, and reports on health care issues and make the data available to any health care practitioner through a state health information network.[121]

<u>Federal and State Antitrust Laws</u>

Federal Laws

Congress passed the first antitrust law, the Sherman Act, in 1890 as a "comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade." The Sherman Act outlaws every contract, combination, or conspiracy in restraint of trade[122], and any

[118] Id., pgs. 7-8.
[119] S. 408.05(4), F.S.
[120] S. 408.05(3), F.S.
[121] S. 408.05(3), F.S., s. 408.05(4), F.S.
[122] 15 U.S.C. §1.

monopolization, attempted monopolization, or conspiracy or combination to monopolize.[123] Certain acts, called "per se" violations, are considered so harmful to competition that they are almost always illegal. Such acts include arrangements among competing individuals or businesses to fix prices, divide markets, or rig bids. Penalties for violating the Sherman Act are severe, resulting in multi-million dollar fines and imprisonment for offending entities and individuals.[124]

The Clayton Act[125], passed in 1914, addresses specific practices that are not specifically prohibited under the Sherman Act, such as mergers and interlocking directorates, which involve the same person making decisions for competing companies. The Clayton Act prohibits mergers and acquisitions where the effect "may be substantially to lessen competition, or to tend to create a monopoly."[126] As amended by the Robinson-Patman Act of 1936, the Clayton Act also bans certain discriminatory prices, services, and allowances in dealings between merchants.[127]

The Clayton Act was amended again in 1976 by the Hart-Scott-Rodino Antitrust Improvements Act to require companies planning large mergers or acquisitions to notify the government of their plans in advance.[128] The Clayton Act also authorizes private parties to sue for triple damages when they have been harmed by conduct that violates either the Sherman or Clayton Act[129] and to obtain a court order prohibiting the anticompetitive practice in the future.[130]

The Federal Trade Commission Act[131], passed in 1914, bolstered the Sherman Act and Clayton Act by providing that the Federal Trade Commission (FTC) could proactively and directly protect consumers rather than only offer indirect protection by protecting business competitors.[132] The FTC was given the authority to fill any remaining gaps in antitrust law and to stop new business practices not yet invented, but contrary to public policy. The FTC was also given broad powers to address new threats to the competitive free market.[133]

Florida Law

Florida's original antitrust law was passed in 1915, and was reenacted in 1980 as the Florida Antitrust Act (FARA).[134] The FAA closely tracks the Sherman Act prohibitions and applies them to trade or commerce in the state.[135] Courts have held that the FAA effectively adopts as the law of Florida the body of antitrust law developed by the federal courts under the Sherman Act.[136] The FAA provides causes of action for treble damages and costs, including reasonable attorneys' fees, to injured persons as well as the Florida attorney general and authorized state attorneys acting as parens patriae on behalf of natural persons residing within the state.[137] Additionally, any person may sue for equitable relief against threatened loss or damage by a violation.[138] The FAA also gives the Attorney General subpoena power to conduct investigations into anticompetitive and collusive conduct.[139]

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[123] 15 U.S.C. §2.
[124] Supra, FN 122 and 123.
[125] 15 U.S.C. §§12-27; 29 U.S.C. §§52-53.
[126] 15 U.S.C. §13(a).
[127] 15 U.S.C. §13a.
[128] 15 U.S.C. §18a.
[129] 15 U.S.C. §15(a) and §15a.
[130] 15 U.S.C. §25.
[131] 15 U.S.C. §§41-58.
[132] Federal Trade Commission, *The Antitrust Laws*, available at: https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws.
[133] 15 U.S.C. §46.
[134] SS. 542.15 through 542.36, F.S.
[135] SS. 542.18 and 542.19, F.S.
[136] *St. Petersburg Yacht Charters v. Charles Morgan Yacht*, 457 So. 2d 1028, 1031 (Fla. 2d D.C.A. 1984), *accord Morris Communications v. PGA Tour*, 117 Fed. Supp. 2d 1322, 1326 n.3 (M.D. Fla. 2000); *Greenberg v. Mt. Sinai Medical Center*, 629 So. 2d 252, 256 (Fla. 3d D.C.A. 1993).
[137] S. 542.22, F.S.
[138] S. 542.23, F.S.
[139] S. 542.27, F.S.

State-Action Doctrine Exemption from Antitrust Law

In Parker v. Brown,[140] the U.S. Supreme Court created the state-action doctrine exemption from antitrust law. Under the state-action doctrine, state and municipal authorities are immune from federal antitrust lawsuits for actions taken pursuant to a clearly expressed state policy that, when legislated, had foreseeable anticompetitive effects. The Court held there was no Sherman Act violation as the antitrust laws were not intended to restrict the sovereign capacity of states to regulate their economies.

