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 268
INTRODUCER:	Senator Brodeur
SUBJECT:	Health Care Expenses
DATE:	April 2, 2023
REVISED:	

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

I. Summary:

SB 268 amends and creates multiple sections of law in order to limit how hospitals and ambulatory surgical centers (ASC) may collect medical debt and to exclude certain property from being collected through legal action on such debt. The bill prohibits certain billing and debt collection practices and limits legal actions on medical debt to three years after the debt has been referred to a collection service.

The bill also requires a hospital or ASC to post standard charges for specified services on its website and establish a process for reviewing and responding to grievances from patients. Additionally, the bill amends a provision of current law that requires hospitals and ASCs to provide estimates of anticipated charges for nonemergency services, to require that facilities also must provide such estimates to the patient's health insurer. The health insurer, in turn, is required under the bill to prepare an "advance explanation of benefits" for the patient, within a specified time frame prior to the service being provided, based on the facility's estimate.

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

II. Present Situation:

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).[1] 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.[2] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

[1] Section 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[2] Section 381.026(3), F.S.

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient's knowledge of rights and responsibilities.

A patient has the right to request certain financial information from health care providers and facilities.[3] 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.[4] Estimates must be written in language "comprehensible to an ordinary layperson."[5] 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.[6] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[7]

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

- 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 the AHCA may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[8]

[3] Section 381.026(4)(c), F.S.
[4] Section 381.026(4)(c)3., F.S.
[5] *Id.*
[6] *Id.*
[7] Section 381.026(4)(c)5., F.S.
[8] Section 381.0261, F.S.

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[9] to publish a schedule of charges for the medical services offered to patients.[10] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[11] 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.[12] 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 two-year period.[13]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[14] This applies to any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures, and licensed health care clinics that operate in three or more locations. The schedule requirements for urgent care centers are the same as those established for primary care providers.[15] 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.[16]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[17] must provide, within seven 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[18] 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 seven days of discharge or release, the licensed facility must provide an itemized statement, in

[9] Section 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.
[10] Section 381.026(4)(c)3., F.S.
[11] *Id.*
[12] *Id.*
[13] Section 381.026(4)(c)4., F.S.
[14] Section 395.107(1), F.S.
[15] Section 395.107(2), F.S.
[16] Section 395.107(6), F.S.
[17] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.
[18] 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.

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.[19] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[20] Hospitals and other facilities post a link to this site – known as Florida Health Finder – to comply with the price transparency requirements. The cost information is searchable, 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.[21]

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.[22]

Federal Price Transparency Laws and Regulations

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[23] 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.[24]

[19] Section 395.301, F.S.
[20] Section 408.05(3)(c), F.S.
[21] *Id.*
[22] Section 456.0575(2), F.S.
[23] 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).
[24] *Id.*

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 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.[25]

Health Insurer Transparency

On October 29, 2020, the federal departments of Health and Human Services, Labor, and Treasury finalized regulations[26] 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 services, to encourage shopping and price competition among providers.[27]

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. Under the federal regulations, this requirement took effect 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.[28]

[25] *Supra* note 23.
[26] 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).
[27] Health Affairs Blog, *Trump Administration Finalizes Transparency Rule for Health Insurers,* November 1, 2020, available at https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last visited March 31, 2023).
[28] *Supra* note 23.

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 (ACA). 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.[29] The ACA established minimum MLR requirements for group and individual health insurance plans.[30] Under the ACA, 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.[31] Further, the law requires a health plan that does not meet these standards to provide annual rebates to individuals enrolled in the plan.[32]

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.[33] Thus, a health plan providing shared savings to members will receive an equivalent credit towards meeting the MLR standards established by ACA. In theory, this policy should provide an additional incentive for insurers to adopt shared savings programs if they have not already done so.

The Federal "No Surprises" Act

On December 27, 2020, Congress enacted the No Surprises Act as part of the Consolidated Appropriations Act of 2021.[34] 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 federal departments of Health and Human Services, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.[35]

Estimates – Facilities

In the spirit of price transparency, the No Surprises Act establishes the concept of an "advanced explanation of benefits" (AEOB) 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).[36]

---

[29] "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 visited March 31, 2023).
[30] Patient Protection and Affordable Care Act, s. 1001; 42 U.S.C. 300gg-18.
[31] *Supra* note 23.
[32] *Id.*
[33] 45 CFR Part 158.
[34] Public Law 116-260. The No Surprises Act is found in Division BB of the Act.
[35] *Id.*
[36] Public Law 116-260, Division BB, Section 112.

