HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1413 Health Care Expenses
SPONSOR(S): Healthcare Regulation Subcommittee, Tramont
TIED BILLS: **IDEN./SIM. BILLS:** SB 268

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	15 Y, 0 N, As CS	Poche	McElroy
2) Commerce Committee	19 Y, 0 N	Lloyd	Hamon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The United States spends more per person on health care than any other high-income country in the world and spending has continued to increase over the past few decades.

Health care prices are a primary driver of health care spending. One study found that commercial health spending per enrollee increased by 21.8% between 2015 and 2019. The rising prices of health care services accounted for approximately two-thirds of that growth, with prices for prescription drugs, provider services (e.g., physical examinations, screenings and procedures) and inpatient and outpatient care rising by 18.3%.

Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. Nationwide, over 100 million have some form of medical debt. Four in ten U.S. adults have some form of health care debt. About half of adults – including three in ten who do not currently have health care debt – are vulnerable to falling in the debt, saying they would be unable to pay a $500 unexpected medical bill without borrowing money. While about a third of adults with health care debt owe less than $1,000, even small amounts of debt can have significant financial consequences for some.

CS/HB 1413 increases patient access to health care cost information, and offers a measure of protection from unreasonable and burdensome medical debt. The various provisions apply to hospitals, ambulatory surgical centers, health insurers, and HMOs. The bill brings provisions from recent federal law and regulation into state law; in doing so, the bill requires compliance by facilities and insurers as a condition of state licensure, thus ensuring that these provisions will be fully adopted and adequately enforced in Florida. Specifically, the bill:

- 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.
- Requires hospitals and ambulatory surgical centers to automatically provide patients with personalized pre-treatment estimates on the costs of care within certain timeframes.
- Requires a health plan, upon receipt of a facility cost estimate, to develop an advanced explanation of benefits, in accordance with the federal No Surprises Act of 2020.
- Prohibits hospitals and ASCs from taking actions to collect medical debt in certain circumstances.
- Requires hospitals and ASCs to establish an internal grievance process for patients to dispute charges.
- 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, and establishes a 3-year statute of limitations on bringing legal action to collect medical debt.
- Specifies that shared savings incentives offered by health plans are to be counted as medical expenses for rate development and rate filing purposes, consistent with recent federal regulations.

The bill does not have a fiscal impact on state or local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

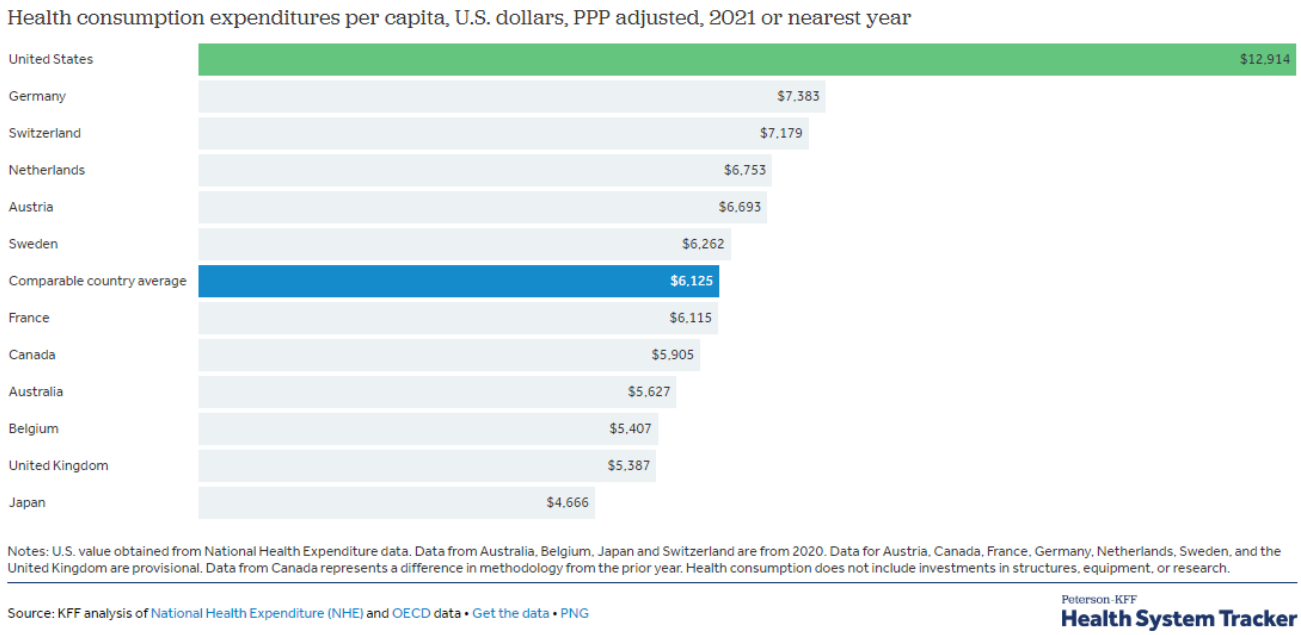
A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Spending

