HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HHS 24-02 Health Care Expenses
SPONSOR(S): Health & Human Services Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee		Lloyd	Calamas

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.

PCB HHS 24-02 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 has no fiscal impact on state or local government.

The bill has an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

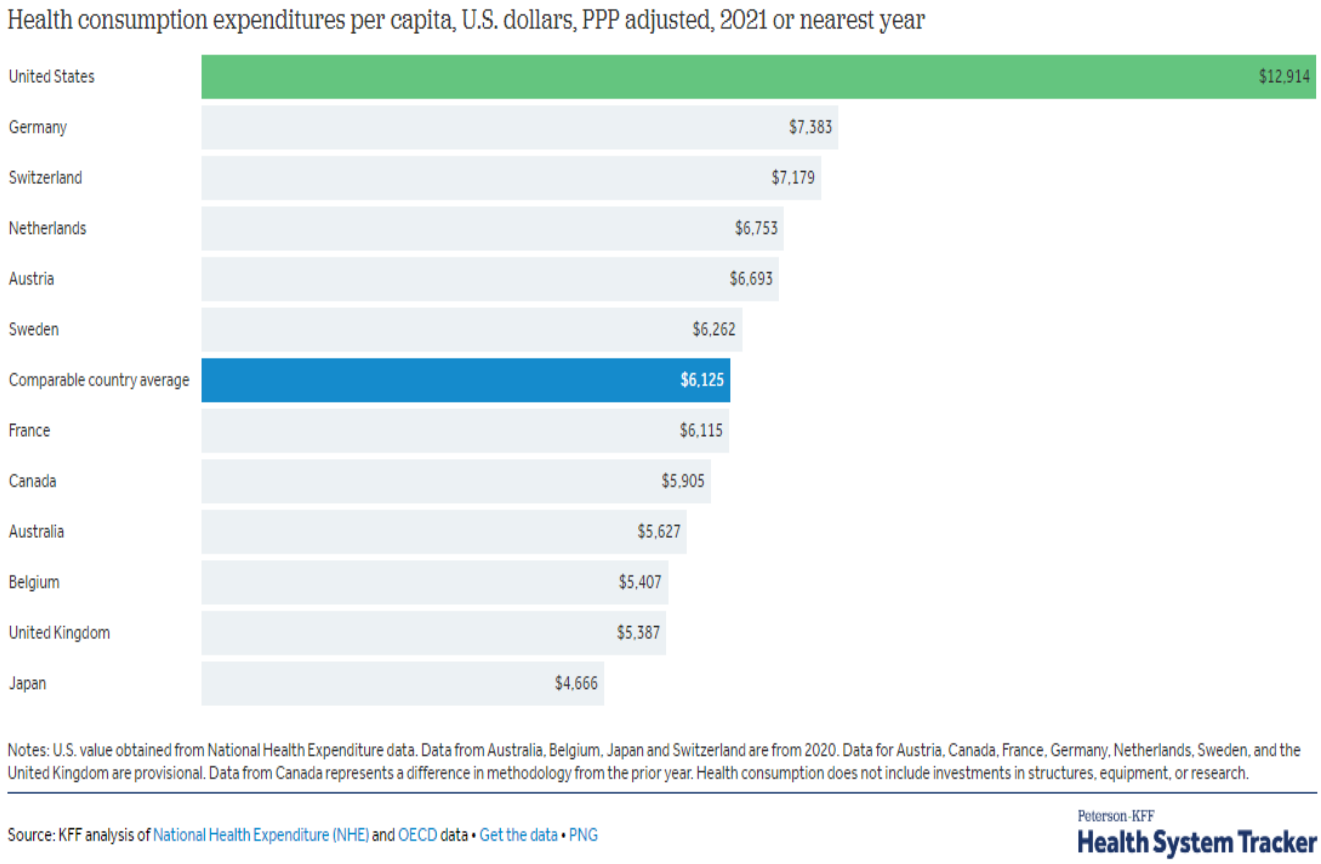
A. EFFECT OF PROPOSED CHANGES:

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] Total national health expenditures grew by $175 billion in 2022 from 2021 with hospital expenditures and retail prescription drugs accounting for approximately one-third of the spending growth.[2]

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 and increased for 2022 to $13,493, more than $5,000 greater than any other high income nation.[3]

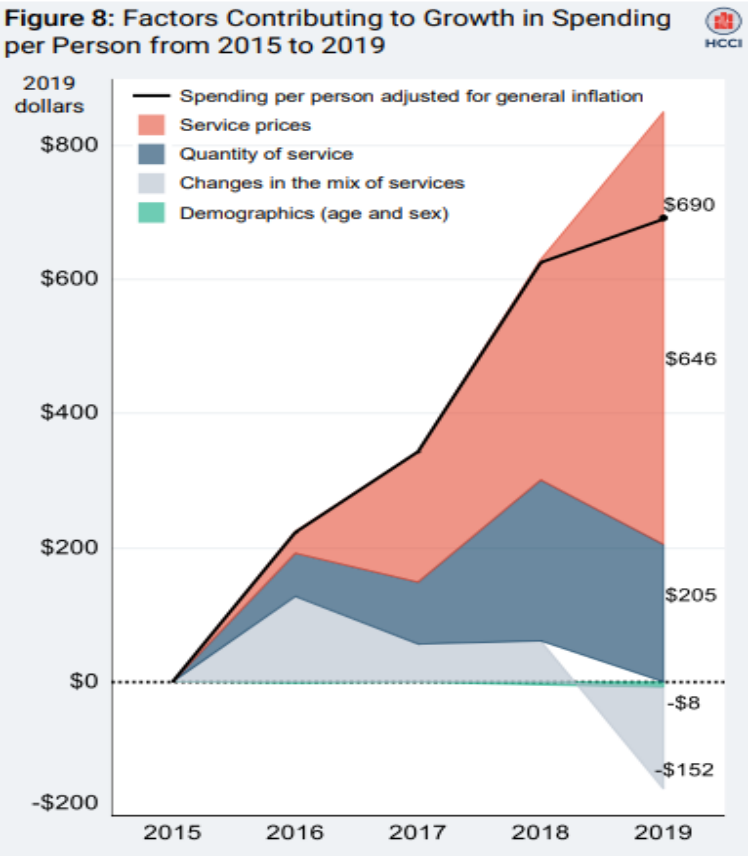


[1] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How has U.S. spending on healthcare changed over time?*, December 15, 2023, available at https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20$%20Billions,%201970-2022 https://healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/ (Last visited on February 18, 2024).

