CARLTON FIELDS

How New Fla. Health Care Laws May Create More Confusion

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On April 14, Florida Gov. Rick Scott signed into law HB 1175 and its companion bill, HB 221, which impose important changes affecting hospitals, surgery centers, urgent care centers, physician practices, and health insurance companies. This article focuses primarily on the provision of health care services in the hospital or surgery center setting, but the new legislation has broad impact on many other entities involved in the health care system. While the laws are designed to help patients price shop for elective, nonemergent care, the Florida Legislature has left various issues to be defined by the Florida Agency for Health Care Administration and the newly named Florida Center of Health Information and Transparency. The Florida Center for Health Information and Policy Analysis was historically responsible for collecting, compiling, analyzing and disseminating health-related data through the FloridaHealthFinder.gov website; however, the new Florida Center of Health Information and Transparency will contract with a vendor to establish a more consumer-friendly, Internet-based platform for consumers to research and find meaningful price comparisons. These laws are set to take effect July 1, 2016. Failure to adhere to these new laws will carry monetary penalties. **Pretreatment Transparency** HB 1175 requires hospitals and surgery centers to list on their websites the average payment received for certain bundled services and procedures.[1] These payment averages are to include all payors, except for Medicare and Medicaid, as well as the estimated payment range for these services, which has yet to be defined. These disclosures must also be accompanied by a notification, in plain language, advising the prospective patient that the information relating to payments "is an estimate of the costs that may be incurred by the patient or prospective patient and that actual costs will be based on the services actually provided …"[2] While it is clear that the purpose of disclosing the average payment is to provide the prospective patient with an indication of the cost that could be incurred for the services provided, the definitions of "payors" and "payment," could undermine the usefulness of this data. For example, the legislation exempts Medicare and Medicaid reimbursement from the definitions of "payors," presumably because they are historically government-imposed, non-negotiated rates and, thus, would not be representative of what price an individual patient should anticipate paying. Under this same logic, the data reflecting gross payments obtained from out-of-network providers or self-pay patients that does not take into account any collection efforts and expenses would likewise not be representative of what a patient should expect under his or her unique circumstances. Finally, if the term

"payments" were to include payments from uninsured patients who made minimal partial patients, that data would likewise be less useful for prospective patients to determine what they could anticipate paying for services. Therefore, the ultimate definitions of "payors" and "payment" could impact patients' payment expectations and contribute to their frustration, rather than their sense that the information provided will assist them in any meaningful manner. Further, the existing obligations on hospitals and surgery centers to make their financial assistance policy and charity policy available upon request have been expanded. Under HB 1175, a licensed facility will have to post on its website, among other things, the facility's financial assistance policy, charity policy and collection policy, as well as the names, mailing addresses, and telephone numbers of all health care practitioners and medical practices with which the facility contracts to provide services, along with instructions on how to contact the practitioners to determine whether they participate in a patient's insurance plan. The companion bill, HB 221, also requires hospitals to list on their websites all the names, websites and hyperlinks to each health insurance and health maintenance organization (HMO) with which they have a contractual relationship as network or covered providers, in addition to other requirements that overlap with the requirements set forth in HB 1175, such as disclosing that a physician participating in a patient's care during his or her hospital visit may bill the patient separately.[3] With potentially hundreds of health care providers on staff, and hundreds of health insurance and HMO contracts, this requirement may be time — and resource — consuming for many hospitals and surgery centers. The present obligation by hospitals and surgery centers to offer estimates for nonemergent services upon request has also been expanded to require that the estimates include mandatory information similar to that required on the facilities' websites. For example, the estimates must conspicuously identify the facility fees and advise prospective patients that they may pay less at another facility or another health care setting. The facility is permitted, however, to exceed the estimated amount. The failure to timely provide a requested estimate could cost the facility $1,000 a day for a maximum of $10,000. In an effort to allow the prospective patient to investigate all the estimated costs for an elective procedure, physicians and other practitioners will also be required to furnish — upon request — a good faith estimate of the professional fees in connection with nonemergent services provided in a hospital or ambulatory surgery center setting. This estimate, similar to the one required of licensed facilities, must be provided within seven business days of receipt of a prospective patient's request. Comparable disclosures of financial assistance and cost-sharing responsibilities, among others, must also be included. The failure to timely furnish such an estimate, absent good cause, will give rise to a $500 fine until the estimate is provided, with a maximum fine of $5,000. **Post-Treatment Transparency** HB 1175 imposes new obligations on hospitals or surgery centers regarding the itemized bills and statements they present to patients. The bills or statements must identify the facility fees, and more importantly "explain the purpose of the fees." The itemized bill must also identify whether the charges are paid, pending payment from a third party source, or currently due from the patient. Although hospitals and surgery centers previously had 30 business days to provide patients requesting access to their records in order to verify the accuracy of the itemized bill, the new legislation shortens that timeframe to 10 business days. These records must be both available at the facility's office, as previously required,

and through Health Insurance Portability and Accountability Act-compliant electronic means. Similarly, the current 30-day window hospitals and surgery centers have to respond to patient inquiries relating to their itemized bills has now been shortened to seven business days from the date of receipt of a patient's inquiry, and must provide the contact information of the review agency if a patient is dissatisfied with the facility's initial response. Most of the new timelines to respond to post-treatment requests concerning billing charges that are imposed by the law undoubtedly pose a sizable burden on any facility. Facilities that service a large volume of patients will likely have to increase their administrative staff and incur costs to comply with these tight timelines, which will conceivably increase indirect costs for the very same health care services that exist today. The Agency for Health Care Administration (AHCA) and the newly established Florida Center for Health Information and Transparency have been tasked with collecting, analyzing and providing a web-based platform to allow the public to compare the prices for services and procedures. Further, data collection by AHCA from health insurers under section 408.061(1)(c), Florida Statutes, may now also include payments made to health care facilities and health care providers — however, the law also allows for the designation of trade secret information pursuant to section 812.081 of the Florida Statutes. Interestingly, section 408.061(1)(d), Florida Statute, which currently states that specific provider reimbursement information "shall not" be included in the data submitted to AHCA by a health care facility, has been edited from "shall" to "may." This minor word change may have a significant impact on health care facilities that have proprietary and confidential contractual agreements with health insurers. With the effective date only months away, these transparency laws are unquestionably at the forefront of Scott's agenda. Accordingly, the health care industry must immediately ensure compliance with these newly implemented or amended laws to avoid monetary penalties. The new laws also place significant responsibility on the consumer to be informed prior to receiving nonemergent services by providing the tools necessary to make an educated decision about receiving services at a particular facility or with a particular health care practitioner. The effect of these tools in litigation for unconscionable or deceptive pricing against health care providers has yet to be determined. -----

[1] https://www.flsenate.gov/Session/Bill/2016/1175/BillText/er/PDF (last visited April 22, 2016).

[2] Id.

[3] https://www.flsenate.gov/Session/Bill/2016/0221/?Tab=BillText (last visited April 22, 2016).

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