Estimates – Health Plans

Under the No Surprises Act, once the "good faith estimate" has been shared with a patient's health plan, the plan must then develop the AEOB. This personalized cost estimate must include the following:

- 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 (e.g., 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.[37]

Furthermore, the Act directs the Secretary of Health and Human Services 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.[38]

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.[39] 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.[40] Another review of more than 6,400 hospitals in 2022 indicated widespread non-compliance with the federal transparency rule in that more than 63 percent of hospitals were estimated to be non-compliant.[41] According to that review, only 38 percent of Florida hospitals were in compliance.[42]

---

[37] Public Law 116-260, Division BB, Section 111.
[38] *Supra* note 30.
[39] 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 visited March 31, 2023).
[40] *Id.*
[41] 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 visited March 31, 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.
[42] *Id.*, pg. 4.

Medical Debt

Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. Nationwide, over 100 million people have some form of medical debt.[43] 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.[44] A more recent analysis, which considered only the impact of hospital charges, found that four percent of U.S. bankruptcies among non-elderly adults resulted from hospitalizations.[45] Four in ten U.S. adults have some form of health care debt.[46] 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.[47] 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.[48] 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.[49]

Medical Debt Collection Process

Current law provides a court process for the collection of lawful debts, including medical debts. A creditor may sue a debtor and, if the creditor prevails, the creditor may receive a final judgment awarding monetary damages. If the debtor does not voluntarily pay the judgment, the creditor has several legal means to collect on the debt, including:

- Wage garnishment.
- Garnishment of money in a bank account.
- Directing the sheriff to seize assets, sell them, and give the proceeds to the creditor.

In order to protect debtors from being destitute, current law provides that certain property is exempt from being taken by a creditor. The Florida Constitution provides that the debtor's homestead and $1,000 of personal property is exempt.[50] Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[51]

---

[43] 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 visited March 31, 2023).

[44] 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 (last visited March 31, 2023)

[45] 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 (last visited Apr. 2, 2023).

[46] 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 visited March 31, 2023).

[47] *Id.*

[48] *Id.*

[49] *Id.*

[50] Art. X, s. 4(a), Fla. Const.

[51] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.

In addition to the protection from creditors contained in the Florida Constitution, chapter 222, F.S., protects other personal property from certain claims of creditors and legal process: garnishment of wages for a head of family;[52] proceeds from life insurance policies;[53] wages or unemployment compensation payments due certain deceased employees;[54] disability income benefits;[55] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[56] $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.[57]

Bankruptcy is a means by which a person's assets are liquidated in order to pay that person's debts under court supervision. The U.S. Constitution gives Congress the right to uniformly govern bankruptcy law.[58] 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.[59] 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.[60] 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.[61]

III. Effect of Proposed Changes:

Medical Debt Protections

SB 268 amends and creates several sections of law in order to establish new protections for consumers who carry medical debt owed to a hospital or ASC.

The bill creates s. 222.26, F.S., in order to shield a debtor's interest, up to $10,000, in a single motor vehicle and, if the debtor does not claim or receive the benefits of a homestead exemption,[62] up to $10,000 of personal property. Under the bill, this property is exempt from attachment, garnishment, or other legal process in an action on such debt.

The bill also amends s. 95.11, F.S., to establish that a legal action to collect such medical debt must commence within three years starting at the time the facility refers the debt to a third party for collection.

[52] Section 222.11, F.S.
[53] Section 222.13, F.S.
[54] Section 222.15, F.S.
[55] Section 222.18, F.S.
[56] Section 222.22, F.S.
[57] Section 222.25, F.S.
[58] Art. 1, s. 8, cl. 4, U.S. Const.
[59] 11 U.S.C. s. 522.
[60] 11 U.S.C. s. 522(b).
[61] Section 222.20, F.S.
[62] Under s. 4, Art. X of the State Constitution

The bill creates s. 395.3011, F.S., to prohibit certain billing and collection activities related to such medical debt. The bill defines the term "extraordinary collection action" to mean any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care covered under the facility's financial assistance policy:

- Selling the individual's debt to another party.
- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
- Deferring, denying, or requiring a payment before providing medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the facility's financial assistance policy.
- Actions that require a legal or judicial process, including, but not limited to:
  - Placing a lien on the individual's property;
  - Foreclosing on the individual's real property;
  - Attaching or seizing the individual's bank account or any other personal property;
  - Commencing a civil action against the individual;
  - Causing the individual's arrest; or
  - Garnishing the individual's wages.