[2] *Id.*

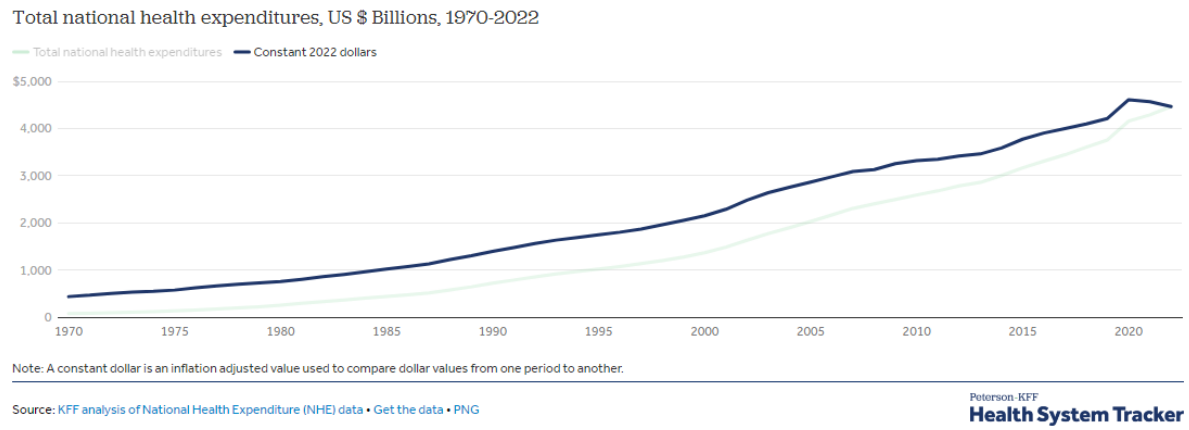
[3] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How does health spending in the U.S. compare to other countries?*, February 9, 2023, available at (https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ (Last visited January 22, 2024). The average amount spent on health per person in comparable countries – $6,125 – is less than half of what the U.S. spends.

The Organization for Economic Cooperation Development estimated that total spending in 2019 in its member countries averaged 8.8 percent of their gross domestic product (GDP), compared with 16.8 percent in the U.S.[4] One study found that United States commercial health spending per enrollee increased by 61.6 percent from 2008 to 2022, faster than both Medicaid and Medicare which rose at 40.8 percent and 21.7 percent, respectively, for the same time period.[5] 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 percent.[6] The following chart details the factors contributing to the growth in spending, per capita, in the United States.[7]



The following chart illustrates the rate of growth in total national health expenditures from 1970 to 2022.[8]

[4] Emma Wagner, et. al., Peterson-KFF Health System Tracker, *How does health spending in the U.S. compare to other countries? (January 23, 2024),* available at https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#GDP%20per%20capita%20and%20health%20consumption%20spending%20per%20capita,%202022%20(U.S.%20dollars,%20PPP%20adjusted) (Last visited February 19, 2024).
[5] *Supra,* note 1.
[6] *Id.*
[7] *Id.*
[8] *Id.*



Health Insurance Expenditures

As a percentage of the country's total expenditures, that number has slowed in recent decades, from a high of 12 percent in the 1970s to the current 9.6 percent for the 2020-2022 period; however, health care spending still consistently exceeds growth in the country's gross domestic product (GDP).[9]

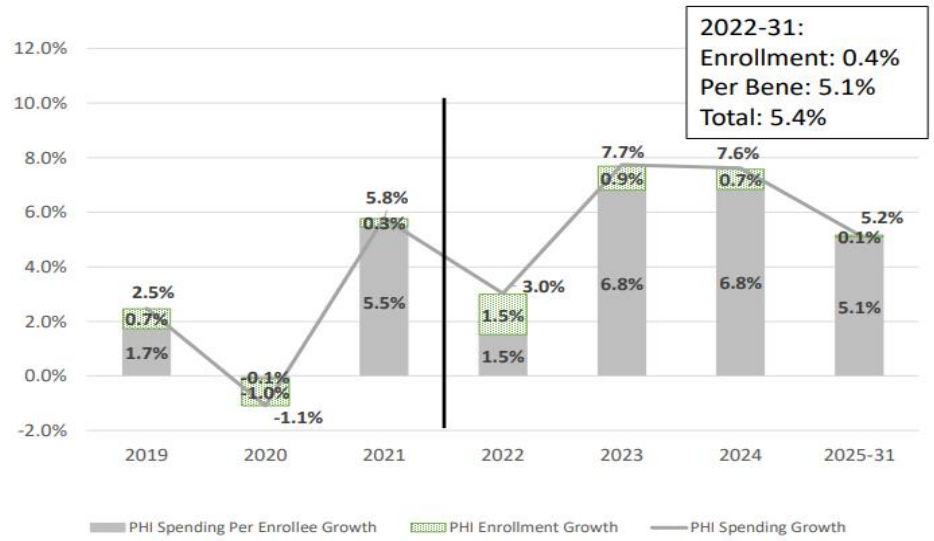
Private insurance expenditures have also been growing at a faster pace than either Medicaid or Medicare spending. In 1970, private health insurance expenditures represented 20.4 percent of total health spending; whereas, for 2022, the percentage had grown to 28.9 percent.[10] Additionally, per enrollee spending by private insurers increased by 61.6 percent from 2008 to 2022, a rate that was faster than the per enrollee spending for public programs such as Medicare and Medicaid. From 2021 to 2022, the rate for private insurers was 4.3 percent while Medicaid rose by 2.2 percent and Medicare by 3.8 percent.[11]

Per enrollee spending for those with private health insurance in 2023 to 2024 is expected to increase at a faster pace than in 2022 due to an increase in health care utilization and health care costs. This growth in the private health insurance market, according to a report by the Office of the Chief Actuary at the Centers for Medicare and Medicaid Services (CMS),[12] is tied to increased enrollment in the Marketplace[13] while additional subsidies were available under the American Rescue Plan Act of 2021 (ARP).[14] Beginning in 2021, the ARP legislation expanded the number of individuals eligible for certain premium tax credits and also provided certain eligible individuals with increased premium tax credits for the purchase of Marketplace coverage.

The CMS Actuary's report shows an average predicted growth rate in national health expenditures (NHE) of 5.4 percent which would outpace the expected average GDP growth rate for the same time period of 4.6 percent.[15]

[9] *Id*.
[10] *Id.*
[11] *Id.*
[12] Centers for Medicare and Medicaid Services, *National Health Expenditures Projections 2022-31: Growth to Stabilize Once Public Health Emergency Ends*, June 14, 2023, Slide 10, available at *https://www.cms.gov/files/document/release-presentation-slides-national-health-expenditure-projections-2022-31-growth-stabilize-once.pdf* (Last visited February 18, 2024).
[13] The Marketplace refers to the federal marketplace, which may also be called the exchange, created by the Patient Protection and Affordable Care Act (PPACA). The purpose of the marketplace is to offer consumers the opportunity to compare a variety of health insurance plans with varying costs and benefits but which meet certain minimum requirements and to purchase such plans with premium tax credits and subsidies, if eligible.
[14] American Rescue Plan of 2021, Pub. Law 117-2 (March 11, 2021).
[15] *Id* at slide 4.

