The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 296
INTRODUCER:	Senator Garcia
SUBJECT:	Health Care Expenses
DATE:	February 9, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 296 requires each Florida-licensed hospital and ambulatory surgical center (ASC) to, consistent with federal requirements on hospital price transparency in 45 C.F.R. part 180, establish, update, and make public a list of its standard charges for all items and services provided by the facility. The Agency for Health Care Administration (AHCA) is required to impose a fine of $500 per day, per instance of noncompliance on the facility if the facility is required to comply with 45 C.F.R. part 180 and violates the above requirement.

The bill creates s. 501.181, F.S., and amends s. 559.72, F.S., to provide requirements for consumer reporting agencies (CRA) related to medical debt. The bill prohibits a CRA from publishing a consumer report containing credit impairments resulting from medical debt under certain circumstances and requires a CRA to remove, without charging the patient a fee, any such credit impairment from the patient's credit report within 30 days after certain notification that the debt has been fully paid or settled or that the patient is in compliance with a payment plan.

To enforce these CRA-related provisions, the bill establishes a private right of action for an aggrieved patient. The bill provides that the patient may bring suit, within two years of the violation, to enjoin the prohibited action and to recover the greater of any actual damages or $1,500, as well as attorney fees and court costs. The Department of Agriculture and Consumer Services (DACS) is required to adopt rules to implement these requirements.

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

II. Present Situation:

Hospital and ASC Price Transparency

Florida Law

Section 395.301, F.S., requires hospitals and ASCs to provide information to current, former, and prospective patients regarding the pricing of services and procedures at that facility. The section requires each facility to post the following on its website:

- Information on payments made to that facility for defined bundles of services and procedures including, at a minimum, the estimated average payment received from all payors, excluding Medicaid and Medicare, for the descriptive service bundles available at that facility and the estimated payment range for such bundles.
- Information to prospective patients on the facility's financial assistance policy, including the application process, payment plans, and discounts, and the facility's charity care policy and collection procedures.
- A notification that services may be provided in the health care facility by the facility as well as by other health care providers who may separately bill the patient and that such health care providers may or may not participate with the same health insurers or health maintenance organizations (HMO) as the facility, if applicable.
- A notification that patients may request from the facility and other health care providers a more personalized estimate of charges and other information, and that patients should contact each health care practitioner who will provide services in the hospital to determine the health insurers and HMOs with which the health care practitioner participates as a network provider or preferred provider.
- The names, mailing addresses, and telephone numbers of the health care practitioners and medical practice groups with which it contracts to provide services in the facility and instructions on how to contact the practitioners and groups to determine the health insurers and HMOs with which they participate as network providers or preferred providers.
- A hyperlink to the health-related data, including quality measures and statistics that are disseminated by the AHCA pursuant to s. 408.05, F.S.

The section requires a hospital to post additional information to its website, including:

- The names and hyperlinks for direct access to the websites of all health insurers and HMOs for which the hospital contracts as a network provider or participating provider;
- A statement that:
  - Services may be provided in the hospital by the facility as well as by other health care practitioners who may separately bill the patient;
  - Health care practitioners who provide services in the hospital may or may not participate with the same health insurers or HMOs as the hospital; and
  - Prospective patients should contact the health care practitioner who will provide services in the hospital to determine the health insurers and HMOs with which the practitioner participates as a network provider or preferred provider; and
- As applicable, the names, mailing addresses, and telephone numbers of the health care practitioners and medical practice groups with which it contracts to provide services in the hospital, and instructions on how to contact the practitioners and groups to determine the

health insurers and HMOs with which they participate as network providers or preferred providers.

In addition, when requested and:

- Before providing any non-emergency medical services, each facility is required to provide a good faith estimate of reasonably anticipated charges by the facility for the treatment of the patient's or prospective patient's specific condition. The estimate:
  - Must include information on the facility's financial assistance policy, including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures.
  - Must clearly identify any facility fees and, if applicable, include a statement notifying the patient or prospective patient that a facility fee is included in the estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.
  - Must notify the patient or prospective patient that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient, if applicable.
- After the patient's discharge or release from a facility, the facility must provide to the patient or to the patient's survivor or legal guardian, as appropriate, an itemized statement or a bill detailing in plain language, comprehensible to an ordinary layperson, the specific nature of charges or expenses incurred by the patient. The statement:
  - Must include notice of hospital-based physicians and other health care providers who bill separately.
  - May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.
  - Must list drugs by brand or generic name and not refer to drug code numbers when referring to drugs of any sort.
  - Must specifically identify physical, occupational, or speech therapy treatment by date, type, and length of treatment when such treatment is a part of the statement or bill.

Federal Law

In addition to the state requirements detailed above, 42 C.F.R. part 180 requires hospitals to make public:

- A machine-readable file containing a list of all standard charges for all items and services; and
- A consumer-friendly list of standard charges for a limited set of shoppable services.[1]

To make its list of standard charges and shoppable services public, a hospital must select a publicly available website to publish the standard charge information and the hospital must make the information available free of charge and without having to create a username and password or submit any personal identifying information.

