HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1529 Applicability of Payments for Nonpreferred Provider Services
SPONSOR(S): Finance & Facilities Subcommittee, Snyder
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Facilities Subcommittee	17 Y, 1 N, As CS	Poche	Lloyd
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Health insurance covers a portion of the cost of an insured's medical costs. How much the insurance covers – and how much the insured pays via copays, deductibles, and coinsurance – depends on the details of the policy itself, with specific rules and regulations that apply to some plans.

Cost-sharing refers to the insured's portion of costs for healthcare services covered by their health insurance plan. The insured is responsible to pay cost-sharing amounts out-of-pocket. Cost-sharing can be in the form of a deductible, copayment, or coinsurance; most plans incorporate all of these types of cost-sharing, with specific payments depending on the service that's provided and whether or not the insured has met their deductible.

Most health plans have a list of doctors, hospitals, and other providers that have agreed to participate in the plan's network. In-network providers have a contract with a plan that limits the amount of money a provider may charge insureds. The agreed-upon contract rate includes both the insured's and insurer's obligations. The portion of the contracted rate an insured pays is determined by his or her policy. Out-of-network providers have not agreed to accept a contracted rate with an insured's insurance company. If an insured chooses to seek treatment outside of the network, insurance companies typically require a larger deductible, copayment and coinsurance amount.

CS/HB 1529 requires an individual health insurer to apply an insured's payments to an out-of-network, nonpreferred provider to the deductible and out-of-pocket maximum obligations under a health insurance policy if:

- The insured asks for such payments to be applied in that manner;
- The service provided by the out-of-network, nonpreferred provider would have been covered under the policy if it was completed by a preferred provider; and
- The amount charged for the service was the same or less than:
  - The average amount charged by the insurer's provider network; or
  - The service's statewide average amount paid based on data reported to the Florida Health Price Finder website.

The bill does not appear to have a fiscal impact on state or local governments.

The bill provides an effective date of January 1, 2023.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Insurance

Health insurance is the insurance of human beings against bodily injury or disablement by accident or sickness, including the expenses associated with such injury, disablement, or sickness.[1] Individuals purchase health insurance coverage for the purpose of managing anticipated expenses related to health or protecting themselves from unexpected medical bills or large health care costs. How much the insurance covers – and how much the policyholder pays via copays, deductibles, and coinsurance – depends on the details of the policy itself, with specific rules and regulations that apply to some plans. Managed care is the most common delivery system for medical care today by health insurers.[2]

Managed care systems combine the delivery and financing of health care services by limiting the choice of doctors and hospitals.[3] In return for this limited choice, however, medical care is less costly due to the managed care network's ability to control health care services. Some common forms of managed care are preferred provider organizations[4] (PPO) and health maintenance organizations[5] (HMO).

Health insurance provides a safety net for a serious injury or illness. All major medical health insurance plans cap in-network out-of-pocket costs, a combination of copays, deductibles, and coinsurance, at no more than an amount determined by the Centers for Medicaid and Medicare Services (CMS) each year. For 2022, it's $8,700 for a single person; $17,400 for a family.[6]

Types of Health Insurance

There are several different types of health insurance in the U.S., including public coverage (Medicare, Medicaid, Children's Health Insurance Program, Indian Health Services, and Veterans Administration coverage) and private coverage. Private healthcare coverage can be provided by an employer or purchased in the individual/family market. Members of the armed services and their families are covered under Tricare, and people employed by the federal government are covered under Federal Employees Health Benefits Program.

Both public and private plans use a managed care model, in which a private insurer will manage and oversee providing services, the quality of the care provided, the reimbursement system, the provider network, and rules, such as prior authorization or step therapy.

In the individual and family market, all major medical healthcare plans with effective dates of January 2014 or later are governed by the Patient Protection and Affordable Care Act and required to comply with its provisions, regardless of whether the plans are sold in the exchange or outside the exchange. These plans offer coverage on a guaranteed-issue basis, regardless of an applicant's medical history. But coverage is only available during open enrollment or a special enrollment period triggered by a qualifying event, like the birth of a child or a marriage.

Regulation of Health Insurance in Florida

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[1] S. 624.603, F.S.

[2] Florida Department of Financial Services, *Health Insurance and Health Maintenance Organizations – A Guide for Consumers*, http://www.myfloridacfo.com/Division/Consumers/understandingCoverage/Guides/documents/HealthGuide.pdf

[3] Id.

[4] S. 627.6471, F.S.

[5] Part I of chapter 641, F.S.

[6] Healthcare.gov, *Out-of-pocket maximum/limits*, available at https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.[7] The Agency for Health Care Administration (AHCA) regulates the quality of care by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from AHCA.[8] As part of AHCA's certification process, an HMO must provide information to demonstrate that it can provide quality of care consistent with the prevailing standards of care.[9] All persons who transact insurance in the state must comply with the Insurance Code (Code).[10] OIR has the power to collect, propose, publish, and disseminate any information relating to the subject matter of the Code,[11] and may investigate any matter relating to insurance.[12]

Health Insurance Cost-Sharing

The term "cost-sharing" refers to how health plan costs are shared between insurers and insureds. Generally, costs are shared in two main ways:

- **Premium contributions**. The employer pays a portion of the premium and the remainder is deducted from employees' paychecks. Most insurers require employers to contribute at least half of the premium cost for covered employees.
- **Cost-sharing at the time of service**. Cost-sharing at the time a service is provided may take the form of copayments, or a fixed amount paid at the time of obtaining services; co-insurance, or a percent of the charge for services that is typically billed after services are received; and deductibles, or a flat amount that must be paid before insurance benefits kick in.