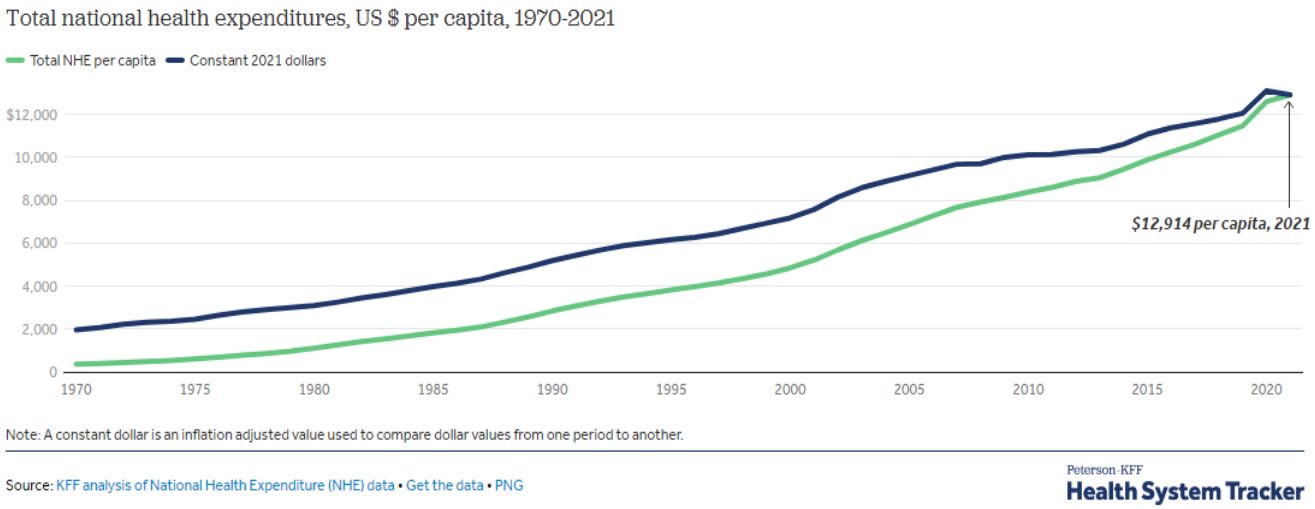
Health spending in the United States has exploded in the last 50 years, totaling $74.1 billion in 1970, increasing to $1.4 trillion by 2000, then tripling in 2021 to $4.3 trillion.[1]

The United States spends more per person on health care than any other high-income country in the world and spending has continued to increase over the past few decades. Health spending per person in the U.S. was $12,914 in 2021, more than $5,000 greater than any other high-come nation.[2]



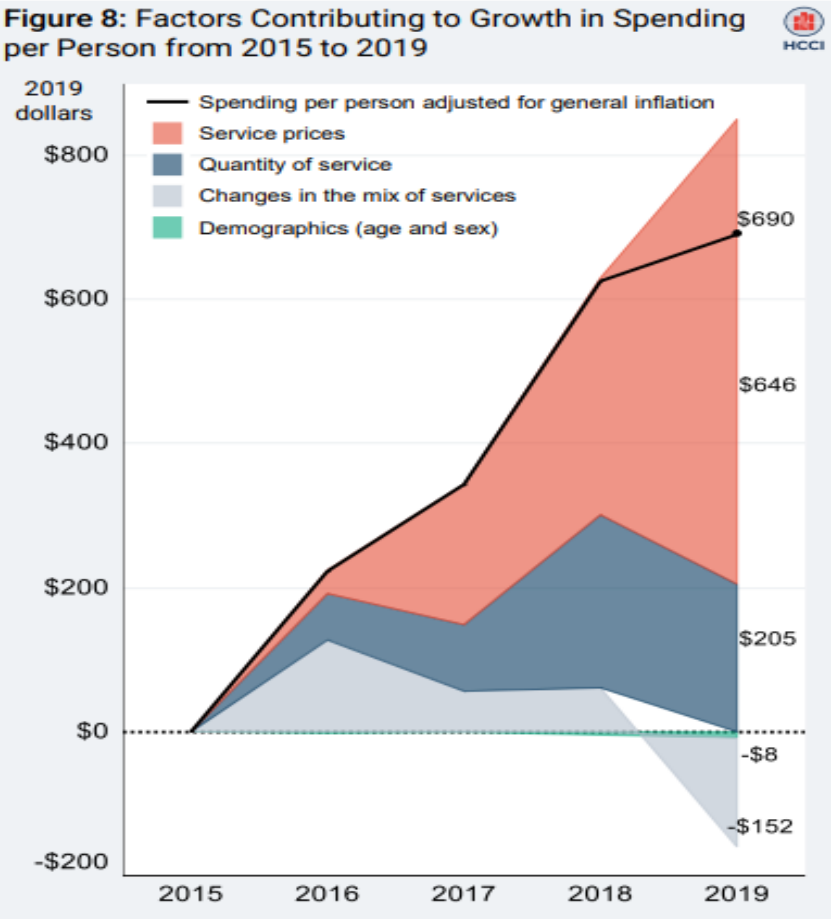
The following chart illustrates the rate of growth in total national health expenditures per capita from 1970 to 2021[3]:

[1] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How has U.S. spending on healthcare changed over time?*, February 7, 2023, available at https://healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/ (last viewed on March 23, 2023).
[2] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How does health spending in the U.S. compare to other countries?*, February 9, 2023, available at https://healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ (last viewed on March 23, 2023). The average amount spent on health per person in comparable countries – $6,125 – is less than half of what the U.S. spends.
[3] Supra, FN 1.



Health care prices are a primary driver of health care spending. Between 1970 and 2019, total U.S. health care spending grew from 6.9 percent of GDP to 17.7 percent of GDP.[4] The Organization for Economic Cooperation Development estimated that total spending in 2019 in member countries averaged 8.8 percent of GDP, compared with 16.8 percent in the U.S.[5] One study found that U.S. commercial health spending per enrollee increased by 21.8% between 2015 and 2019.[6] The rising prices of health care services accounted for approximately two-thirds of that growth, with prices for prescription drugs, provider services (physical examinations, screenings and procedures) and inpatient and outpatient care rising by 18.3%.[7] At the same time, increased service quantity accounted for nearly one-fifth of overall spending growth, as per capita use increased by only 3.6 percent.[8] The following chart details the factors contributing to the growth in spending, per capita, in the U.S.:[9]

[4] Health Affairs, Research Brief – Considering Health Spending, *The Role of Prices in Excess US Health Spending*, June 9, 2022, available at https://www.healthaffairs.org/do/10.1377/hpb20220506.381195/full/> (citing the Centers for Medicare and Medicaid Services statistics at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected) (last viewed on March 23, 2023).
[5] Id.
[6] Health Care Cost Institute, *2019 Health Care Cost and Utilization Report*, pg. 2, available at https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf.
[7] Id.
[8] Supra, FN 4.
[9] Id., pg. 6.



