HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1527 Health Care Expenses
SPONSOR(S): Finance & Facilities Subcommittee, Tomkow
TIED BILLS: **IDEN./SIM. BILLS:** SB 296

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Facilities Subcommittee	15 Y, 0 N, As CS	Poche	Lloyd

SUMMARY ANALYSIS

The United States is experiencing significant changes in health care payment and delivery. Consumers bear a greater share of health care costs, and more participate in high deductible health plans. Clear, accurate information about the cost and quality of health care is necessary for consumers to select value-based health care.

CS for HB 1527 requires hospitals and ambulatory surgical centers (ASCs) to post a consumer-friendly list of standard charges for at least 300 shoppable health care services on a facility website, consistent with federal rule.

The bill prohibits hospitals and ASCs from taking actions to collect medical debt before determining whether a patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, and for 30 days after notifying a patient in writing that a collections action will commence. The bill also requires hospitals and ASCs to establish an internal grievance process for patients to dispute charges that appear on an itemized statement or bill.

Current law provides a court process for the collection of lawful debts, and makes some limited exemptions for personal property. The bill increases exemptions from attachment, garnishment, or other legal process to include a single motor vehicle and personal property of a debtor of a value up to $10,000 when debt is incurred as a result of medical services provided in a licensed hospital facility, unless the property receives the higher protection of a homestead exemption.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Health Care Price Transparency

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

Price transparency can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[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 of the price or cost of health care has different meanings depending on who is incurring the cost.[4]

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the Kaiser Family Foundation, more than one in five Americans with private insurance is enrolled in a high deductible health plan. Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. Eighty-five percent of covered workers have a general annual deductible[5] for single coverage that must be met before most services are paid for by their health plan.[6]

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,644.[7] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $2,295 in small firms, compared to $1,418 for workers in large firms.[8] Sixty-four percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 54 percent in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (42 percent for small firms vs. 20 percent for large firms). 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 2009 through 2020.[9]

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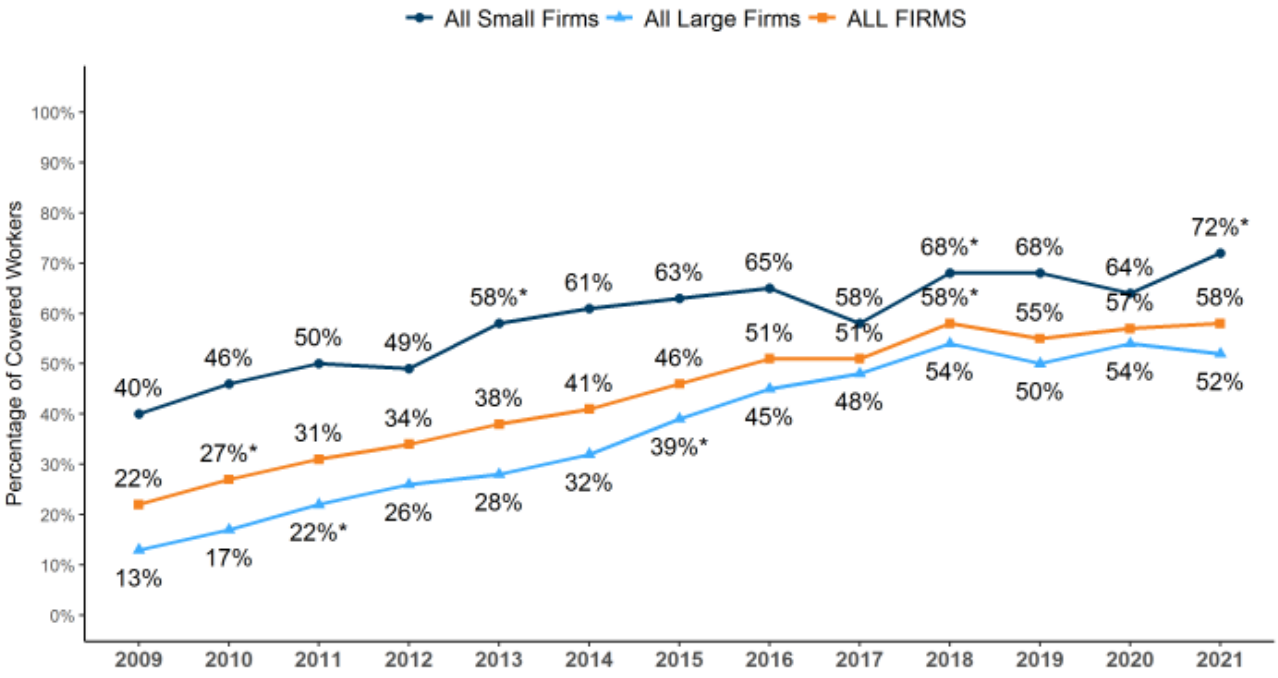
[1] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, pg. 2, available at http://www.gao.gov/products/GAO-11-791.
[2] Id.
[3] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, pg. 2, 2014, available at https://www.hfma.org/content/dam/hfma/document/policies_and_practices/PDF/22279.pdf.
[4] Id.
[5] The term "general annual deductible" means a deductible which applies to both medical and pharmaceutical benefits and which must be met by the insured individual before most services are covered by the health plan.
[6] The Henry J. Kaiser Family Foundation, *2021 Employer Health Benefits Survey*, November 10, 2021, available at https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/.
[7] Id.
[8] Id.
[9] Id., at figure 7.13.