The chart below illustrates the average annual growth in enrollment per beneficiary spending, and total spending, by the designated time period for private health insurance coverage.[16]



NOTE: Average annual growth rates are from previous year shown.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

The reductions shown above for the outlier years of 2025 through 2031 are tied to the expiration of the Marketplace subsidies. These subsidies exist in current law, and when those subsidies expire, the CMS Actuary's office projects an associated enrollment drop of 10 percent or two million beneficiaries in directly purchased health insurance coverage.[17]

Health Care Price Transparency

As consumers bear a greater share of health care costs, and more consumers participate in high deductible health plans (HDHP), consumers need clear, factual and easy to access information about the cost and quality of health care. Such information is essential for consumers if they are to make value-driven health care decisions. To promote consumer involvement and provider accountability, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Price transparency often refers to the availability of provider-specific information on the cost for a specific health care service or set of services to consumers and other interested parties.[18] Price can also be defined as an estimate of a consumer's complete cost for a health care service or bundle of services that reflects any negotiated discounts; is inclusive of all other service or services to the consumer, including hospital, physician, and lab fees; and, identifies a consumer's out-of-pocket cost.[19] Further, price transparency is the easy availability of information, including price disclosure match with quality data, which enables patients and other care purchasers to identify, compare, and choose providers that meet the consumer's desired level of quality and value.[20]

Employee Out of Pocket Costs

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 other out-of-pocket expenses, such as higher copayments or deductibles. According to the *2023 Kaiser Family Foundation Employer Health*

[16] *Supra,* note 12.
[17] *Id.*
[18] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, pg. 2, available at https://www.gao.gov/products/gao-11-791 (Last visited January 22, 2024).
[19] *Id.*
[20] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, pg. 2, available at: https://www.hfma.org/wp-content/uploads/2022/10/Price20Transparency20Report.pdf (Last visited February 18, 2024).

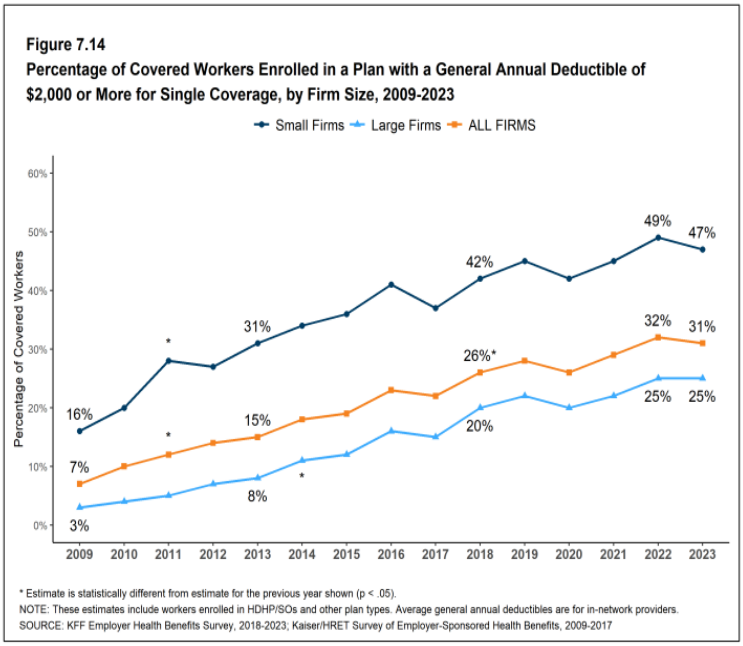
Benefits Survey, 30 percent of Americans with private insurance were enrolled in a HDHP in 2023.[21] Additionally, employees in most firms, 77 percent, do not have a choice of health plans or benefit options, including 26 percent who are in firms where the only offer is a high deductible plan with savings option (HDHP/SO).

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. For 2023, 90 percent of covered workers had a general annual deductible[22] for single coverage that must be met before most services are paid for by their health plan.[23] Ten years ago, the percentage of covered workers with a general annual deductible was 78 percent and 85 percent five years ago.[24]

Among covered workers with a general annual deductible, the 2023 average deductible amount for single coverage across all plan types was $1,735 which is similar to the average amount for 2022 of $1,763.[25] Deductibles can differ greatly by a number of factors, including firm size, region, or whether a plan incorporates other cost sharing provisions. Looking at costs by firm size in 2023; the average amount for single coverage was $2,434 in small firms and $1,478 in large firms.[26]

The 2023 plan deductible averages reflect moderate reductions from the average deductibles for small and large group plans in 2022 which were $2,543 and $1,493, respectively. Seventy-four percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 58 percent in large firms;[27] a similar pattern exists for those in plans with a deductible of at least $2,000 (47 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 2023.[28]



[21] The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey,* October 18, 2023, p. 79, available at https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (Last visited February 19, 2024).
[22] 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. *See* The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey, October 18, 2023, p.106,* available at: https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (Last visited February 19, 2024).
[23] *Id.*
[24] *Id.*, and FIG. 7.2 at p.108.
[25] *Id.*
[26] *Id.,* at 107-108.
[27] *Id.,* at 115 and FIG. 7.13.
[28] *Id.*, at116 and FIG.7.14.

From 2013 to 2023, the average premium contribution required of covered workers with family coverage increased 19 percent and if broken down by just the last five years, the average worker contribution towards family health insurance coverage has increased by 22 percent compared to a 27 percent in workers' wages and 21 percent inflation.[29] Employer contributions to coverage vary widely based on the type of coverage and plan. For small plans, 30 percent of employers pay the entire premium for individual coverage of their workers whereas this is only the case with six percent of large firm employers. For family coverage, however, only small firm employees contribute more than half the premium costs for family coverage, compared to eight percent of covered workers in large firms.[30]

For workers in a HDHP, they may receive contributions from their employer into a savings account which may be used to reduce cost sharing amounts or to cover items not included in the employer's benefit package. In 2023, seven percent of covered workers with a HDHP with a health reimbursement arrangement (HRA)[31] and four percent of covered workers in a Health Savings Account (HSA) – qualified HDHP received an employer contribution to their accounts that was greater than or equal to their annual deductible.[32] An HRA is defined by the Internal Revenue Service (IRS) as an account-based group health plan provided by an employer to provide for the reimbursement of medical expenses under IRS Code section 213(d) and is subject to maximum, fixed-dollar amounts for reimbursements within a specified period, usually a plan year.[33]