When a state approves and regulates market conduct, even if it is anticompetitive under FTC or U.S. Department of Justice standards, the federal government must respect the decision of the state. If a state sanctions anticompetitive conduct, the state is immune from investigation and possible prosecution by the FTC.

This doctrine can also provide immunity to private, non-state actors if a two-pronged requirement is met:

- The state or municipality must clearly articulate a policy to displace competition; and
- The state or municipality actively supervises the policy or activity.[141]

Effect of Proposed Changes

CS/CS/HB 1175 establishes a Florida-specific APCD, using an existing national database, including an online price calculator for Florida consumers. It also requires hospitals, ASCs, insurers and HMOs to make prices transparent to patients, and make quality data available to them.

<u>All-Payer Claims Database</u>

AHCA is directed to competitively procure a vendor to provide a user-friendly, Internet-based platform which allows a consumer to research and compare the cost of health care services and procedures. The vendor must also establish and maintain a Florida-specific dataset of health care claims information available to the public and any interested party. Access to state-specific data is designed to encourage research and innovation in the delivery and payment of health care in Florida. The bill delineates criteria that the vendor must meet in order to contract with AHCA for the purposes outlined in the bill. By October 1, 2016, the vendor must:

- Be qualified to receive Medicare claims data;
- Receive claims, payment and patient cost-share data from multiple private insurers nationwide;
- Have a national database consisting of at least 15 billion claim lines of data from multiple payers, including employers with ERISA plans, and be capable of expanding by adding claims data from third party vendors;
- Have a well-developed methodology for analyzing claims data within health care service bundles that is understandable by the general public; and
- Have a bundling methodology available to the public to allow for consistency and comparison of state and national benchmarks with local regions and specific providers.

The patient must be able to search the price information based on specific services or procedures, and using service bundles that compose a whole episode of hospital care. The service bundles must be understandable to an ordinary layperson. Patients must be able to search the information without a password or registration requirement.

To ensure the collection of health claims data, the bill requires each insurer and HMO participating in the State Group Insurance plan or Statewide Medicaid Managed Care and their affiliates to contribute

[140] 317 U.S. 341 (1943).
[141] *California Retail Liquor Dealers Ass'n v. Midcal Aluminum Inc.*, 445 U.S. 97 (1980).

all Florida claims data to the vendor selected by AHCA. The bill specifies claims data that shall not be contributed to the contract vendor, which includes claims reflecting coverage for limited benefits or non-major medical benefits, including:

- Coverage only for accident, or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641;
- Limited scope dental or vision benefits;
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
- Coverage only for a specified disease or illness;
- Hospital indemnity or other fixed indemnity insurance; and
- Medicare supplemental insurance and similar supplemental coverage provided to supplement coverage under a group health plan.

The bill requires insurers and HMOs to designate any information considered a "trade secret" which they submit to the contracted vendor. Documents designated as such are confidential and exempt from public records provisions in chapter 119, F.S., pursuant to s. 815.045, F.S.

Further, the bill requires Medicaid managed care plans to comply with information disclosure and cost calculation requirements in s. 627.6385, F.S., or s. 641.54, F.S., as applicable. The bill requires the Department of Management Services to make arrangements to contribute State Group Insurance plan claims data to the vendor selected by AHCA and requires each contracted vendor for the State Group plan to do the same.

Lastly, the bill includes necessary language to make the activities required by the bill exempt from state and federal antitrust laws under the state-action doctrine.

<u>Hospital and ASC Transparency Requirements</u>

Pre-Treatment Transparency

The bill requires hospitals, ASCs, health care practitioners providing non-emergency hospital services, insurers and HMOs to provide patients with information on price and quality prior to treatment.

Hospitals and ASCs

The bill requires every licensed hospital and ASC (facilities) to provide timely and accurate financial information and quality of service measures to prospective and actual patients, or to patients' survivors or legal guardians. State mental health facilities and mobile surgical facilities are exempt from these requirements.

First, each facility must make information on the payments it receives for services available on its websites. The information must be searchable, and use the same format as that used by the APCD, including the descriptive bundles of services and procedures created by the vendor. The facility may meet this requirement by including a hyperlink on its' website to the service bundles created by the vendor. 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. 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. The facility must also publish

on its website information on the facility's financial assistance policy, including any application process, payment plans, discounts, and the facility's collections procedures.

Second, each facility must identify on its website all insurers and HMOs for which the facility is in-network, or is a preferred provider, and post a link to each of them. The facility must notify patients, on its website, that services in the hospital may be provided by health care providers who may separately bill the patient.

Third, each facility must provide to patients and prospective patients, on request, a personalized, estimate of the reasonably anticipated charges by the facility. The estimate must be provided within 7 days of request. The estimate may be based on the service bundles created by the APCD vendor, or, if the patient requests, must be based on the specific condition and characteristics of the patient. The estimate must clearly identify any facility fees, explain their purpose, and notify the patient that another facility or setting may have lower cost. If the patient requests it, the facility must notify the patient of any revisions to the estimate. Actual charges can vary from the estimate.

