ALTARUM
HEALTHCARE VALUE HUB

Florida Healthcare Affordability: A Closer Look

September 2022

CONTENTS

All materials produced as part of the Healthcare Affordability State Policy Scorecard project, including the methodology report and scorecards for individual states, are available on our website at: www.HealthcareValueHub.org/Affordability-Scorecard

INTRODUCTION

States play an important role in making healthcare more affordable for their residents. They have the power to pass and implement policies to curb excess prices, expand coverage and limit cost-sharing for high-value care (among other interventions) and can exercise this authority to protect state residents from high (and rising) healthcare costs in the absence of slow-moving and/or politically gridlocked federal action. On a recent Scorecard effort conducted by the Healthcare Value Hub, Florida scored 23.8 out of 80 possible points (an F grade) on healthcare affordability policies and outcomes, ranking 41st out of 47 states, plus D.C.[1] While Florida has taken a few steps to address healthcare affordability, such as implementing comprehensive surprise medical bill protections, it generally performs poorly on a suite of measures across four comprehensive healthcare affordability domains—curbing excess prices, reducing low-value care, expanding coverage and reducing out-of-pocket costs.[2]

A 2019 survey conducted in Florida by the Healthcare Value Hub found that 55 percent of respondents experienced one or more healthcare affordability burdens: Forty-six percent of respondents encountered one or more cost related barriers in the past twelve months, such as delaying going to the doctor or cutting pills in half or skipping doses of medicine, and 34 percent of respondents got the care they needed but struggled to pay the resulting bill, with some reporting being contacted by a collection agency or using up all or most of their savings.[3] Further survey work finds this still holds true years later, with Perry Undem's 2022 survey revealing that more than 2 in 5 (45%) of Florida adults say they or a family member have sacrificed healthcare because of costs, with half (51%) reporting that they are not confident they can pay for their usual healthcare services. Furthermore, 43 percent report facing financial hardship as a result of medical bills—including being contacted by a collection agency (18%); using up all of their savings (16%); being unable to pay for basic necessities (14%); and having to borrow money or take out a loan to pay off medical debt (14%).[4]

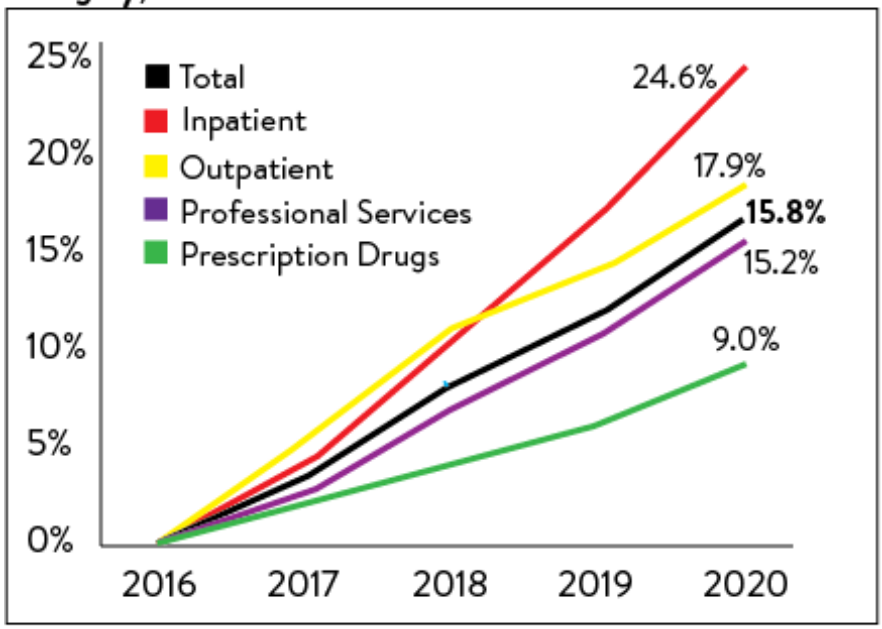
In light of residents' grave healthcare affordability burdens, Florida has much work to do to make healthcare more affordable for all. This memo describes Florida's current performance in two priority areas—curbing excess prices and reducing out-of-pocket costs—and provides recommendations for actions policymakers can take to address Floridians' primary healthcare concern.[5]

CURB EXCESS PRICES

For many reasons, the healthcare prices that many Americans pay are unrelated to the cost of providing those services and often exhibit unwarranted variation across geographic area, as well as providers, within the same city, county or state.[6] This pricing problem, in part, reflects excessive profit-taking and particularly affects people who are uninsured and those with private health insurance (about 13.1% and 49.8% of Florida's population in 2019, respectively[7]). Even for people with generous, protective health coverage, excess prices are embedded in the premiums they pay. A 2019 study found that roughly $230.7 billion to $240.5 billion of wasteful health spending each year was associated with excess prices.[8]

According to the Health Care Cost Institute, inpatient prices, on average, increased more than prices associated with other service categories (including outpatient, prescription drug and professional services) from 2016 to 2020 (see Figure 1).[9] An analysis conducted by John's Hopkins University for Altarum's Healthcare Value Hub found that Florida's inpatient private payer prices were more than double (216%) of Medicare prices on average for a basket of the top 25 most frequent inpatient Diagnostic Related Groups (DRGs),[10] placing them in the upper range of all states (Florida ranked 40th out of 48 states, plus D.C., for this Scorecard measure). The median commercial breakeven amount for hospitals in Florida—that is, the payment required from commercial payers to allow hospitals to cover maximum expenses without a profit—was 148 percent of Medicare prices in 2019. Florida hospital profits were above the national average in 2019, with a median net profit margin of 9.8 percent, compared to 4.4 percent nationally.[11]

Figure 1: Change in Average Price per Person by Service Category, 2016-2020



Source: Adapted from 2020 Health Care Cost and Utilization Report, Health Care Cost Institute (May 2022).