For those employees with an HDHP and an HRA, 12 percent of those workers received an employer contribution that if the amount had been applied to the worker's annual deductible, the remaining deductible would be less than $1,000.[34] HSA-qualified HDHPs are required by federal law to have an annual out of pocket maximum of no more than $7,500 for single coverage and $15,000 for family coverage. For HDHPs with an HRA option that are not grandfathered plans, the out of pocket maximum in 2023 was $9,100 for single coverage and $18,200 for family coverage. The average out of pocket maximum for 2023 was $5,456 for HDHP/HRAs and $4,415 for HSA-qualified HDHPs.[35]

Such funding arrangements are more likely to be found in firms with more than 200 workers (57 percent) than smaller firms (29 percent).[36] Enrollment has increased over the past 10 years in HDHP/SOs growing from 10 percent of covered workers in 2013 to 29 percent in 2023.[37]

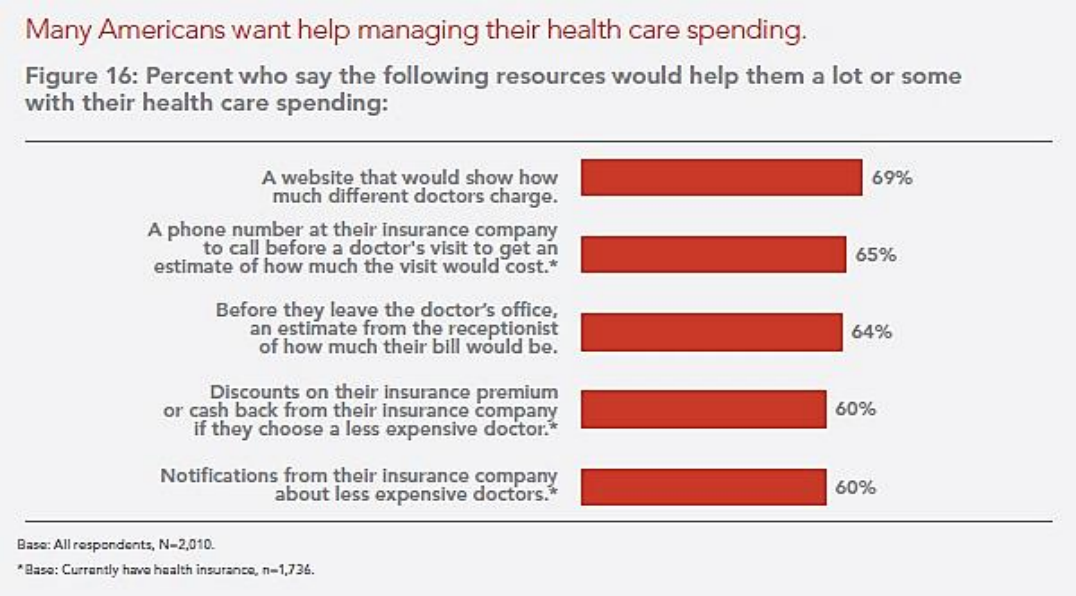
As the percentage of insured individuals taking on greater shares of their health care costs increases, the necessity for easy to access, accurate, and timely information on the availability, cost, and quality of health care services becomes more evident. If consumers are to make informed decisions about their health care and how to spend their health care funds, consumers need obtainable and readable data before and after the delivery of health care services.

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." As noted by the authors, American consumers have historically found it difficult to comparison shop for health care services as information about pricing and service delivery is buried in secrecy and shrouded in medical jargon once

[29] *Id*. at 7.
[30] *Id*. at 9.
[31] A high deductible health plan with a savings option (HDHP/SOs) are health plans which have a deductible of at least $1,000 for individual coverage and $2,000 for family coverage which are paired with a health reimbursement account (HRA), or a high deductible health plan that is considered by federal requirements to be a qualified HDHP. Funds in these savings accounts are pre-tax dollars which may be used to cover out-of-pocket medical expenses and other plan cost sharing.
[32] *Supra*, note 21, at 12.
[33] *Health Reimbursement Arrangements and Other Account Based Group Health Plans*, Supplementary Information – Final Rule, 84 Fed.Reg.119, 28887 (June 20, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf (Last visited January 22, 2024).
[34] *Supra*, note 21, at 12.
[35] *Supra*, note 21, at 147.
[36] *Supra*, note 21, at 140.
[37] *Supra*, note 21, at 142.

information is uncovered by the consumer.[38] As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[39]



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.[40] 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.[41]

Individuals who compared prices stated that research affected their health care choices and saved them money.[42] In addition, the study found that most Americans do not equate price with quality of

[38] 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, p. 3, available at https://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf (Last visited February 18, 2024).
[39] 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/ (Last visited February 18, 2024).
[40] *Id.*, at 3.
[41] *Id.*, at 13.
[42] *Id.*, at 4.

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.[43] Consumers enrolled in HDHP and consumer-directed health plans are more price-sensitive than consumers with plans with less out of pocket 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.[44] 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.[45]

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).[46] 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.[47] 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
- Patient's knowledge of rights and responsibilities.

A patient has the right to request certain financial information from health care providers and facilities.[48] 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.[49] Estimates must be written in language "comprehensible to an ordinary layperson."[50] 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.[51] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[52]

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.

[43] *Id.,* at 14.
[44] 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.air.org/sites/default/files/Resource-rwjf402126.pdf (air.org)(Last visited January 22, 2024).
[45] 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 ,available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.1168 (Last visited January 22, 2024).
[46] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[47] S. 381.026(3), F.S.
[48] S. 381.026(4)(c), F.S.
[49] S. 381.026(4)(c)3., F.S.
[50] *Id.*
[51] *Id*.
[52] S. 381.026(4)(c)5., F.S.

- 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 AHCA may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[53]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[54] to publish a schedule of charges for the medical services offered to patients.[55] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[56] 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.[57] 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.[58]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[59] 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.[60] 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).[61]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility must comply, 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[62] 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 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

[53] S. 381.0261, F.S.
[54] 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.
[55] S. 381.026(4)(c)3., F.S.
[56] *Id.*
[57] *Id*.
[58] S. 381.026(4)(c)4., F.S.
[59] S. 395.107(1), F.S.
[60] S. 395.107(2), F.S.
[61] S. 395.107(6), F.S.
[62] 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 (last viewed January 22, 2024).

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.[63] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[64] 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.[65]

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.[66]

Regulation of Health Care Facilities and Providers

Oversight of Florida's health care facilities and health care providers is often a joint effort by the Agency for Health Care Administration (AHCA) and the Department of Health (department), depending upon the regulatory issue. The AHCA regulates and monitors health care facilities under ch. 395, Part I, F.S., including those defined under s. 395.301, F.S. The definition of a health care facility includes, but is not limited to hospitals, ambulatory surgical centers, and urgent care facilities. As the regulatory entity for enforcement of , the AHCA has the ability, within statutory guidelines, to fine entities for failure to adhere to the law or take other administrative actions, as permitted.