Figure 7.13
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2009-2021



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

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 59% in 2008 to 74% in 2011 to 85% in 2021. 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 2021 is $1,669, up 89% from $883 in 2013 and 279% from $433 in 2008.

From 2015 to 2021, the average premium for covered workers with family coverage increased 22%, while inflation totals just 11% over the same period; over the last ten years, the average premium rose 47%, while inflation grew at 19% over the same time frame.[10] The dramatic increases in the costs of health care in recent years have focused significant attention on the need for greater communication and transparency to inform individual health care choices.

National Price Transparency Studies

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

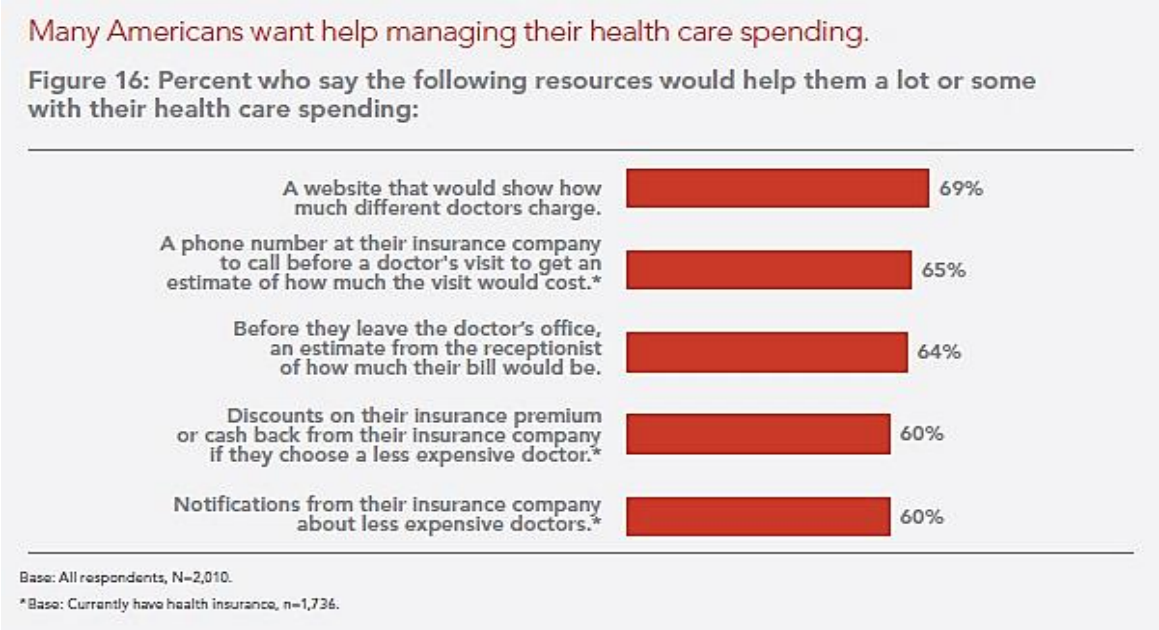
- Provide personalized out-of-pocket expense information to patients and families before receiving care.