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.

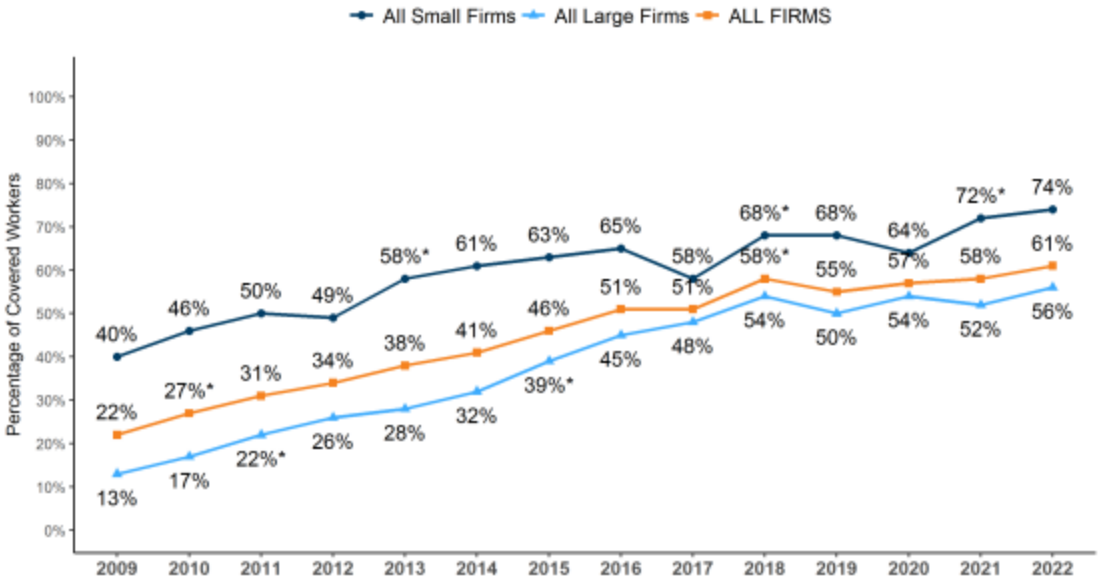
Price transparency can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[10] Price can be defined as an estimate of a consumer's complete cost on a health care service or services that 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.[11] 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."[12] Indeed, the definition of the price or cost of health care has different meanings depending on who is incurring the cost.[13]

[10] 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.
[11] Id.
[12] 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.
[13] Id.

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-eight percent of covered workers have a general annual deductible[14] for single coverage that must be met before most services are paid for by their health plan.[15]

Among covered workers with a general annual deductible, the average deductible amount for single coverage is $1,763.[16] Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $2,543 in small firms, compared to $1,493 for workers in large firms.[17] Sixty-one percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 56 percent in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (49 percent for small firms vs. 25 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 2022.[18]

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, 2009-2022



* 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, 2018-2022; 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 88% in 2022. 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 2022 is $1,763, up nearly 100% from $883 in 2013 and over 400% from $433 in 2008.

[14] 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.
[15] The Henry J. Kaiser Family Foundation, *2022 Employer Health Benefits Survey*, October 27, 2022, available at https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/ (last viewed on March 23, 2023).
[16] Id.
[17] Id.
[18] Id., figure 7.13.

From 2016 to 2022, the average premium for covered workers with family coverage increased 20%, while inflation totals just 11% over the same period; over the last ten years, the average premium rose 43%, while inflation grew at 17% over the same time frame.[19] 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.

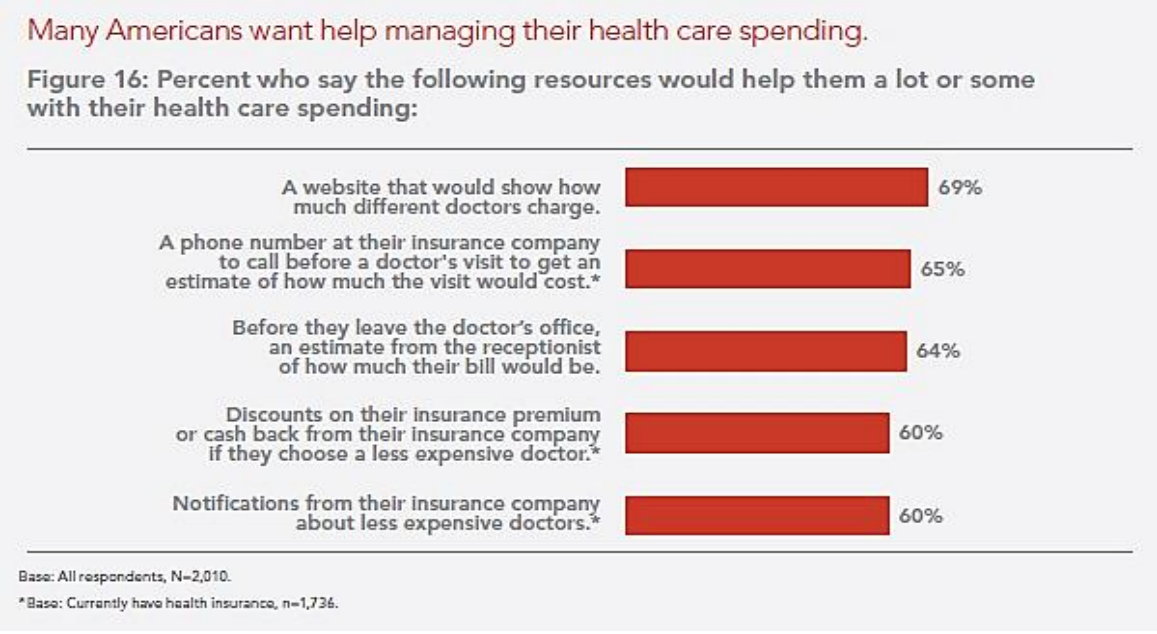
National Price Transparency Studies

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.
- 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.[20]