The AHCA 's Bureau of Facility Regulation (bureau) is responsible for the licensure of facilities, registration, and federal certification requirements for 27 different facilities and providers. The bureau implements statutory standards, targets, and guidelines, conducts surveillance, performs assessments and audits, conducts audits, and enforces sanctions and other regulatory actions when necessary.[67]

The Department of Health (department) designates eligible facilities as trauma centers, either as a level I, level II, or a pediatric trauma center if the facility meets the statutory requirements outlined in ch. 395, Part II, F.S., and in ch. 64J—2, F.A.C. Hospitals must complete applications with the department for the appropriate trauma level being sought and certify as to the availability of certain types of providers, provide a description of the trauma team, and satisfy quality management protocols.[68]

The department also licenses and regulates health practitioners for the preservation of the health, safety, and welfare of the public. The department must investigate complaints and reports about health care practitioners which are licensed by the department and may take administrative actions against a practitioner to enforce state laws or regulations.[69]

Federal Price Transparency Laws and Regulations

[63] S. 395.301, F.S.
[64] S. 408.05(3)(c), F.S.
[65] *Id.*
[66] S. 456.0575(2), F.S.
[67] Agency for Health Care Administration, State of Agency Organization and Operation (Revised Feb. 14. 2014), Division of Health Quality Assurance, Bureau of Health Facility Regulation, available at https://ahca.myflorida.com/content/download/4859/file/OrganizationAndOperationStatementRevised.pdf (Last visited February 19. 2024).
[68] Florida Department of Health, *Trauma Center Designation, Application Process, available athttps://www.floridahealth.gov/licensing-and-regulation/trauma-system/trauma-center-designation.html* (Last visited February 19, 2024).
[69] Florida Department of Health, Licensing and Regulation, Enforcement, available at https://www.floridahealth.gov/licensing-and-regulation/enforcement/index.html?utm_source=floridahealth.gov%26utm_medium=text-

Congress and federal regulatory agencies took steps in 2019 to improve the quantity and quality of health care cost information available to patients. Federal price transparency laws and regulations; however, does not cover all types of health care facilities. For example, federal transparency requirements excluded certain facilities leaving requirements and compliance to the States.

Hospital Facility Transparency

On November 15, 2019, the CMS finalized regulations[70] 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 (MRF) 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.[71]

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.

Compliance Reports

The penalty for facility noncompliance under the federal regulations is a maximum fine of $300 per day.[72] Very early indications suggested that there were varying levels of compliance with the new rules among hospital facilities and many facilities complaining about the high cost of implementation.[73] At least one patient advocacy group has consistently posted much lower compliance rates by hospitals in its semi-annual reports which highlight the status of each hospital.[74]

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.[75] Further, an August 2022 review of 2,000 hospitals found that 16 percent complied with all transparency requirements.[76] Nearly 84 percent of hospitals failed to post MRF containing standard charges, and

link%26utm_campaign=mqa%26utm_term=medical+quality+assurance+file+complaint%26utm_content=https://www.floridahealth.gov/licensing-and-regulation/ (Last visited February 19, 2024).

[70] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and available at: 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).

[71] *Id.*

[72]. 45 CFR s. 180.90. The maximum daily fine will be adjusted annually by the Office of Management and Budget.

[73] Dave Muoio, *Hospital, payer price transparency compliance improves, but new requirements are kicking in this year (January 4, 2024), Fierce Healthcare*, available at Hospital, payer price transparency improves across 2023: report finds (fiercehealthcare.com) (Last visited February 18, 2024).

[74] *See Florida Fifth Semi-Annual Hospital Price Transparency Report,* http(s://www.patientrightsadvocate.org/s/FL-Florida-Fifth-Semi-Annual-Hospital-Price-Transparency-Compliance-Report.pdf *(Patientsrightsadvocate.org;)* (Last visited February 18, 2024).

[75] 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 January 4, 2024).

[76] Patients' Rights Advocates, *Third semi-annual hospital transparency compliance report, 2022*, available at https://www.patientrightsadvocates.org/august-semi-annual-compliance-report-2022 (last revisited January 5, 2024).

roughly 78 percent of hospitals did not provide a consumer-friendly shoppable services display.[77] Another review of more than 6,400 hospitals showed wide-spread non-compliance with the federal transparency rule- more than 63 percent of hospitals were not in compliance as of the report date.[78] According to that same review, only 38 percent of Florida hospitals were in compliance.[79]

The first fines were not levied by federal CMS until almost 18 months after the rule's effective date. When levied against Northside-Atlanta, the total amount of those fines is less than 0.1 percent of Northside Hospital system's total gross revenues[80]. That assessment is still shown as under review on the CMS enforcement website.

A year ago, CMS reported an improving compliance rate as high as 70 percent by hospitals; however, CMS has also issued a very high volume of warning letters and corrective actions plans.[81] In April 2023, CMS reported the issuance of over 730 warning letters and 269 requests for corrective action plans.[82] More recently, a data transparency vendor reviewed the 2023 compliance rate by facilities and found at least 90 percent of facilities had submitted some of the listed mandated services via the required MRF requirement. The MRF contains a facility's cash, list, and negotiated rates for a significant number of the facility's services.[83] The same report also updated the number of warning letters in the past year to a cumulative of 1,000 letters and issuance of 14 civil penalties.[84]

As mentioned above, CMS maintains a website with a list of facilities assessed civil monetary penalties for non-compliance, the non-compliance notices, and the status of any facilities which have requested a review of an enforcement activity.[85] The Office of the Inspector General at HHS has announced its plans to review and audit HHS' monitoring and enforcement of the law and regulations. The Inspector General will review HHS' controls and randomly sample hospitals to determine if those controls are sufficient and issue a report later in 2024.[86]

Health Insurer Transparency

On October 29, 2020, the federal Departments of HHS, Labor, and Treasury finalized regulations[87] 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