[10] Id.

- Provide prices to physicians through electronic health record systems when ordering treatments and tests.
- Expand state-based all-payer health claims databases, which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[11]

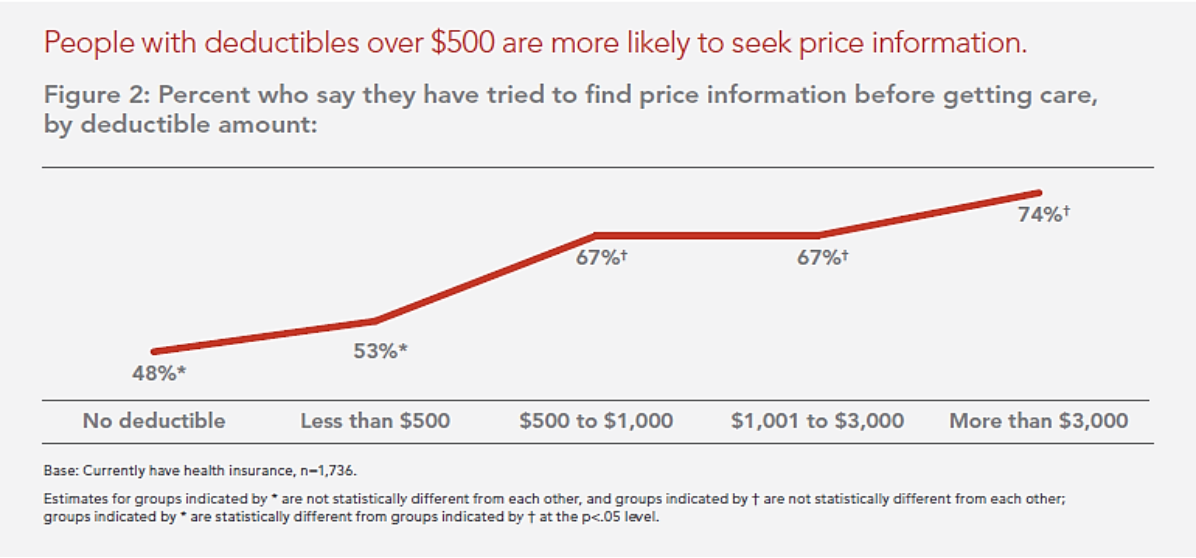
The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[12]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[13]



One study in 2014, which included a survey of more than 2,000 adults from across the country, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[14] 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.[15]

[11] 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.
[12] Id., pg. 1.
[13] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at https://www.publicagenda.org/reports/how-much-will-it-cost-how-americans-use-prices-in-health-care/.
[14] Id., pg. 3.
[15] Id., pg. 13.



The individuals who compared prices stated that such research affected their health care choices and saved them money.[16] In addition, the study found that most Americans do not equate price with quality of care. Seventy-one percent do not believe higher price reflects a higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[17] Consumers enrolled in high-deductible and consumer-directed health plans are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. Accordingly, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price transparency tool.[18] 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.[19]

Florida Price Transparency: Florida Patient's Bill of Rights and Responsibilities

In 1991, the Legislature enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[20] 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.[21] 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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[16] Id., pg. 4.
[17] Supra, FN14.
[18] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, pg. 4, available at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402126.
[19] 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.
[20] 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.
[21] S. 381.026(3), F.S.