The bill prohibits a hospital or ASC from engaging in an extraordinary collection action:

- Before the facility has made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy for the care provided and, if eligible, before a decision is made by the facility on the patient's application for such financial assistance;
- Before the facility has provided the individual with an itemized statement or bill;
- During an ongoing grievance process as described in s. 395.301(6) or an ongoing appeal of a claim adjudication;
- Before billing any applicable insurer and allowing the insurer to adjudicate a claim;
- For 30 days after notifying the patient in writing, by certified mail, or by other traceable delivery method, that a collection action will commence absent additional action by the patient; or
- While the individual:
  - Negotiates in good faith the final amount of a bill for services rendered; or
  - Complies with all terms of a payment plan with the facility.

The bill amends s. 395.301, F.S., to require each hospital and ASC to establish an internal process for reviewing and responding to grievances from patients. The process must allow a patient to dispute charges that appear on the patient's itemized statement or bill and the facility must prominently post on its website and print on each itemized statement or bill, in bold print, the instructions for initiating, and the direct contact information required to initiate, a grievance. The facility must respond to a patient's grievance within seven business days after the patient formally files the grievance.

Price Transparency Provisions

SB 268 amends s. 395.301, F.S., to require a hospital or an ASC to post on its website a consumer-friendly list of standard charges for at least 300 shoppable health care services. If the facility posts less than 300 services, it must include each service it provides. The bill defines:

- "Shoppable health care service" to mean a service that can be scheduled by a health care consumer in advance. The term includes, but is not limited to, the services described in s. 627.6387(2)(e), F.S.,[63] and any services defined in regulations or guidance issued by the U.S. Department of Health and Human Services.
- "Standard charge" to mean the same as that term is defined in regulations or guidance issued by the U.S. Department of Health and Human Services for purposes of hospital price transparency.

The bill also amends provisions requiring a hospital or ASC to provide a good faith estimate for nonemergency medical services to a patient. The bill requires this estimate to be provided to the patient or prospective patient upon scheduling the medical service, rather than within seven days of receiving the request for the service as under current law, and also requires the facility to provide the estimate to the patient's health insurer[64] and to the patient at least three business days before the service but no more than one business day after the service is scheduled, or three business days after the service is scheduled if the service is scheduled at least ten days in advance.

The bill removes current-law provisions that require the facility to take action to educate the public that such estimates are available upon request and that specify that the estimate does not preclude the actual charges from exceeding the estimate.

The bill creates s. 627.445, F.S., to require a health insurer to prepare an "advance explanation of benefits" (AEB) after receiving an estimate from a hospital or ASC. The bill defines "health insurer" as a health insurer issuing individual or group coverage or a health maintenance organization issuing coverage through an individual or a group contract. The AEB must be provided to the patient no later than one business day after the insurer receives the estimate or no later than three business days for services scheduled at least ten business days in advance. At a minimum, the AEB must include detailed coverage and cost-sharing information pursuant to the federal No Surprises Act.

Shared Savings Incentive Programs

The bill amends ss. 627.6387, 627.6648, and 641.31076, F.S. to specify that a health insurer or health maintenance organization must count a shared saving incentive program as a medical

[63] These services include clinical laboratory services, infusion therapy, inpatient and outpatient surgical procedures, obstetrical and gynecological services, inpatient and outpatient nonsurgical diagnostic tests and procedures, physical and occupational therapy services, radiology and imaging services, prescription drugs, services provided through telehealth, and any additional services published by the Agency for Health Care Administration that have the most significant price variation pursuant to s. 408.05(3)(m).
[64] As defined in s. 627.445(1), F.S.

expense for rate development and rate filing purposes. This change removes a barrier to such programs and aligns Florida law with federal law.[65]

Conforming Changes

The bill amends ss. 475.01 and 475.611, F.S., to make conforming cross-reference changes.

Effective Date

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

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:

Article II, Section 3, of the Florida Constitution has been interpreted by Florida courts to prohibit the Legislature from delegating its legislative power to others.[66] Under this non-delegation principle, Florida courts have held that the Legislature may enact laws that adopt federal statutes or other federal regulations in existence and in effect at the time the Legislature acts; however, if the Legislature incorporates into a Florida statute a *future* federal act or regulation, courts have held that such incorporation constitutes an unconstitutional delegation of legislative power.[67]

However, when a statute incorporates a federal law or regulation by reference, in order to avoid holding the subject statute unconstitutional, Florida courts generally interpret the statute as incorporating only the federal law or regulation in effect on the date of the

[65] *Supra* note 23.
[66] *Abbott Laboratories v. Mylan Pharmaceuticals, Inc.*, 15 So.3d 642 (Fla. 1d DCA 2009), citing *Gallagher v. Motors Ins. Corp.*, 605 So.2d 62, 71 (Fla. 1992).
[67] *State v. Rodriquez*, 365 So.2d 157, 160 (Fla.1978).