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[77] *Id.*
[78] 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 January 4, 2024). As of the date of the report, only two hospitals to date had been fined for noncompliance with the transparency rule, both of which were in Georgia's Northside Hospital System.
[79] *Id*. at 4.
[80] *Id*. at 4.
[81] American Bar Ass'n., *CMS States 70% of Hospitals Are Now Complying With Hospital Price Transparency Rules (April 23, 2023),* available at: *https://www.americanbar.org/groups/health_law/section-news/2023/february/cms-states-hospitals-are-now-complying-with-hospital-price-transparency-rules/* (Last visited February 18, 2024).
[82] Centers for Medicare and Medicaid Services, *Hospital Transparency Enforcement Update (April 23, 2023),* available at https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparncy-enforcement-update (Last visited February 18, 2024).
[83] *Supra,* note 76.
[84] *Id.*
[85] Centers for Medicare and Medicaid Services, *CMS Enforcement Actions,* available at : https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions (Last visited: February 18, 2024).
[86] Department of Health and Human Services, Office of the Inspector General, *Hospital Price Transparency, available at: https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000728.asp* (Last visited February 18, 2024).
[87] 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).

estimate their out-of-pocket costs *before* receiving health care to encourage shopping and price competition amongst providers.[88]

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 must provide personalized cost-sharing information to patients across the full range of covered health care services.[89]

Medical Loss Ratio

The regulations also clarify the treatment of shared savings expenses under medical loss ratio (MLR) calculations required by PPACA. The 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.[90] The PPACA established minimum MLR requirements for group and individual health insurance plans.[91] 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.[92] Further, the law requires a health plan that does not meet these standards to provide annual rebates to individuals enrolled in the plan.[93]

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.[94] 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* (Act) as part of the Consolidated Appropriations Act of 2021.[95] The Act included 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 went into effect on January 1, 2022, and the Departments of Health and Human Services, Treasury, and Labor were tasked with issuing regulations and guidance to implement a number of the provisions.[96] Additional public notice requirements become effective July 1, 2024 resulting in further hospital charge information being posted for easily accessible viewing.

Estimates – Facilities

In the realm of price transparency, the 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).[97]

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[88] 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 visited January 22, 2024).
[89] 45 CFR Part 180.
[90] "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 January 22, 2024).
[91] PPACA, s. 1001; 42 U.S.C. 300gg-18.
[92] Sections 627.6405, 641.31097, F.S.
[93] *Id.*
[94] 45 CFR Part 158.
[95] P.L. 116-260. The *No Surprises Act* is found in Division BB of the Act.
[96] *Id.*
[97] P.L. 116-260, Division BB, Section 112.

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:

- 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.[98]

Furthermore, the Act directed the Secretary of HHS to establish by January 1, 2022, a "patient-provider dispute resolution process" to resolve any disputes concerning bills received by uninsured individuals or individuals with insurance who received care not covered by insurance that substantially differ from a provider's good faith estimate provided prior to the service being rendered.[99] If one of the providers or facilities billed $400 more than the good faith estimate, the patient may dispute the bill through an independent third party.[100] To be considered, a patient must begin the dispute process within 120 days of receipt of the initial bill. The new requirements placed on hospitals and health plans by the 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.

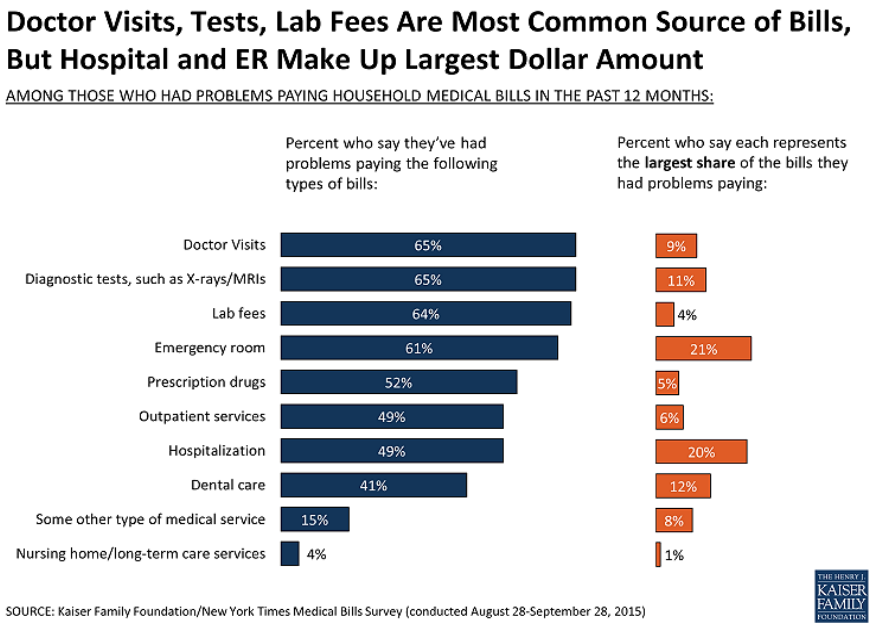
Medical Debt

Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. Nationwide, over 100 million have some form of medical debt.[101] A 2007 study suggested that illness and medical bills contributed to 62.1 percent of all personal bankruptcies filed in the United States during that year.[102] 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.[103] Four in ten U.S. adults have some form of health care debt,[104] including one in eight people who reported health care debts of at least $10,000 or more in a 2022 Kaiser Family Foundation poll.[105]

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.[106] While about a third of adults with health care debt owe less than $1,000, even

[98] P.L. 116-260, Division BB, Section 111.
[99] *Supra*, note 80.
[100] Centers for Medicare and Medicaid Services, *The No Surprises Act protects people from unexpected medical bills, https://www.cms.gov/medical-bill-rights (Last visited February 18, 2024).*
[101] 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 January 22, 2024).
[102] 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://pubmed.ncbi.nlm.nih.gov/19501347/ (Last visited February 18, 2024) .
[103] 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 February 19, 2024).
[104] 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 January 22, 2024).
[105] *Id.*
[106] *Id.*

small amounts of debt can have significant financial consequences for some.[107] 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.[108]



Even when medical costs do not result in personal bankruptcy, the debts 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 having an inability to pay medical bills in the past 12 months.[109] 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.[110]

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 had accumulated over time. Respondents to the Kaiser 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).[111]

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 which pursue patients for years on unpaid bills. Further, one in five providers deny nonemergency care to people with outstanding medical debt.

Further polling results contained in the 2022 Kaiser report also showed that families who had experienced medical debt problems were also more likely to ask about the cost of a medical service or doctor's office visit beforehand than someone who had not had such difficulties (49 percent compared to 34 percent). Such families were also much more likely to shop around for services for the best price (34 percent compared to 17 percent) and to attempt to negotiate a lower rate before receiving a health

[107] *Id.*
[108] *Id.*
[109] 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/(Last visited January 22, 2024).
[110] *Id.*
[111] *Id.*

care service (22 percent compared to six percent). Impacted families with medical debt also reported a higher rate of being asked to pay for health care services up front before services would be delivered.[112]

Personal Credit Ratings

Recognizing the inherent difficulties associated with medical debt, the three major credit rating companies in July 2023 agreed to exclude from an individual's credit report medical debts that have been paid off and unpaid medical debts less than $500. This action followed a 2015 settlement agreement with several state Attorney Generals which had established a minimum time period of 180 days before a medical debt could be reported to a credit agency.[113] The national credit reporting companies announced that this time period would be expanded voluntarily to one year in 2022.