A patient has the right to request certain financial information from health care providers and facilities.[22] 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.[23] Estimates must be written in language "comprehensible to an ordinary layperson."[24] 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.[25] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[26]

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 website of the Agency for Health Care Administration (AHCA).
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[27]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[28] to publish a schedule of charges for the medical services offered to patients.[29] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[30] 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.[31] 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.[32]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[33] 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

[22] S. 381.026(4)(c), F.S.
[23] S. 381.026(4)(c)3., F.S.
[24] Id.
[25] Id.
[26] S. 381.026(4)(c)5., F.S.
[27] S. 381.0261, F.S.
[28] 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.
[29] S. 381.026(4)(c)3., F.S.
[30] Id.
[31] Id.
[32] S. 381.026(4)(c)4., F.S.
[33] S. 395.107(1), F.S.

established for primary care providers.[34] 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).[35]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[36] must provide, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group[37] or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law also directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services actually provided.[38] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[39] Hospitals and other facilities post a link to this site - https://pricing.floridahealthfinder.gov/ - to comply with the price transparency requirements. The cost information is searchable, and based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[40]

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.[41]

Hospital Facility Transparency

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[34] S. 395.107(2), F.S.
[35] S. 395.107(6), F.S.
[36] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.
[37] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention and resource intensity. For more information, see https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf.
[38] S. 395.301, F.S.
[39] S. 408.05(3)(c), F.S.
[40] Id.
[41] S. 456.0575(2), F.S.

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations[42] changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, CMS also established new requirements for hospitals to publish standard charges for a wide range of health care services offered by such facilities. Specifically, the regulations require hospitals to make public both a machine-readable file of standard charges and a consumer-friendly presentation of prices for at least 300 shoppable health care services. The regulations became effective on January 1, 2021.[43]

The regulations define a shoppable service as one that can be scheduled in advance, effectively giving patients the opportunity to select the venue in which to receive the service. This is a more expansive designation of shoppable services than currently exists in Florida law. For each shoppable service, a hospital must disclose several pricing benchmarks to include:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This information should provide a patient with both a reasonable point estimate of the charge for a shoppable service, and also a range in which the actual charge can be expected to fall.

The penalty for facility noncompliance under the federal regulations is a maximum fine of $300 per day.[44] Very early indications suggest that there are varying levels of compliance with the new rules among hospital facilities.[45]

Medical Debt

Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. A 2007 study suggested that illness and medical bills contributed to 62.1% of all personal bankruptcies filed in the U.S. during that year.[46] A more recent analysis, which considered only the impact of hospital charges, found that 4% of U.S. bankruptcies among non-elderly adults resulted from hospitalizations.[47]

Even when medical costs do not result in personal bankruptcy, they often weigh heavily on the financial health of patients and their families. According to the Kaiser Family Foundation, about a quarter of U.S. adults ages 18-64 say they or someone in their household had problems paying or an inability to pay medical bills in the past 12 months.[48] About three in ten survey respondents reported medical debt of $5,000 or more, with 13 percent of respondents indicating medical debt in excess of $10,000. Even patients with lower amounts of medical debt reported that the outstanding bills led to financial distress, in light of other financial commitments and/or limited income.[49]