The publication of a hospital's standard charges must include:

- A description of each item or service provided by the hospital.

[1] A shoppable service is defined as a service that can be scheduled by a healthcare consumer in advance.

- A gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- A payer-specific negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each payer-specific negotiated charge must be clearly associated with the name of the third party payer and plan.
- A de-identified minimum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- A de-identified maximum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- Discounted cash price that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the Diagnosis Related Group, the National Drug Code, or other common payer identifier.

The publication of a hospital's shoppable services must include:

- A plain-language description of each shoppable service.
- An indicator when one or more of the federal Centers for Medicare & Medicaid Services (CMS)-specified shoppable services are not offered by the hospital.
- The payer-specific negotiated charge that applies to each shoppable service (and to each ancillary service, as applicable). Each list of payer-specific negotiated charges must be clearly associated with the name of the third party payer and plan.
- The discounted cash price that applies to each shoppable service (and corresponding ancillary services, as applicable). If the hospital does not offer a discounted cash price for one or more shoppable services (or corresponding ancillary services), the hospital must list its undiscounted gross charge for the shoppable service (and corresponding ancillary services, as applicable).
- The de-identified minimum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).
- The de-identified maximum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).
- The location at which the shoppable service is provided.
- Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, as applicable, the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the Diagnosis Related Group, or other common service billing code.

The CMS is charged with monitoring and enforcing hospital compliance with the above transparency provisions. If a hospital is found to be noncompliant, the CMS may take the following actions, in order:

- Provide a written warning notice to the hospital of the specific violation(s).
- Request a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements, according to 42 C.F.R. s. 180.80.

- Impose a civil monetary penalty on the hospital and publicize the penalty on a CMS website according to 42 C.F.R. s. 180.90 if the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan. The maximum daily amount of a penalty for violation is $300 even if the hospital is in violation of multiple discrete requirements of 42 C.F.R. part 180.

Compliance with Federal Requirements

A report published by Patient Rights Advocate.org[2] looked at a random sample of 500 of the 6,002 hospitals subject to the requirements above for compliance with the requirements.[3] The report estimated that only 5.6 percent (or 28) of the hospitals sampled were fully compliant with the rule.[4] The report found a hospital to be noncompliant with the rule "if it omitted any of the five standard charge criteria required by the rule, if it posted blanks or zeros in the data fields, if it did not post all negotiated payer rates associated with specific plans, or if the price estimator tool did not show both the negotiated rates and discounted cash prices to provide pricing for all healthcare consumers, including the uninsured and those desiring to pay cash directly."[5]

Of the hospitals surveyed, 49 were in Florida and only two of the 49 were found to be fully compliant with the transparency requirements.[6]

Credit Reports

A credit report is a record of a consumer's credit history and other information about the consumer, including his or her name, address, social security number, employment information, date of birth, and court judgments.[7] Three major credit bureaus—Equifax, Experian, and TransUnion—compile and sell consumer credit reports. Lenders, insurers, utility and cell phone companies, employers, and others may obtain a consumer's credit report for their use in determining (i.e., whether to extend credit), set insurance rates, or employ the consumer.[8] A consumer may also review his or her credit report at no charge once every 12 months from each of the credit bureaus.

Generally, the federal Fair Credit Reporting Act (FCRA)[9] regulates the activities of CRAs, the users of consumer reports, and those who furnish information to CRAs. In 2003, the FCRA was amended by the Fair and Accurate Credit Transactions Act (FACTA) to address identity theft,

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[2] Semi-Annual Hospital Price Transparency Compliance Report, July 2021, Patient Rights Advocate.org, available at https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/60f1c225e1a54c0e42272fbf/1626456614723/PatientRightsAdvocate.org+Semi-Annual+Hospital+Compliance+Report.pdf (last visited Oct. 26, 2021).
[3] *Id.* at p. 1
[4] *Id.* at p. 2
[5] *Id.*
[6] *Id.* at pp. 9-11
[7] 15 U.S. Code s. 1681 defines a "credit report" as any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, … general reputation, [or] personal characteristics… which is used…for the purpose of…establishing the consumer's eligibility for credit or employment purposes…. The Florida KIDS Act adopts this definition of a "credit report" in s. 501.0051(1)(a), F.S.
[8] Board of Governors of the Federal Reserve System, *Credit Reports and Credit Scores: Consumer's Guide*, *available at* https://www.federalreserve.gov/creditreports/pdf/credit_reports_scores_2.pdf (last visited Oct. 26, 2021).
[9] Fair Credit Reporting Act, Pub. L. No. 91-508, codified as amended at 15 U.S.C. s. 1681-1681x.

improve the accuracy of consumer records, and to increase consumer access to credit information.[10]

In general, the FCRA does not preempt state law with respect to consumer reports. However, the FCRA in section 625[11] lists several areas that are specifically preempted to federal law. Included in the list is section 605[12] of the FCRA, which establishes requirements relating to information contained in consumer reports, and section 611[13] of the FCRA, relating to the time by which a CRA must take any action in any procedure related to the disputed accuracy of information in a consumer's file.