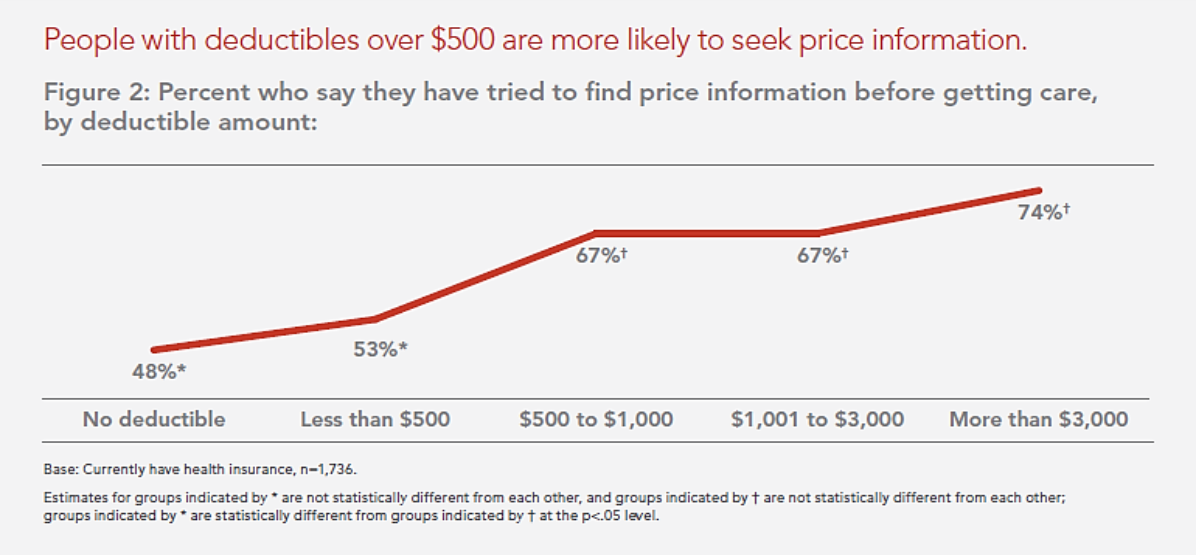
The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[21]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[22]



[19] Id.
[20] 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.
[21] Id., pg. 1.
[22] 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/.

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.[23] 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.[24]



The individuals who compared prices stated that such research affected their health care choices and saved them money.[25] 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 higher level care quality and 63 percent do not believe that lower price is indicative of lower level care quality.[26] 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.[27] 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.[28]

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).[29] 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.[30] 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

[23] Id., pg. 3.
[24] Id., pg. 13.
[25] Id., pg. 4.
[26] Supra, FN 14.
[27] 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.
[28] 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.
[29] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[30] S. 381.026(3), F.S.

- Patient's knowledge of rights and responsibilities.

A patient has the right to request certain financial information from health care providers and facilities.[31] 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.[32] Estimates must be written in language "comprehensible to an ordinary layperson."[33] 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.[34] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[35]

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.[36]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[37] to publish a schedule of charges for the medical services offered to patients.[38] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[39] 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.[40] 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.[41]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[42] 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

[31] S. 381.026(4)(c), F.S.
[32] S. 381.026(4)(c)3., F.S.
[33] Id.
[34] Id.
[35] S. 381.026(4)(c)5., F.S.
[36] S. 381.0261, F.S.
[37] 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.
[38] S. 381.026(4)(c)3., F.S.
[39] Id.
[40] Id.
[41] S. 381.026(4)(c)4., F.S.
[42] S. 395.107(1), F.S.

in three or more locations. The schedule requirements for urgent care centers are the same as those established for primary care providers.[43] 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).[44]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[45] 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[46] 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.[47] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[48] 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.[49]

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.[50]

Federal Price Transparency Laws and Regulations

[43] S. 395.107(2), F.S.
[44] S. 395.107(6), F.S.
[45] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.
[46] 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.
[47] S. 395.301, F.S.
[48] S. 408.05(3)(c), F.S.
[49] Id.
[50] S. 456.0575(2), F.S.

Congress and federal regulatory agencies recently took steps to improve the quantity and quality of health care cost information available to patients.

Hospital Facility Transparency

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations[51] 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.[52]

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.[53] Very early indications suggest that there are varying levels of compliance with the new rules among hospital facilities.[54]

Health Insurer Transparency

On October 29, 2020, the federal Departments of Health and Human Services, Labor, and Treasury finalized regulations[55] imposing new transparency requirements on issuers of individual and group health insurance plans.

Estimates

Central to the new regulations is a requirement for health plans to provide an estimate of an insured's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurance plans must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs *before* receiving health care to encourage shopping and price competition amongst providers.[56]

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[51] 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).
[52] Id.
[53] Supra, FN 42.
[54] ADVI, "*Implementation of Newly Enacted Hospital Price Transparency*," available at https://advi.com/analysis/Hospital_Transparency_-_ADVI_Summary.pdf.
[55] Transparency in Coverage, 85 FR 73158 (November 12, 2020)(codified at 29 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 147, and 45 CFR Part 158).
[56] Trump Administration Finalizes Transparency Rule for Health Insurers," Health Affairs Blog, November 1, 2020. Available at https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last accessed on March 23, 2023).