With the 2023 agreement and the $500 capped medical debt collection, regulators expect the majority of medical debt will fall under this dollar threshold. However, geographic differences in the average amount of medical debt exist across the county, including in neighborhoods that are majority Black or Hispanic, and in areas with lower median incomes.[114]

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.

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.[115]

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

[112] *Id.,* at 23.
[113] Consumer Financial and Protection Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports,* July 27, 2022, available at https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/ (Last visited January 22, 2024).
[114] *Id.*
[115] 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:* Michelle McGhee and Will Chase, *How America's top hospitals hound patients with predatory billing,* AXIOS, (July 2021), available at https://www.axios.com/hospital-billing (Last visited February 19, 2024). Twelve Florida hospitals were included in the analysis, with a wide range of scores in each category.

$1,000 of personal property is exempt.[116] Statutory law provides numerous categories of exempt property, and federal law also provides certain exemptions that apply in all of the states.[117]

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;[118] proceeds from life insurance policies;[119] wages or unemployment compensation payments due certain deceased employees;[120] disability income benefits;[121] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[122] $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.[123]

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.[124] 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.[125] 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.[126] 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.[127]

Statutes of Limitations

A statute of limitations bars a lawsuit's filing after a certain amount of time elapses following an injury.[128] 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.[129] 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.[130]
- 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 s. 95.11(5)(e), s. 255.05(10), s. 337.18(1),

[116] Art. X, s. 4(a), Fla. Const.
[117] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.
[118] S. 222.11, F.S.
[119] S. 222.13, F.S.
[120] S. 222.15, F.S.
[121] S. 222.18, F.S.
[122] S. 222.22, F.S.
[123] S. 222.25, F.S.
[124] Art. 1, s. 8, cl. 4, U.S. Const.
[125] 11 U.S.C. s. 522.
[126] 11 U.S.C. s. 522(b).
[127] S. 222.20, F.S.
[128] Legal Information Institute, Statute of Limitations, https://www.law.cornell.edu/wex/statute_of_limitations (Last visited January 22, 2024).
[129] *Id.*
[130] S. 95.11(1), F.S.

or s. 713.23(1)(e), and except for an action for a deficiency judgment governed by s. 95.11(5)(h), F.S.
    - An action to foreclose a mortgage.
    - An action alleging a willful violation of s. 448.110, F.S.
    - Notwithstanding s. 95.11(b), F.S., an action for breach of a property insurance contract, with the period running from the date of loss.[131]
- WITHIN FOUR YEARS.—
    - 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 the authority having jurisdiction issues a temporary certificate of occupancy, a certificate of occupancy, a certificate of completion, or the date of abandonment of construction if not completed, whichever is earliest; except that, when the action involves a latent defect, the time runs from the time the defect is discovered or should have been discovered with the exercise of due diligence. In any event, the action must be commenced within seven years after the date the authority having jurisdiction issues a temporary certificate of occupancy, a certificate of occupancy, or a certificate of completion, than as to the construction which is within the scope of such building permit and certificate, the correction of defects to completed work or repair of completed work, whether performed under warranty or otherwise, does not extend the period of time within which an action must be commenced. If a newly constructed single-dwelling residential building is used as a model home, the time begins to run from the date that a deed is recorded first transferring title to another party. Notwithstanding any provision of this section to the contrary, if the improvement to real property consists of the design, planning, or construction of multiple buildings, each building must be considered its own improvement for purposes of determining the limitations period set forth in this paragraph. 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. F.S.[132]
- WITHIN TWO YEARS.—
    - An action founded on negligence.
    - 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

[131] S. 95.11(2), F.S.
[132] S. 95.11(3), F.S.

diligence. However, the limitation of actions herein for professional malpractice shall be limited to persons in private with the professional.
    - An action for medical malpractice[133] shall be commenced within two years from the time the incident giving rise to the action occurred or within two 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 four years from the date of the incident or occurrence out of which the cause of action accrued, except that this four year period shall not bar an action brought on behalf of a minor on or before the child's eighth birthday. The limitation of actions shall be limited to the health care provider and persons in privity with the provider of health care. In those actions in which it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury the period of limitations is extended forward two years from the time that the injury is discovered or should have been discovered with the exercise of due diligence, but in no event to exceed seven years from the date the incident giving rise to the injury occurred, except that this seven-year period shall not bar an action brought on behalf of a minor on or before the child's eighth birthday. This paragraph shall not apply to actions for which ss. 766.301-766.316 provide the exclusive remedy. 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, F.S. 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 five 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.[134]
- 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, F.S.
    - 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 ss. 255.05(10), 337.18(1), or 713.23(1)(e), F.S., 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, F.S., 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 s. 95.11(8), F.S., , 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, F.S.
    - Except for actions described in s. 95.11(8), F.S., an action brought by or on behalf of a prisoner, as defined in s. 57.085, F.S., 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

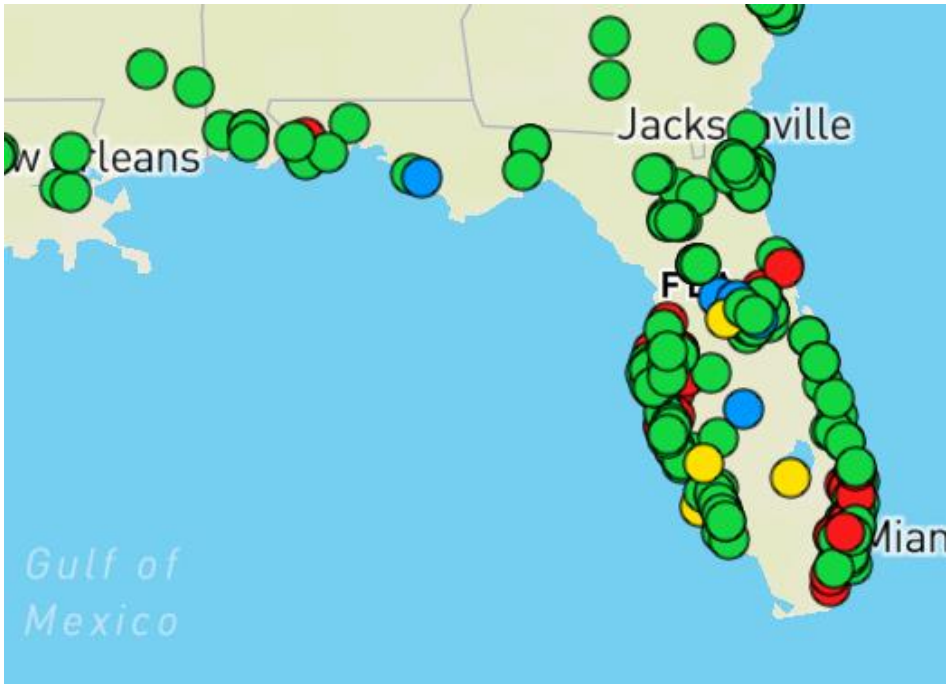
[133] An "action for medical malpractice" is defined as a claim in tort or in contract for damages because of the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of health care. *See s. 95.11(4)(c), F.S.*
[134] S. 95.11(4), F.S.