Legislature's action to enact the Florida law, reasoning that the Legislature is presumed to have intended to enact a valid and constitutional law.[68]

Lines 106-115 of the bill define the terms "shoppable health care service" and "standard charge" with reference to how those terms are defined in "regulations or guidance issued by the United States Department of Health and Human Services." Considering that the bill does not specify that it is referring to such definitions as they exist at a specific date prior to the enactment of the bill, these references may be considered an unauthorized delegation of legislative powers if interpreted to make reference to future revisions of those definitions in federal law and may be interpreted to maintain the meaning of how those federal definitions stand on the date the bill becomes effective instead of incorporating such future revisions.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 268 may have an indeterminate positive fiscal impact on consumers of health care services at hospitals and ASCs through providing additional price transparency prior to the consumer obtaining a health care service and through protecting the consumer against certain debt collection practices for medical debt. The bill may have an indeterminate negative fiscal impact on hospitals, ASCs, and health insurers related to meeting the new requirements in the bill and on hospitals and ASCs that may not be able to collect on medical debt that they may have collected prior to the passage of the bill.

C. Government Sector Impact:

The Office of the State Courts Administrator reports that the State Courts System receives $195 in filing fees for each civil proceeding, and those funds are deposited into the State Courts Revenue Trust Fund (SCRTF). To the extent that the number of such proceedings will be reduced by the bill's prohibition against hospitals and ASCs pursuing "extraordinary collection activities," combined with the bill's other limitations related to the collection of medical debt, the bill will negatively impact deposits into the SCRTF. The extent of this impact is indeterminate.[69]

The AHCA has not provided an estimate of the costs it will incur under the bill's numerous measures that increase the regulation of hospitals and ASCs, both of which are licensed and regulated by the AHCA. By requiring new regulatory and disciplinary actions by the AHCA to enforce the bill's new requirements, the bill will have a negative

[68] *Id.*
[69] Office of the State Courts Administrator, *2023 Judicial Impact Statement: HB 1413*, Mar. 22, 2023 (on file with the Senate Committee on Health Policy).

fiscal impact on that agency. The extent of this impact is unknown without an estimate from the AHCA.

VI. Technical Deficiencies:

Lines 121-122 of the bill require a hospital or ASC to provide the good faith estimate to a patient "upon scheduling a medical service." However, lines 126-132 require the facility to provide the estimate to the patient "no later than one business day after the service is scheduled" (or three business days in certain scenarios). As such, it is unclear when a facility is required to provide the estimate to the patient or whether the facility must provide the estimate to the patient twice.

VII. Related Issues:

Line 128 requires the good faith estimate to be provided by the hospital or ASC to the health insurer and to the patient "at least 3 business days before a service is to be furnished." It may be impossible for a facility to meet this deadline if a service is to be furnished less than three days after it is scheduled and may preclude services from being furnished less than three days after they are scheduled.

The federal No Surprises Act requires the issuance of an "advanced" explanation of benefits. Meanwhile, SB 268 requires the issuance of an "advance" explanation of benefits.

Many of the bill's new requirements placed on hospitals, ASCs, and insurers are already required under federal law. For example, the federal Centers for Medicare & Medicaid Services (CMS) reports that, "CMS expects hospitals to comply with these legal requirements and is actively enforcing these rules to ensure people know what a hospital charges for items and services. The public is invited to submit a complaint to CMS if it appears that a hospital has not posted information online."[70] It is unclear how much duplicative effort and confusion would be created by dual enforcement of these laws under the enactment of SB 268.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 95.11, 395.301, 627.6387, 627.6648, 641.31076, 475.01, 475.611, 517.191, and 768.28.

This bill creates the following sections of the Florida Statutes: 222.26, 395.3011, and 627.445.

[70] Centers for Medicare & Medicaid Services, *Hospital Price Transparency Frequently Asked Questions (FAQs)*, pg. 21, available at: https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf (last visited Apr. 2, 2023).

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.