Each health plan will be required to establish an online shopping tool that will allow insureds to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket cost for 500 of the most shoppable items and services. This requirement is scheduled to take effect on January 1, 2023. Beginning in 2024, health plans will need to provide personalized cost-sharing information to patients across the full range of covered health care services.[57]

Medical Loss Ratio

The regulations also clarify the treatment of shared savings expenses under medical loss ratio (MLR) calculations required by the Patient Protection and Affordable Care Act (PPACA). MLR refers to the percentage of insurance premium payments that are actually spent on medical claims by an insurer. In general, MLR requirements are intended to promote efficiency among insurers.[58] The PPACA established minimum MLR requirements for group and individual health insurance plans.[59] Under the PPACA, large group plans must dedicate at least 85 percent of premium payments to medical claims, while small group and individual market plans must dedicate at least 80 percent of premium payments to medical claims.[60] Further, the law requires a health plan that does not meet these standards to provide annual rebates to individuals enrolled in the plan.[61]

The regulations finalized in October 2020 specify that expenses by a health plan in direct support of a shared savings program shall be counted as medical expenditures.[62] Thus, a health plan providing shared savings to members will receive an equivalent credit towards meeting the MLR standards established by PPACA. In theory, this policy should provide an additional incentive for insurers who have not already done so to adopt shared savings programs.

The Federal No Surprises Act

On December 27, 2020, Congress enacted the No Surprises Act as part of the Consolidated Appropriations Act of 2021.[63] The No Surprises Act includes a wide-range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of care. Most sections of the Act go into effect on January 1, 2022, and the Departments of Health and Human Services, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.[64]

Estimates – Facilities

In the realm of price transparency, the No Surprises Act establishes the concept of an "advanced explanation of benefits" that combines information on charges provided by a hospital facility with patient-specific cost information supplied by a health insurance plan. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a "good faith estimate" of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured).[65]

Estimates – Health Plans

Once the "good faith estimate" has been shared with a patient's health plan, the plan must then develop a more detailed and "advanced explanation of benefits". This personalized cost estimate must include the following:

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[57] Supra, FN 51.
[58] "Explaining Health Care Reform: Medical Loss Ratio (MLR)", Henry J Kaiser Family Foundation, February 29, 2012. Available at https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ (last accessed on March 23, 2023).
[59] PPACA s. 1001; 42 U.S.C. 300gg-18.
[60] Supra note 51.
[61] Id.
[62] 45 CFR Part 158.
[63] PL 116-260. The No Surprises Act is found in Division BB of the Act.
[64] Id.
[65] PL 116-260, Division BB, Section 112.

- An indication of whether the facility participates in the patient's health plan network. If the facility is non-participating, information on how the patient can receive services from a participating provider;
- The good-faith estimate prepared by the hospital facility based on billing/diagnostic codes;
- A good-faith estimate of the amount to be covered by the health plan;
- A good-faith estimate of the amount of the patient's out-of-pocket costs;
- A good-faith estimate of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's health plan;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (i.e., medical necessity determinations, prior authorization, step therapy, etc.); and,
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.[66]

Furthermore, the Act directs the Secretary of Health and Human Services (HHS) to establish by January 1, 2022, a "patient-provider dispute resolution process" to resolve any disputes concerning bills received by uninsured individuals that substantially differ from a provider's good faith estimate provided prior to the service being rendered.[67]

The new requirements placed on hospitals and health plans by the No Surprises Act are cumulatively intended to provide patients with increased certainty about the total and out-of-pocket costs associated with health care services. In turn, patients may be more equipped to seek out cost-effective care and avoid unforeseen costs that can lead to financial strain.

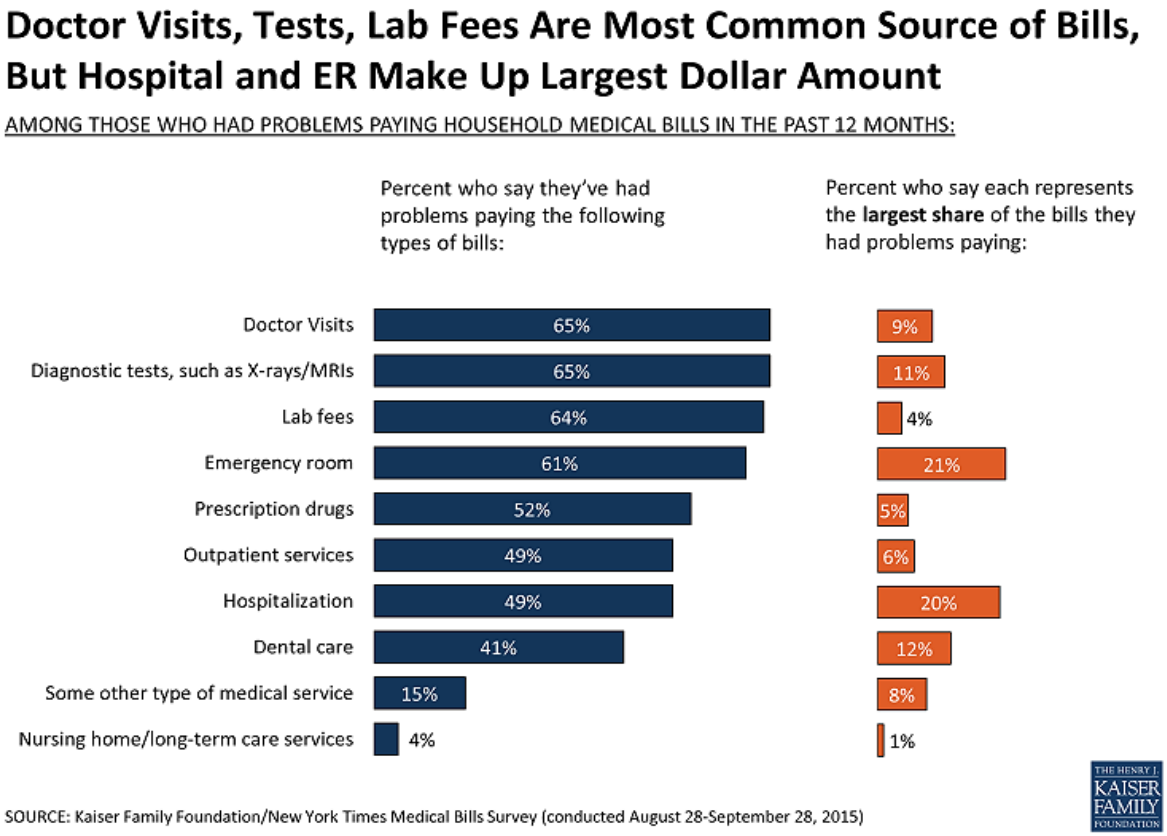
Many hospitals do not comply with the federal transparency requirement. A 2021 review of more than 3,500 hospitals found that 55 percent of hospitals were not compliant with the rule and had not posted price information for commercial plans or had not posted any prices at all.[68] Further, an August 2022 review of 2,000 hospitals found that 16 percent with all transparency requirements.[69] Nearly 84 percent of hospitals failed to post machine-readable files containing standard charges, and roughly 78 percent of hospitals did not provide a consumer-friendly shoppable services display.[70] Another review of more than 6,400 hospitals showed wide-spread non-compliance with the federal transparency rule- more than 63 percent of hospitals are not complying.[71] According to that review, only 38 percent of Florida hospitals are in compliance.[72]