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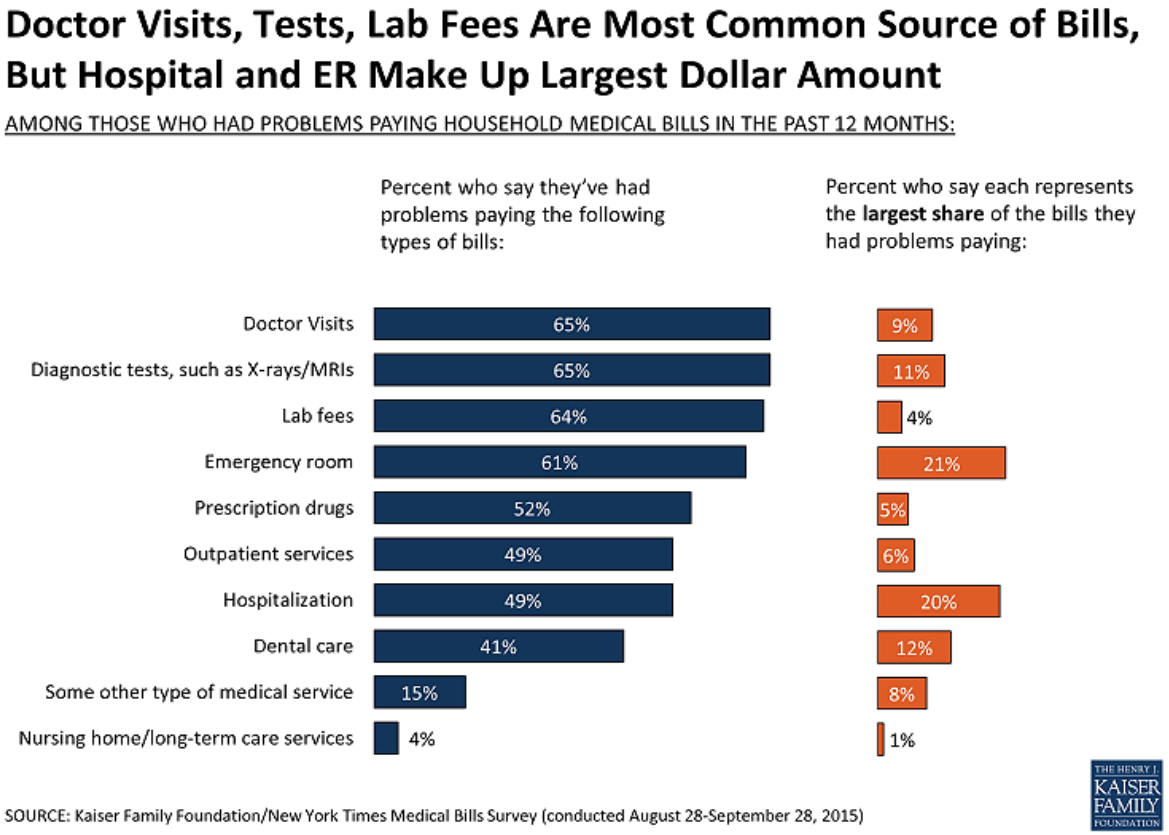
[42] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public, 84 FR 65524 (November 27, 2019)(codified at 45 CFR Part 180).
[43] Id.
[44] Supra note 47.
[45] ADVI, "Implementation of Newly Enacted Hospital Price Transparency," available at https://advi.com/analysis/Hospital_Transparency_-_ADVI_Summary.pdf.
[46] David U. Himmelstein, et al. "Medical Bankruptcy in the United States, 2007: Results of a National Study." *American Journal of Medicine* 2009; 122: 741-6. Available at https://www.amjmed.com/article/S0002-9343(09)00404-5/abstract.
[47] Carlos Dobkin, et al. "Myth and Measurement: The Case of Medical Bankruptcies." *New England Journal of Medicine* 2018; 378:1076-1078. Available at https://www.nejm.org/doi/full/10.1056/NEJMp1716604.
[48] The Henry J. Kaiser Family Foundation, "The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey." January 5, 2016. Available at https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/.
[49] Id.

Among those who reported problems paying medical bills, 66 percent said the bills were the result of a one-time or short-term medical expense such as a hospital stay or an accident, while 33 percent cited bills for treatment of chronic conditions that have accumulated over time. Respondents to the Kaiser survey reported a wide range of illnesses and injuries that led to an accumulation of medical debt. The largest share (36 percent) named a specific disease, symptom, or condition like heart disease or gastrointestinal problems, followed by issues related to chronic pain or injuries (16 percent), accidents and broken bones (15 percent), surgery (10 percent), dental issues (10 percent), and infections like pneumonia and flu (9 percent).[50] The following illustration provides additional detail on the type of medical services that led to an accumulation of medical debt.[51]



Medical Debt Collection Process

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.[52] Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[53]

[50] Id.
[51] Id., Figure 4.
[52] Art. X, s. 4(a), Fla. Const.
[53] 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;[54] proceeds from life insurance policies;[55] wages or unemployment compensation payments due certain deceased employees;[56] disability income benefits;[57] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[58] $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.[59]

Bankruptcy is a means by which a person's assets are liquidated in order to pay the person's debts under court supervision. The United States Constitution gives Congress the right to uniformly govern bankruptcy law.[60] 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.[61] 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.[62] 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.[63]

Effect of Proposed Changes

Shoppable Services

CS for HB 1527 requires each licensed hospital and ambulatory surgical center to post a consumer-friendly list of standard charges for at least 300 shoppable health care services on a facility website. A facility that provides less than 300 distinct services will be required to post standard charges for each service it does provide.