Types of Cost-sharing

Types of cost-sharing in health insurance plans include:

- **Premium Contribution**. A health insurance premium is the total amount that must be paid in advance in order obtain coverage for a particular level of services. Usually health insurance premiums are billed and paid on a monthly basis. Employers typically require employees to share the cost of the plan premium. Most insurers require the employer to cover at least half of the premium cost for employees. Employers are free to require employees to cover some or all of the premium cost for dependents, such as a spouse or children.
- **Copayments.** A copayment or "copay" is a flat fee that the patient pays at the time of service. After the insured pays the copay, the health plan usually pays 100 percent of the balance on eligible services. Eligible services are those services that the plan includes in its coverage. The fee usually ranges between $10 and $40. Copayments are common in HMO products and are often characteristic of PPO plans as well.
- **Coinsurance.** Insureds must pay a portion of the services they receive under a health plan. This payment is called "coinsurance" and is usually a small percentage of the service cost after the plan pays benefits. If the plan pays 70 percent of the cost, the patient pays 30 percent of the cost. If the plan pays 90 percent, the patient pays 10 percent, and so forth. Coinsurance is common for PPO products and less common in HMOs.
- **Deductible.** The deductible is the amount an insured pays before the plan pays anything. Deductibles generally apply per person per calendar year. Under PPOs with coinsurance, a deductible usually applies to all services, including laboratory tests, hospital stays and doctor's office visits. Some plans, however, waive the deductible for office visits. Most HMOs do not have general deductibles, but may have a service-specific deductible for inpatient hospitalization or for brand-name prescription drugs. Generally, the higher the deductible, the lower the premium. Some plans with particularly high deductibles are known as "high-deductible" plans. While these plans may have significantly lower premiums, insureds are exposed to high out-of-pocket costs.

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[7] S. 20.121(3)(a), F.S.
[8] S. 641.21(1), F.S.
[9] S. 641.495, F.S.
[10] S. 624.11, F.S.
[11] S. 624.307(4), F.S.
[12] S. 624.307(3), F.S.

- **Out-of-Pocket Maximum.** Once out-of-pocket expenses per insured reach a defined limit in a single calendar year, the plan will pay 100 percent of eligible charges for the rest of the calendar year. The definition of out-of-pocket maximum will differ depending on your insurance carrier. Some carriers exclude specific costs or increase the maximum for care provided by out-of-network providers. Out-of-pocket cap levels typically are in the range of $1,000 to $5,000 per person.

Preferred Providers vs. Out-of-Network Providers

Most health plans have a list of doctors, hospitals, and other providers that have agreed to participate in the plan's network. Providers in the network have a contract with a health plan to care for its members at a certain cost. A member of the plan will generally pay less for medical services when they use one of the providers on this list. If a plan member sees a doctor or uses a hospital that does not participate with the health plan, the member is going out-of-network and will usually have to pay more for out-of-network care. Some plans will not cover any amount of out-of-network care, while others cover a percentage of care.

In-network providers have a contract with an insurer that limits the amount of money the provider may charge individuals who are covered under the contracted insurance company. The agreed-upon contract rate includes both the patient and insurer shares and may be based on certain assumptions regarding the volume of patients that will use that provider's services. The portion of the contracted rate a patient pays is determined by his or her policy.

Out-of-network providers are providers who have not agreed to accept a contracted rate with a patient's insurance company. If a patient chooses to seek treatment outside of his or her network, insurance companies typically require the patient to pay a larger deductible, copayment and coinsurance amount.

Florida Health Price Finder

The state's Health Price Finder website allows consumers and caregivers to look up the average amounts paid by insurance plans for a specific service, giving them a better estimate of what their total out-of-pocket expenses will be.[13] The average payments are based on billions of lines of claims data from three Florida health plans, and claims data from additional plans. The website lists the services as "care bundles" in order to factor in all aspects that account for the final price.

Effect of Proposed Changes

CS/HB 1529 requires an individual health insurer to apply an insured's payments to an out-of-network, nonpreferred provider to the insured's deductible and out-of-pocket maximum under the policy if:

- The insured asks for such payments to be applied in that manner;
- The service provided by the out-of-network, nonpreferred provider would have been covered under the policy if it was completed by a preferred provider; and
- The amount charged for the service was the same or less than:
  - The average amount charged by the insurer's provider network; or
  - The service's statewide average amount paid based on data reported to the Florida Health Price Finder website.

The bill will likely allow insureds to reach their deductible and out-of-pocket maximums under a health insurance policy more quickly, lowering out-of-pocket payments for the remainder of each year the maximums are reached. This may require insurers to cover a greater amount of services than under current law, and may prompt changes in network contracting to reflect shifting care volume and use patterns.

The bill provides an effective date of January 1, 2023.

[13] Agency for Health Care Administration, *Florida Health Price Finder*, available at https://pricing.floridahealthfinder.gov/#!.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment; limitations; coinsurance and deductibles.
Section 2: Provides an effective date of January 1, 2023.

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:

Insureds will likely reach out-of-pocket maximum and meet their deductible faster by applying all fees paid, to both in network and out-of-network providers, to those cost-sharing requirements.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provisions do not require rulemaking authority for implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 16, 2022, the Finance & Facilities Subcommittee adopted one amendment and reported the bill favorable as a committee substitute. The amendment changed the effective date to January 1, 2023, to coincide with the beginning of the next health plan year.

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