Medical Debt

Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. Nationwide, over 100 million have some form of medical debt.[73] A 2007 study suggested that illness and medical bills contributed to 62.1 percent of all personal bankruptcies filed in the U.S. during that year.[74] A more recent analysis, which considered only the impact of hospital charges, found that 4

[66] PL 116-260, Division BB, Section 111.
[67] Supra note 59.
[68] John Xuefeng Jiang, et al., Factors associated with compliance to the hospital price transparency final rule: A national landscape study, Journal of General Internal Medicine (2021), available at https://link.springer.com/article/10.1007/s11606-021-07237-y (last viewed on March 10, 2023).
[69] Patients' Rights Advocates, *Third semi-annual hospital transparency compliance report, 2022*, available at https://www.patientrightsadvocates.org/august-semi-annual-compliance-report-2022.
[70] Id.
[71] Foundation for Government Accountability, *How America's Hospitals Are Hiding the Cost of Health Care*, pg. 3, August 2022, available at https://www.TheFGA.org/paper/americas-hospitals-are-hiding-the-cost-of-health-care. (last viewed on March 10, 2023). Only two hospitals to date have been fined for noncompliance with the transparency rule, both of which are in Georgia's Northside Hospital System.
[72] Id., pg. 4.
[73] Kaiser Health News, *Diagnosis: Debt – 100 Million People in America Are Saddled with Health Care Debt*, June 16, 2022, available at https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/ (last viewed on March 23, 2023).
[74] 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.

percent of U.S. bankruptcies among non-elderly adults resulted from hospitalizations.[75] Four in ten U.S. adults have some form of health care debt.[76] About half of adults – including three in ten who do not currently have health care debt – are vulnerable to falling in the debt, saying they would be unable to pay a $500 unexpected medical bill without borrowing money.[77] While about a third of adults with health care debt owe less than $1,000, even small amounts of debt can have significant financial consequences for some.[78] Though a third of those with current debt expect to pay it off within a year and about a quarter expect to pay it within one to two years, nearly one in five adults with health care debt think they will never be able to pay it off.[79]



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.[80] 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.[81]

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

[75] 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.
[76] Lopes, L., Kearney, A., et al, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, June 16, 2022 (using results from the Kaiser Family Foundation Health Care Debt Survey), available at https://www.kff.org/health-costs/report/kff-health-care-debt-survey/ (last viewed on March 12, 2023).
[77] Id.
[78] Id.
[79] Id.
[80] 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/.
[81] Id.

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).[82] The following illustration provides additional detail on the type of medical services that led to an accumulation of medical debt.[83]

More than two thirds of hospitals sue or take other legal action against patients with outstanding bills. Nearly 25 percent sell patient medical debt to collection agencies, who in turn can pursue patients for years to collect on unpaid bills. Further, 1 in 5 providers deny nonemergency care to people with outstanding medical debt.

Recognizing the inherent difficulties associated with medical debt, the major credit rating companies recently agreed to exclude from an individual's credit report medical debts that have been paid off and unpaid medical debts less than $500.

Personal Credit Rating

When a person first takes out a line of credit as an individual—a first credit card or a loan to pay for college, for example—this begins a personal credit history and the process of building a personal credit score. This score is linked to a person's Social Security Number.

From then on, the score reflects one's personal financial history. If a person always pays bills on time, does not use too much of the available credit at once, and avoids negative information like foreclosures and charge-offs, the person will develop a good personal credit score, also known as a FICO score. If, instead, one carries a balance on lines of credit, fails to develop a diverse mix of credit sources—different credit cards, an automobile loan, and a mortgage, for example—and accrues many "hard inquiries" on your credit score (which occurs when upon application for a new source of credit), the FICO score will be low. Personal credit scores generally range 350-800 with 800 being a "perfect" score.

Effective July 1, 2022, the three largest credit reporting agencies, Equifax, Experian, and TransUnion, starting removing medical debt remarks from millions of credit reports, which will eliminate an estimated 70 percent of negative medical debt remarks. Further actions include:

- Paid medical debt that was in collections will no longer be included on consumer credit reports.
- Unpaid medical debt that is currently in collections for one year will be reported on credit reports. This is an increase from six months that was enacted in 2017.
- Starting in 2023, medical debt in collections under $500 will not appear on credit reports.

In 2018-2020, more than a quarter of the nation's largest hospitals and health systems pursued nearly 39,000 legal actions regarding consumer medical debt.[84]

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:

[82] Id.
[83] Id., figure 4.
[84] Using data from Johns Hopkins University, study authors analyzed the top 100 hospitals in the U.S. (by revenue) to measure debt collection methods and frequency, average charges markups and billing scores, and compare that data to safety grades and charity care ratings, by hospital type (government, nonprofit and for-profit). See, "How America's top hospitals hound patients with predatory billing", July 2021, available at https://www.axios.com/hospital-billing (last viewed on March 26, 2023). Twelve Florida hospitals were included in the analysis, with a wide range of scores in each category.