The bill requires facilities to post pricing information for shoppable services in accordance with the definition of "standard charges" established in federal rule.[64] This information extends beyond the traditional concept of charges to include negotiated and actual prices paid for selected services. For each shoppable service, a hospital must disclose the following pricing benchmarks:

- 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 bill is intended to mirror the shoppable services requirement included in the hospital facility transparency regulations finalized by the CMS in 2019. The bill requires facilities to disclose the relevant cost information as a condition of state licensure, which should result in uniform compliance among facilities.

[54] S. 222.11, F.S.
[55] S. 222.13, F.S.
[56] S. 222.15, F.S.
[57] S. 222.18, F.S.
[58] S. 222.22, F.S.
[59] S. 222.25, F.S.
[60] Art. 1, s. 8, cl. 4, U.S. Const.
[61] 11 U.S.C. s. 522.
[62] 11 U.S.C. s. 522(b).
[63] S. 222.20, F.S.
[64] Supra, FN 47.

Medical Debt Collection

The bill prohibits hospitals and ASCs from engaging in any "extraordinary collection actions" against a patient prior to determining whether that patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, and for 30 days after notifying a patient in writing that a collections action will commence. For purposes of the provision, "extraordinary collection action" means any action that requires a legal or judicial process, including:

- Placing a lien on an individual's property;
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or any other personal property;
- Commencing a civil action against an individual;
- Causing an individual's arrest; or,
- Garnishing an individual's wages.

The bill also establishes a new set of debt collection exemptions in chapter 222, F.S. that apply explicitly to debt incurred as a result of medical services provided in hospitals, ambulatory surgical centers, or urgent care centers. Under current law, this type of medical debt is subject to the uniform exemptions that apply to all types of debt and are described above. The bill increases the ceiling on the debt collection exemptions, when the debt results from services provided in a hospital facility or ambulatory surgical center, as follows:

- To $10,000 interest in a single motor vehicle (versus the current law exemption of $1,000);
- To $10,000 interest in personal property, provided that a debtor does not claim the homestead exemption under s. 4, Art. X of the state constitution (versus the current law exemption of $4,000).

The bill also requires each hospital and ASC to establish an internal grievance process allowing a patient to dispute any charges that appear on an itemized statement or bill. When a patient initiates a grievance, the facility must then provide an initial response to that patient within 7 business days.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Creates s. 222.26, F.S., relating to additional exemptions from legal process concerning medical debt.
Section 2: Amends s. 395.301, F.S., relating to price transparency; itemized patient statement or bill; patient admission status notification.
Section 3: Creates s. 395.3011, F.S., relating to billing and collection activities.
Section 4: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The increased dollar limit on personal property exemptions under chapter 222, F.S., may reduce revenues for medical service providers or their collection agents.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to require counties or municipalities to spend funds or act requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Current law provides AHCA with sufficient rule-making authority to execute the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 3, 2022, the Finance & Facilities Subcommittee adopted one amendment to the PCS and reported the bill favorably as a committee substitute. The amendment required hospitals and ASCs to establish an internal process for reviewing and responding to grievances from patients, allowing patients to

dispute charges that appear on the patient's itemized statement or bill, and to respond to a grievance within 7 days after it is formally filed by a patient. The amendment also required each facility to prominently post on its website and on each itemized statement or bill the grievance process instructions and necessary direct contact information required to initiate the grievance process.

This analysis is drafted to the committee substitute as passed by the Finance & Facilities Subcommittee.