III. Effect of Proposed Changes:

SB 296 amends s. 395.301, F.S., to require each licensed ASC and hospital to establish, update, and make public a list of the facility's standard charges for all items and services provided by the facility, consistent with federal requirements for price transparency in 45 C.F.R. part 180. The bill requires the AHCA to impose a fine of $500 per day, per instance of noncompliance, on a facility that is required to comply with 45 C.F.R. part 180 and that violates this provision.

The bill also creates s. 501.181, F.S., to establish requirements for patient credit protection. The bill defines the following terms:

- "Consumer report" has the same meaning as in 15 U.S.C. s. 1681a(d).
- "Consumer reporting agency" has the same meaning as in 15 U.S.C. s. 1681a(f).
- "Health benefit plan" means any individual, blanket, or group plan, policy, or contract for health care services issued in this state by an authorized health care insurer, HMO, hospital medical service corporation, or self-insured plan in this state. The term does not include supplemental plans.
- "Health care provider" means a person or an entity that is licensed, certified, or otherwise authorized by the laws of this state to provide health care services.
- "Medical debt" means the outstanding balance a patient-consumer owes to a health care provider for health care services.
- "Patient-consumer" means an individual who receives health care services from a health care provider.

The bill prohibits a CRA from publishing a consumer report containing a credit impairment resulting from a patient-consumer's medical debt if the patient-consumer was covered by a health benefit plan when the health care services giving rise to the medical debt were provided and such services were covered by the health benefit plan and the patient-consumer's medical debt is an outstanding balance after the patient-consumer's copayments, deductibles, and coinsurance amounts owed for health care services were fully paid or settled or are being paid as part of a payment plan. The bill also prohibits a CRA from publishing a consumer report with a credit impairment resulting from a patient-consumer's medical debt without the express written

[10] Fair and Accurate Credit Transactions Act, Pub. L. No. 108-159 (2003).
[11] 15 U.S.C. s 1681t
[12] 15 U.S.C. s. 1681c
[13] 15 U.S.C. s. 1681b

consent of the patient consumer's health care provider. The bill amends s. 559.72, F.S., with a conforming prohibition.

The bill requires a CRA that receives a notification from a creditor indicating that a patient-consumer's medical debt has been fully paid or settled, or that the patient-consumer is in compliance with a payment plan, to remove any credit impairment resulting from the applicable medical debt within 30 days after receiving such notification. The bill specifies that such notification may include, but is not limited to, documentation showing the status of the patient-consumer's medical debt. The bill also prohibits a CRA from charging the patient-consumer any fee to remove the credit impairment.

The bill provides that a patient-consumer who is aggrieved by a violation of these provisions may bring an action to:

- Enjoin the violation.
- Recover actual damages or $1,500, whichever is greater.

In addition to any damages awarded under the bill, a patient-consumer will also be awarded reasonable attorney fees and court costs. The action must be commenced within two years after the violation occurs and all parties to the action may agree to arbitration to resolve the medical debt reporting dispute.

The bill requires the DACS to adopt rules to implement s. 501.181, F.S., as created by the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Sections 2 and 3 of the bill create s. 501.181, F.S., and amend s. 559.72, F.S., respectively, to establish new prohibitions on CRAs publishing certain types of debt on credit reports as well as establish time frames for CRAs to address certain consumer disputes of inaccurate information on credit reports. Subsections 625(b)(1)(E) and

625(b)(1)(B) of the FCRA, respectively, state that no requirement or prohibition may be imposed under the laws of any state with the respect to:

- Section 605 of the FCRA relating to information contained in consumer reports; and
- Section 611 of the FCRA relating to the time by which a CRA must take any action in any procedure related to the disputed accuracy of information in a consumer's file.

As such, it is possible that the above provisions in sections 2 and 3 of SB 296 make changes in areas that are statutorily preempted to federal law and those sections of SB 296 may be found to violate the supremacy clause in Article VI, section 2, of the U.S. Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 296 may have an indeterminate negative fiscal impact on hospitals that are in violation of federal price transparency requirements in 45 C.F.R. part 180.

SB 296 may have an indeterminate negative fiscal impact on CRAs that are required to pay damages and attorney fees in suits brought under the provisions of the bill.

SB 296 may have an indeterminate positive fiscal impact on consumers who bring and win suits against CRAs under the provisions of the bill.

C. Government Sector Impact:

The AHCA may see an indeterminate positive fiscal impact from fees collected from hospitals that are in violation of federal price transparency requirements in 45 C.F.R. part 180.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 1 of the bill requires "each licensed facility" to publish certain information consistent with federal price transparency requirements in 45 C.F.R. part 180. Under ch. 395, F.S., "each licensed facility" would include ASCs. However, 45 C.F.R. part 180 only applies to hospitals. It is unclear whether the bill intends to require ASCs to publish the required information. Additionally, should ASCs be required to do so, it is likely that ASCs would not be subject to the fines imposed by the bill for noncompliance because a requirement of those fines being imposed is that the facility is required to comply with 45 C.F.R. part 180. It may be advisable to clarify whether this portion of the bill is meant to be applied to ASCs.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.301 and 559.72.

This bill creates section 501.181 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.