- 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.[85] Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[86]

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;[87] proceeds from life insurance policies;[88] wages or unemployment compensation payments due certain deceased employees;[89] disability income benefits;[90] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[91] $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.[92]

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.[93] 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.[94] 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.[95] 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.[96]

Statutes of Limitations

A statute of limitations bars a lawsuit's filing after a certain amount of time elapses following an injury.[97] This time period typically begins to run when a cause of action accrues (that is, on the date of the injury), but may also begin to run on the date the injury is discovered or on which it would have been discovered with reasonable efforts.[98] In other words, a statute of limitations bars the available civil remedy if a lawsuit is not timely filed after an injury.

Chapter 95, F.S., contains the bulk of Florida's statutes of limitations. Specifically, s. 95.11, F.S., details a variety of statutes of limitation for legal actions other than for recovery of real property. Some of the limitations require legal actions to be commenced as follows:

- WITHIN TWENTY YEARS.—An action on a judgment or decree of a court of record in this state.[99]

[85] Art. X, s. 4(a), Fla. Const.
[86] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.
[87] S. 222.11, F.S.
[88] S. 222.13, F.S.
[89] S. 222.15, F.S.
[90] S. 222.18, F.S.
[91] S. 222.22, F.S.
[92] S. 222.25, F.S.
[93] Art. 1, s. 8, cl. 4, U.S. Const.
[94] 11 U.S.C. s. 522.
[95] 11 U.S.C. s. 522(b).
[96] S. 222.20, F.S.
[97] Legal Information Institute, Statute of Limitations, https://www.law.cornell.edu/wex/statute_of_limitations (last visited March 23, 2023).
[98] Id.
[99] S. 95.11(1), F.S.

- WITHIN FIVE YEARS.—
    - An action on a judgment or decree of any court, not of record, of this state or any court of the United States, any other state or territory in the United States, or a foreign country.
    - A legal or equitable action on a contract, obligation, or liability founded on a written instrument, except for an action to enforce a claim against a payment bond, which shall be governed by the applicable provisions of paragraph (5)(e), s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), and except for an action for a deficiency judgment governed by paragraph (5)(h).
    - An action to foreclose a mortgage.
    - An action alleging a willful violation of s 448.110.
    - Notwithstanding paragraph (b), an action for breach of a property insurance contract, with the period running from the date of loss.[100]
- WITHIN FOUR YEARS.—
    - An action founded on negligence.
    - An action relating to the determination of paternity, with the time running from the date the child reaches the age of majority.
    - An action founded on the design, planning, or construction of an improvement to real property, with the time running from the date of actual possession by the owner, the date of the issuance of a certificate of occupancy, the date of abandonment of construction if not completed, or the date of completion of the contract or termination of the contract between the professional engineer, registered architect, or licensed contractor and his or her employer, whichever date is latest, with some exceptions.
    - An action to recover public money or property held by a public officer or employee, or former public officer or employee, and obtained during, or as a result of, his or her public office or employment.
    - An action for injury to a person founded on the design, manufacture, distribution, or sale of personal property that is not permanently incorporated in an improvement to real property, including fixtures.
    - An action founded on a statutory liability.
    - An action for trespass on real property.
    - An action for taking, detaining, or injuring personal property.
    - An action to recover specific personal property.
    - A legal or equitable action founded on fraud.
    - A legal or equitable action on a contract, obligation, or liability not founded on a written instrument, including an action for the sale and delivery of goods, wares, and merchandise, and on store accounts.
    - An action to rescind a contract.
    - An action for money paid to any governmental authority by mistake or inadvertence.
    - An action for a statutory penalty or forfeiture.
    - An action for assault, battery, false arrest, malicious prosecution, malicious interference, false imprisonment, or any other intentional tort, except as provided in subsections (4), (5), and (7).
    - Any action not specifically provided for in these statutes.
    - An action alleging a violation, other than a willful violation, of s. 448.110.[101]
- WITHIN TWO YEARS.—
    - An action for professional malpractice, other than medical malpractice, whether founded on contract or tort; provided that the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence.
    - An action for medical malpractice shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence; however, in no event shall the action be commenced later than 4 years from the date of

[100] S. 95.11(2), F.S.
[101] S. 95.11(3), F.S.

the incident or occurrence out of which the cause of action accrued, except that this 4-year period shall not bar an action brought on behalf of a minor on or before the child's eighth birthday, providing for an extension in certain circumstances.
    - An action to recover wages or overtime or damages or penalties concerning payment of wages and overtime.
    - An action for wrongful death.
    - An action founded upon a violation of any provision of chapter 517, with the period running from the time the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence, but not more than 5 years from the date such violation occurred.
    - An action for personal injury caused by contact with or exposure to phenoxy herbicides while serving either as a civilian or as a member of the Armed Forces of the United States during the period January 1, 1962, through May 7, 1975; the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence.
    - An action for libel or slander.[102]
- WITHIN ONE YEAR.—
    - An action for specific performance of a contract.
    - An action to enforce an equitable lien arising from the furnishing of labor, services, or material for the improvement of real property.
    - An action to enforce rights under the Uniform Commercial Code—Letters of Credit, chapter 675.
    - An action against any guaranty association and its insured, with the period running from the date of the deadline for filing claims in the order of liquidation.
    - Except for actions governed by s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), an action to enforce any claim against a payment bond on which the principal is a contractor, subcontractor, or sub-subcontractor as defined in s. 713.01, for private work as well as public work, from the last furnishing of labor, services, or materials or from the last furnishing of labor, services, or materials by the contractor if the contractor is the principal on a bond on the same construction project, whichever is later.
    - Except for actions described in subsection (8), a petition for extraordinary writ, other than a petition challenging a criminal conviction, filed by or on behalf of a prisoner as defined in s. 57.085.
    - Except for actions described in subsection (8), an action brought by or on behalf of a prisoner, as defined in s. 57.085, relating to the conditions of the prisoner's confinement.
    - An action to enforce a claim of a deficiency related to a note secured by a mortgage against a residential property that is a one-family to four-family dwelling unit. The limitations period shall commence on the day after the certificate is issued by the clerk of court or the day after the mortgagee accepts a deed in lieu of foreclosure.[103]