In issuing the estimate, the facility is not required to take the patient's insurance coverage into account, but must inform the patient that the patient may contact his or her insurer to get information about cost-sharing obligations. The estimate must also include notice of the facility's financial assistance policy. The facility must inform patients that they may request this personalized estimate, both from the facility and from the health care providers who provide care in the facility but bill the patient separately.

For a facility that fails to provide the estimate timely, the bill requires AHCA to fine the facility $1,000 per day until the estimate is provided, up to $10,000.

Finally, the bill requires facilities to post on their websites a web link to the quality data available on the AHCA website FloridaHealthFinder.gov, and to notify the public that the data is available.

Health Care Practitioners

The bill requires health care practitioners to provide a good faith estimate of reasonably anticipated charges for nonemergency treatment of the patient's condition provided in a hospital or ASC within 7 days of a patient's request for the estimate. In issuing the estimate, the practitioner is not required to take the patient's insurance coverage into account, but must advise the patient that he or she may contact his or her insurer or HMO for more information on cost-sharing obligations related to the treatment. Actual charges can vary from the estimate.

These health care practitioners must also to provide to uninsured patients, and insured patients for whom the practitioner is out-of-network, information on the practitioner's financial assistance policy, including the application process, payment plans discounts and collection procedures. Failure to provide the estimate within 3 business days shall result in disciplinary action against the HCP under his or her practice act and a daily fine of $500, capped at $5,000.

Diagnostic-Imaging Centers

The bill requires all diagnostic-imaging centers owned by a hospital but not located on the premises of the hospital to publish and post a schedule of charges for services pursuant to s. 395.107, F.S. Currently, urgent care centers are required by the statute to publish and post charges for services. To comply with the statute, diagnostic-imaging centers must:

- Describe the imaging services in language comprehensible to a layperson;
- Include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card;
- Post the schedule of charges in a conspicuous place in the reception area, which must include, but is not limited to, the 50 services most frequently provided;

- Include text that notifies insured patients whether the charges for imaging services received at the center will be the same as, or more than, charges for imaging services received at the hospital which owns the center, and include such text in all media and Internet advertisements for the center.
- List the schedule of charges in a font size equal to or greater than the font size used for prices and be in a contrasting color.

A diagnostic-imaging center subject to the provisions of s. 395.107, F.S., will incur a daily fine of up to $1,000 for failing to publish and post a schedule of charges.

Insurers and HMOs

The bill requires each health insurer and HMO to make available on its website a method that consumers can use to estimate copayments, deductibles, and other cost-sharing requirements for health care services and procedures. The method to determine the consumer's cost-sharing obligations must be based on the service bundles established by the APCD vendor. The insured must be able to create an estimate using the service bundles, a specific provider, or a comparison of providers, or any combination thereof. Estimates must be calculated using the insured's policy and known plan usage during coverage period, and based on in-network or out-of-network providers.

Insurers and HMOs must also establish, on their websites, a method for patients to obtain a personalized estimate of their cost-sharing obligations, using the personalized estimates received from a facility or in-facility health care practitioner.

Insurers and HMOs must include, in every policy issued and in prospective enrollee materials, a notice that these estimates are available.

The bill requires insurers and HMOs to post on their websites a web link to the quality data available on the AHCA website FloridaHealthFinder.gov.

Post-Treatment Transparency

Hospitals and ASCs

The bill amends current billing requirements in s. 395.301, F.S., to require hospitals and ASCs to meet additional standards for clear and comprehensible billing.

Following the patient's discharge or request, whichever is later, the bill requires the facility to provide an itemized bill or statement to the patient within 7 days. The bill or statement must be in plain language. Services received and expenses incurred must be listed by date and by provider, enumerating items at a level of detail proscribed by AHCA. The bill or statement must clearly identify any facility fee and explain its purpose. The itemized bill or statement must identify each item as "paid", "pending third-party payment", or "pending payment by the patient," and include the amount due. If an amount is due from the patient, the itemized bill or statement has to also provide the due date. Finally, the bill or statement must inform the patient or the patient's survivor or legal guardian to contact his or her insurer or HMO regarding the patient's cost-sharing obligation for the medical services and procedures. Any subsequent bills or statements must meet these requirements, and clearly identify any revisions.

Each bill or statement issued by a facility must notify the patient of any health care practitioners who will bill the patient separately.

The bill requires facilities to make available electronically, upon request of the patient, all records necessary for verifying the accuracy of the itemized bill or statement within 10 business days of the request. A facility must respond to patient questions about the itemized bill within 7 business days of

receiving the question. Lastly, the facility must provide AHCA's contact information if the patient is not satisfied with the answers to his or her questions about the bill or statement.