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.[135]

Direct Health Care Agreements

Created in Florida law by the 2018 Legislature,[136] *direct health care agreements*, are non-insurance contracts between certain, statutorily designated health care providers or groups of providers and patients. Such agreements are not subject to the Florida Insurance Code and are not regulated by the Department of Financial Services or the Office of Insurance Regulation.

The direct provider arrangement eliminates third party payors and instead creates a contractual relationship between the health care provider and the patient usually with a small monthly fee (usually around $70 per individual) for access to the designated scope of benefits. Nationally, the Direct Primary Care Coalition reports over 1,600 associated practices.[137] On the map below, each green dot equals a pure direct primary care model, a red dot is a hybrid model, and a blue dot equals an onsite model. A provider with a hybrid model may have a mix of both direct primary care patients as well as other patients.



The agreement between the parties must adhere to specific statutory requirements to be a valid agreement. To be valid, the agreement must:

- Be in writing.
- Be signed by the health care provider or an agent of the health care provider and the patient, the patient's legal representative, or the patient's employer.
- Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The agreement may provide for immediate termination due to a violation of the physician-patient relationship or a breach of the terms of the agreement.
- Describe the scope of health care services that are covered by the monthly fee.
- Specify the monthly fee and any fees for health care services not covered by the monthly fee.
- Specify the duration of the agreement and any automatic renewal provisions.

[135] S. 95.11(5), F.S.
[136] Ch. Law 2018-89, L.O.F.
[137] Direct Primary Care Coalition, *Direct Primary Care Mapper,* available at https://mapper.dpcfrontier.com/ (Last visited January 22, 2024).

- Offer a refund to the patient, the patient's legal representative, or the patient's employer of monthly fees paid in advance if the health care provider ceases to offer health care services for any reason.
- Contain, in contrasting color and in at least 12-point type, the following statement on the signature page: "*This agreement is not health insurance and the health care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any health care services covered by the agreement. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and Affordable Care Act, 26 U.S.C. s. 5000A. This agreement is not workers' compensation insurance and does not replace an employer's obligations under chapter 440.*"[138]

Patients who seek services under these agreements may see health care providers for any services for which the provider is licensed and has the competency and training to provide.[139] Currently, direct health care arrangements are limited to those providers who are defined as a "health care provider", under s. 624.27, F.S., and licensed as one of the following:

- Chapter 458 (medical doctors);
- Chapter 459 (osteopathic doctors);
- Chapter 460 (chiropractic physicians);
- Chapter 461 (podiatrists);
- Chapter 464 (nursing, including advanced or specialized nursing practice, advanced practice registered nurse, licensed practice nurse, or registered nurse);
- Chapter 466 (dental or dental hygienist); or
- A health care group practice, who provides health care services to patients.[140]

Health Care Price Transparency and Medical Debt

The bill 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.[141]

Facility Price Transparency

Facility Billing Estimates

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 three 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 one business day after the service is scheduled.
- In the case of a service scheduled 10 or more business days in advance, no later than three business days after a service is scheduled.

[138] S. 624.67(4)(a)-(h), F.S.
[139] S. 624.67(1)(c), F.S.
[140] S. 624.27(1)(b), F.S.
[141] SS. 395.003, 395.301, 408.802, 624.401, and 641.22, F.S.

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 (Act).[142] Compliance with the Act was required by January 1, 2022. The bill subjects ASCs to these requirements, which the federal Act does not; to that end, the bill makes its provisions applicable to ASCs beginning January 1, 2026. This grants the ASCs additional time to implement the bill requirements, which the hospitals already had.

Shoppable Services

The bill requires each licensed hospital and ambulatory surgical center (ASC) 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.[143] 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 or ASC 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;
- 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:

[142] The *No Surprises Act* was enacted as part of the Consolidated Appropriations Act of 2021; (Pub. Law 116-260).
[143] *Supra*, note 43.

- 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 collection 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.[144] This change aligns Florida law with the federal regulations that became final in 2020.[145]

Advanced Explanation of Benefits

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 by January 1, 2022.

Cash Price Communication

Under the Public Health Services Act, section 2799A-9(a)(2), health insurance issuers that offer individual health insurance coverage are prohibited from entering into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the issuer from—

(1) Providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or
(2) Sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in (1) with a business associate, consistent with the privacy regulations promulgated pursuant to section 264(c) of HIPAA, GINA, and the ADA.[146]

[144] 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.
[145] *Supra*, note 47.
[146] Centers for Medicare and Medicaid Services, *Gag Clause Prohibition Attestation Compliance,* https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/gag-clause-prohibition-compliance-attestation (last viewed January 22, 2024).

These regulations further restrict group health plans and health plan issuers from restricting the release of provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage.[147]

The first attestation of compliance from health plans and issuers was due on December 31, 2023 and will be due annually thereafter.

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 2: Amends s. 395.301, F.S., relating to price transparency; itemized patient statement or bill; patient admission status notification.
Section 3: Creates s. 395.3011, F.S., relating to billing and collection activities.
Section 4: Amends s. 624.27, F.S., relating to direct health care agreements; exemption from code.
Section 4: Amends s. 641.31076, F.S., relating to shared savings incentive program.
Section 5: Amends s. 627.6387, F.S., relating to shared savings incentive program.
Section 6: Amends s. 627.6648, F.S., relating to shared savings incentive program.
Section 7: Amends s. 475.01, F.S., relating to definitions.
Section 8: Amends s. 475.611, F.S., relating to definitions.
Section 9: Amends s. 517.191, F.S., relating to injunction to restrain violations; civil penalties; enforcement by Attorney General.
Section 10: 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 11: Amends s. 787.061, F.S., relating to civil actions by victims of human trafficking.
Section 12: Creates an unnumbered section of law, relating to ambulatory surgical centers.
Section 12: Provides an effective date of July 1, 2024.

[147] *Id.*

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill has no fiscal impact on state or local governments.

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 affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill or current law provide sufficient authority to all impacted state agencies and boards necessary to implement its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES