Committee on Health Policy

CS/CS/HB 1175 — Transparency in Health Care

by Health and Human Services Committee; Health Care Appropriations Subcommittee; Rep. Sprowls and others (CS/SB 1496 by Appropriations Committee; and Senators Bradley and Gaetz)

The bill increases the transparency and availability of health care pricing and quality of service information to enable consumers to make informed choices regarding health care treatment. The Agency for Health Care Administration (AHCA) is required to contract with a vendor to provide a consumer-friendly, Internet-based platform that allows a consumer to research the cost of health care services and procedures. The AHCA is to select the vendor through a competitive procurement process.

Services and procedures will be grouped by a descriptive service bundle to facilitate price comparisons provided in hospitals and ambulatory surgery centers (ASC). Quality indicators for services at the facilities will also be made available to the consumer to assist with health care decision making.

Hospitals and ASCs are required to provide access to the searchable service bundles on their website. Consumers will be presented with the estimated average payment received, excluding Medicaid and Medicare, and estimated payment ranges for each service bundle, by facility, facilities within geographic boundaries, and nationally. The facility must disclose that this information is an estimate of costs and that actual costs will be based on services actually provided to the patient. Additionally, the facility must disclose the facility's financial assistance policies and collection procedures.

The hospital and ASC must notify prospective patients that other health care providers may provide services in the facility and bill separately from the facility. Furthermore, the prospective patient must be informed that these healthcare providers may or may not participate with the same health insurers or health maintenance organizations (HMOs) as the facility. Accordingly, the patient should contact the applicable practitioners to determine the health insurers and HMOs with which the practitioner participates as a network or preferred provider. The facility must provide contact information for the practitioners.

Insurers and HMOs are required to provide on their websites a method for policy holders to estimate their cost-sharing responsibilities by service bundle based on the insured's policy and known plan usage. These estimates shall include both in-network and out-of-network providers. Insurers and HMOs are also required to provide hyperlinks on their website to the AHCA's performance outcome and financial data.

Consumers may request personalized good faith estimates of charges for nonemergency medical services from hospitals, ASCs, and health care practitioners relating to medical services provided in the hospital or ASC. These good faith estimates must be provided to the consumer within 7 days after the consumer's request. The bill provides for a daily fine for non-compliance by

facilities and health care practitioners. The personalized estimate must also inform the patient about the health care provider's financial assistance policies and collection procedures.

A patient may also request an itemized bill or statement from the hospital and ASC after discharge. The requested itemized bill or statement must be provided within 7 days and be specific, written in plain language, and identify all services provided by the facility and any facility fees, as well as rates charged, amounts due, and the payment status. The itemized bill or statement must inform the patient to contact his or her insurer regarding the patient's share of costs. The facility must provide records to verify the bill or statement within 10 days after a request and respond to questions concerning the statement or bill.

The bill requires health insurers and HMOs that participate in the state group health insurance plan or Medicaid managed care to submit all claims data from Florida policy holders, with certain supplemental plan exceptions, to the vendor selected by the AHCA.

Each diagnostic-imaging center operated by a hospital but not located on the hospital grounds is required to post in the reception area prices charged to uninsured persons for the 50 most frequently provided services. The bill prohibits the AHCA from establishing an all-payor claims database or a comparable database without express legislative authority.

If approved by the Governor, these provisions take effect July 1, 2016.
Vote: Senate 34-1; House 116-1

CS/CS/CS/HB 221 — Health Care Services

by Health and Human Services Committee; Appropriations Committee; Insurance and Banking Subcommittee; Rep. Trujillo and others (CS/CS/CS/SB 1442 by Appropriations Committee; Banking and Insurance Committee; Health Policy Committee; and Senator Garcia)

The bill prohibits an out-of-network provider from balance billing members of a preferred provider organization (PPO) or an exclusive provider organization (EPO) for covered emergency services or covered nonemergency services. The bill establishes a payment process for insurers to provide reimbursement for such out-of-network services.

The bill amends the claims resolution process to add several mandatory components and voluntarily steps to resolve billing issues between providers and insurers. The parties may make offers and the other party has 15 days to accept once received. If the party does not accept the offer and the final order amount is greater than 90 percent or less than 110 percent of the offer amount, the party receiving the offer must pay the final order amount to the offering party and is deemed the non-prevailing party.

The bill requires insurers to provide coverage for emergency services without a prior authorization determination and regardless of whether the provider is a participating provider. Applicable cost sharing must be the same for participating or nonparticipating providers for the same services. An insurer is solely liable for the payment of fees to a non-participating provider for covered nonemergency services other than any applicable copays, deductibles and coinsurance when such services are provided in a facility that has a contract with the insurer for the nonemergency services and would have otherwise been obligated to provide services under the contract, and the insured does not have the opportunity to choose a participating provider at the facility. Insurers or health care providers may not balance bill the insured.

The bill also provides that willful noncompliance by a provider (health care practitioners subject to regulation under ch. 456, 458, or 459, F.S.) with the balance billing provisions for covered emergency services and nonemergency services, are grounds for discipline by the Department of Health (DOH) if such noncompliance occurs with such frequency as to constitute a general business practice. Other specified providers (hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers) are required to comply with the balance billing provisions as a condition of licensure.

Additionally, the bill provides that willfully failing to comply with the balance billing provisions with such frequency as to constitute a general business practice is defined as an unfair method of competition and an unfair or deceptive act or practice.

In order to put the public on notice, hospitals are required under the bill to maintain information on their websites with contact information for practitioners and practice groups contracting with the hospital. The website must also provide notice that services may be provided in the hospital by practitioners who bill separately from the hospital and that such practitioners might or might not participate with the same health insurance carriers as the hospital. The bill adds compliance

with these new provisions as a condition of licensure for hospitals, surgical centers, and urgent care centers.

Insurers must also provide on its website, by specialty, a current listing of all participating providers, their address, phone numbers, languages spoken, hospital affiliations, and board certifications. Such lists must be updated monthly with additions and terminations.

Effective January 1, 2017, certain insurance policies must include a specific disclosure warning insureds that limited benefits will be paid when nonparticipating providers are used.

The bill requires a health insurance plan or health maintenance contract to provide coverage for the treatment of Down syndrome through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services.

The bill also provides more detailed provisions relating to the use of a uniform prior authorization form that was also enacted in HB 423 during this Session. The bill expressly provides that the provisions in this act control regardless of the order in which the bills are enacted. In this bill, the prior authorization form, if applicable, must be used beginning January 1, 2017, or six months after rules adopting the prior authorization form take effect, and specific elements to be included in the two-page form are provided.

If approved by the Governor, these provisions take effect July 1, 2016, except where otherwise provided.
Vote: Senate 39-0; House 118-1