Florida Center for Health Information and Transparency

The bill renames the Florida Center for Health Information and Policy Analysis as the Florida Center for Health Information and Transparency (Florida Center). The bill streamlines the Florida Center's functions, eliminating unnecessary language, obsolete provisions and duties that are redundant to the activities of other agencies. The bill specifically prohibits AHCA from establishing an all payers claim database without express authority to do so from the Legislature.

Under the bill, the Florida Center must identify available datasets, compile new data when specifically authorized, and promote the use of extant health-related data and statistics. The Florida Center must maintain the datasets existing before July 1, 2016, unless those datasets duplicate information that is readily available from other credible sources. The Florida Center may collect or compile data on:

- Licensed health professionals, including physician surveys conducted under ss. 458.3191 and 459.0081, F.S.;
- Health service inventories;
- Service utilization data for licensed heath care facilities; and
- Specific health care quality initiatives when other extant data is not adequate to achieve the objectives of the initiative.

The bill revises data submission requirements that apply to facilities and health care practitioners. Specifically, the bill directs AHCA to require the submission of data to facilitate transparency in health care pricing data and quality measures. Also, data to be submitted by insurers may include payments to health care facilities and HCPs, as specified by rule. The bill further directs AHCA to consult with vendors, the State Consumer Health Information and Policy Advisory Council, and public and private users to determine the data to be collected and the use of the data. AHCA must monitor data collection procedures and test data quality to ensure the data is accurate, valid, reliable, and complete.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   AHCA may realize an increase in revenue by imposing fines on facilities for failing to timely provide an estimate to a patient or prospective patient. Similarly, the Department of Health may realize an increase in revenue by imposing fines on health care practitioners providing non-emergency services in a facility who do not timely provide the estimate to patients or prospective patients. The amount of fines that may be collected under the bill is indeterminate.

2. Expenditures:

   The bill directs AHCA to contract with a vendor that has already developed an APCD and currently operates the database with the functionality required by the bill. The cost for the database and associated data collection and storage activities is estimated to require $600,000 in recurring funds and $3,100,000 in nonrecurring funds from the Health Care Trust Fund.

   The following deliverables are included in the cost estimates:

   - Claims Data Collection from Limited Payers:

    - Includes the costs to "on-board" a limited number of payers in Year 1, which allows the payers to submit and the vendor to receive data.
    - It is anticipated that customization may be needed for certain payers' on-boarding, with a less expensive standardized template used for other payers.
    - The estimate also includes data validation and quality assurance activities.
- Data Collection-Annual Refresh:
    - The contracted vendor will run an annual data refresh to incorporate the latest price information gathered from the medical claims data submitted by payers.
    - Includes data validation and quality assurance activities to ensure accurate and valid data is submitted.
- Modifying Service Bundles-Provider Level Price Data:
    - Includes the modification of existing service bundles to incorporate the robust medical claims data provided by Florida payers that allows a consumer to search for prices at the provider level.
- Website Development-Functionality Enhancements for Florida:
    - Includes programming to allow a consumer to search for Florida-specific information.
    - Includes development work to implement enhancements to the website to accomplish the required functionality in the bill.
    - Includes third party testing of the site and program management.
- Data Storage:
    - Storage of the Florida-specific data for research purposes, as required in the bill.
- Research Request and Cost Recovery Planning:
    - One-time cost for setting the criteria, terms, and cost recoupment fees for access to the Florida-specific data set by researchers.

	YEAR 1		**YEAR 2**	
Deliverable	**Recurring**	**Non-Recurring**	**Recurring**	**Non-Recurring**
Claims Data Collected from Limited Payers	-	$1,250,000	-	-
Data Collection – Annual Refresh	$450,000	-	$450,000	-
Modifying Service Bundles-Provider Level Price Data	-	$800,000	-	-
Website Development-Functionality Enhancements for Florida	-	$1,000,000	-	-
Data Storage	$150,000	-	$150,000	-
Research Request and Cost Recovery Planning	-	$50,000	-	-
Total	**$600,000**	**$3,100,000**	**$600,000**	**-**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals and ASCs may incur costs associated with posting the required information on their websites, providing pre-treatment written, good faith estimates to patients and including more detailed information on itemized bills or statements provided to patients within 7 days of discharge from the facility.

Insurers and health maintenance organizations may incur costs associated with compiling and sending data to the vendor selected by AHCA to maintain the Florida-specific dataset accessible by the public and any interested party.

Consumers will have estimates of charges for health care, prior to receiving such care, and can plan financially for those costs. Also, the estimates will be clear and transparent, allowing a consumer to question charges and empowering him or her to negotiate prices.

Consumers will have access to a database that provides the average cost of health care service bundles for procedures or treatments. Such a tool will also empower a consumer to plan for health care and negotiate prices for medical services and treatment.

D. FISCAL COMMENTS:

None.