Effect of Proposed Changes

CS/HB 1413 increases patient access to health care cost information, and offers a measure of protection from unreasonable and burdensome medical debt. The various provisions apply to hospitals, ambulatory surgical centers, health insurers, and HMOs. The bill brings provisions from recent federal law and regulation into the Florida Statutes; in doing so, the bill requires compliance by facilities and insurers as a condition of state licensure, thus ensuring that these provisions will be fully adopted and adequately enforced in Florida.[104]

Facility Price Transparency

Facility Billing Estimates

[102] S. 95.11(4), F.S.
[103] S. 95.11(5), F.S.
[104] SS. 395.003, 395.301, 408.802, 624.401, and 641.22, F.S.

The bill requires that all patients receive cost-of-care information prior to receiving scheduled, nonemergency treatment in hospitals and ambulatory surgical centers, and from physicians providing services in those facilities.

At present, licensed facilities are required to provide a customized estimate of "reasonably anticipated charges" to a patient for treatment of the patient's specific condition, *upon request of the patient*. The bill makes these personalized estimates mandatory, rather than dependent on patient requests. A facility must submit the estimate of charges to a patient's health plan at least 3 business days before a service is to be furnished, according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after the service is scheduled;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after a service is scheduled.

By requiring facilities to provide a good-faith estimate of charges to each patient in advance of treatment, the bill mirrors the requirements of the federal No Surprises Act. Compliance with the Act was required by January 1, 2022.

Shoppable Services

The bill 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.[105] 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.

Facility 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, for 30 days after notifying a patient in writing that a collections action will commence, and while the patient is negotiating in good faith the final amount of the bill or is complying with the terms of a payment plan with the facility. 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;

[105] Supra, FN 47.

- 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.

Lastly, the bill creates a three-year statute of limitations for any legal action related to medical debt for services rendered by a facility licensed under chapter 395, F.S., such as hospitals, ambulatory surgical centers, and urgent care centers. The statute of limitations begins running on the date that the facility refers the debt to a third-party collections entity.

Insurer Price Transparency

Shared Savings Programs

The bill establishes an accounting standard to remove a barrier to shared savings incentive programs. It specifies that insurer shared savings payments to patients shall be counted as medical expenses for rate development and rate filing purposes.[106] This change aligns Florida law with the federal regulations that became final in 2020.[107]

Advanced Explanation of Benefits

Effective July 1, 2022, the bill requires health plans to issue an advance explanation of benefits statement when a covered patient schedules a service in a hospital or ambulatory surgical center. This requirement builds on the facility charges estimate provision in the bill. Once a facility notifies a health plan that a patient has scheduled a medical service, the health plan must prepare a personalized estimate of costs for the patient in accordance with the federal No Surprises Act. A health plan must provide an advanced explanation of benefits to the patient according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after receiving the estimate of charges from the facility;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after receiving the estimate of charges from the facility.

Health insurers and HMOs were required comply with the federal Act on January 1, 2022.

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

[106] Current law indicates that a shared savings incentive offered by a health plan is "not an administrative expense for rate development or rate filing purposes," but does not affirmatively categorize the expense. SS. 627.6387, 627.6648, and 641.31076, F.S.
[107] Supra, FN 51.

B. SECTION DIRECTORY:

Section 1: Amends s. 95.11, F.S., relating to limitations other than for the recovery of real property.
Section 2: Creates s. 222.26, F.S., relating to additional exemptions from legal process concerning medical debt.
Section 3: Amends s. 395.301, F.S., relating to price transparency; itemized patient statement or bill; patient admission status notification.
Section 4: Creates s. 395.3011, F.S., relating to billing and collection activities.
Section 5: Creates s. 627.445, F.S., relating to advanced explanation of benefits.
Section 6: Amends s. 627.6387, F.S., relating to shared savings incentive program.
Section 7: Amends s. 627.6648, F.S., relating to shared savings incentive program.
Section 8: Amends s. 641.31076, F.S., relating to shared savings incentive program.
Section 9: Amends s. 475.01, F.S., relating to definitions.
Section 10: Amends s. 475.611, F.S., relating to definitions.
Section 11: Amends s. 517.191, F.S., relating to injunction to restrain violations; civil penalties; enforcement by the Attorney General.
Section 12: Amends s. 768.28, F.S., relating to waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.
Section 13: Provides an effective date of October 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:

The bill may increase costs for facilities licensed under ch. 395, F.S., by requiring them to issue cost estimates for all non-emergency patients, but only if the facilities are out of compliance with the current federal requirement to provide these estimates.

Facilities may forego revenues due to the bill's limits on the use of extraordinary collection activities; however, some facilities may already be providing similar due process for patients, such that the bill will have little impact on them.

The bill may have a negative, but indeterminate, fiscal impact on health insurers and HMOs, due to the costs of producing advanced explanations of benefits for insureds and subscribers, triggered by the estimates provided by facilities, but only if these health plans are out of compliance with the current federal requirement to provide these to subscribers.

Additionally, the bill's increased dollar limit on personal property exemptions under ch. 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. The bill does not appear to impact municipalities or counties.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority to implement the bill provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 28, 2023, the Healthcare Regulation Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment changed the effective date from July 1, 2023, to October 1, 2023.

The bill was reported favorably as amended. The analysis is drafted to the committee substitute as passed by the Healthcare Regulation Subcommittee.