STREGTHEN THE STATE'S ALL-PAYER CLAIMS DATABASE

All-payer claims databases (APCDs) are large-scale databases typically created by states that contain diverse types of healthcare data, including claims data from private insurance companies, state employee health benefit programs and, in some cases, Medicare and Medicaid.[12] APCDs (or their near cousin, multi-payer claims datasets) can provide useful information on payment, utilization and disease patterns, which can be used by a wide range of stakeholders to aid in health system transformation efforts, including initiatives designed to reduce excess prices.

Florida established an all-payer claims database in 2016, however only insurers who participate in state group health insurance plans or Medicaid managed care plans are required to submit all of their claims data, which does not apply to all insurers in the state.[13,14]

Recommendation:

- ***Require All Insurers to Submit Claims to the Database***: Without claims from all insurers in the state, Florida's APCD provides an incomplete view of service utilization and price variation within the state. Florida should strengthen existing legislation to require all insurers, including fully-funded employee health plans and individual, small group plans within and outside the Marketplace and public payers, including Medicare and Medicaid, to submit all of their claims to the database for a more thorough and accurate representation of healthcare service usage and costs. However, states cannot require self-funded employee health plans to submit claims.[15] Florida should encourage self-insured employee health plans to voluntarily submit their claims data to the APCD.

ESTABLISH A HEALTH SPENDING OVERSIGHT ENTITY

Many states lack a comprehensive, inter-agency, multi-payer plan to address the healthcare segment of their economies. In order to systematically and comprehensively address the healthcare affordability burdens of state residents (and inform health system transformation efforts more generally), states need an entity empowered to look across various types of health and social spending and to identify opportunities for improvement in terms of value for each dollar spent, quality shortcomings and affordability problems for residents—in other words, a permanently convened, health spending oversight entity.

Health spending oversight entities can take many forms. As of 2021, seven states have established comprehensive oversight entities that target all healthcare spending (Colorado, Connecticut, Delaware, Massachusetts, Oregon, Vermont and Washington) and seven states have established entities that target narrow forms of spending, such as hospital or drug spending (Maine, Maryland, New Hampshire, New York, Ohio, Pennsylvania and Rhode Island). Florida does not have a health spending oversight entity as of August 2022.

Recommendation:

- ***Establish a Health Spending Oversight Entity:*** Florida should consider establishing a health spending oversight entity that targets all forms of health spending. The entity should be empowered to make legislative recommendations that improve quality of care provision and improve affordability for consumers.

POLICY IN ACTION: HEALTH SPENDING OVERSIGHT ENTITY

Maryland's Health Services Cost Review Commission monitors the efficiency and effectiveness of hospitals using financial data (revenue, expenditures and utilization) to inform the Commission's recommendations on global hospital spending targets, uncompensated care and community benefits.

Colorado's Office of Saving People Money on Health Care works to reduce patient costs for hospital stays and expenses, improve price transparency, lower the price of prescription drugs and make health insurance more affordable.

Vermont's Green Mountain Care Board is empowered to: monitor spending and quality of care across sectors; operate the state's all-payer claims database; review health insurance rates and identify drivers of rate increases; oversee pilots and innovations; align activity across payers; and make legislative recommendations.

CONSIDER A HEALTHCARE COST GROWTH BENCHMARK

Healthcare cost growth benchmarks seek to constrain annual healthcare spending growth across sectors. Benchmarks can target different types of health spending and may be accompanied by quality benchmarks (e.g., Delaware) and/or spending minimums for high-value services like primary care (e.g., Connecticut) to ensure that reductions in spending growth do not sacrifice healthcare quality. Several states have implemented spending benchmarks with varying degrees of enforcement: Some states do not have an enforcement mechanism, relying on public displays of performance to incentivize cooperation, while others (like Massachusetts and Oregon) require entities that exceed the benchmark to complete a performance improvement plan to address excessive price growth and have the power to fine entities for exceeding the benchmark as well.[16]

Massachusetts' benchmark has been in effect for the longest and spending within the state has varied significantly over the years—cost growth has been below the benchmark for four of the eight years that data has been available. Prior to the coronavirus pandemic, spending was on an upward trajectory above the 3.1 percent benchmark, growing 3.6 percent in 2018 and 4.1 percent in 2019 (spending declined significantly in 2020 due to a reduction in care during the pandemic, as seen across the country).[17] However, spending growth in Massachusetts has been lower than the spending growth rate nationally. While the benchmark is not solely responsible for this, it does factor into Massachusetts' healthcare landscape. 2022 was the first year that the Massachusetts Health Policy Commission (HPC)—the entity that oversees the benchmark—voted to require a hospital system to implement a Performance Improvement Plan for the first time, in response to evidence that the system has the highest prices in the state.[18]

Delaware was the second state to implement a benchmark in 2019, and spending grew 5.8 percent—well over the 3.8 percent target—in in its first year. In its second year, spending growth declined an estimated 1.2 percent (likely also affected by the coronavirus pandemic). Though it is important to note that Delaware does not have an enforcement mechanism for its benchmark and has one of the highest rates of healthcare spending in the country. Additionally, the state had a mixed performance on its quality metrics—improving in some areas and worsening in others.[19] Similarly in **Rhode Island**, spending grew 4.1 percent, above the state's benchmark of 3.2 percent in its first year, but declined in its second year in 2020 (likely affected by the coronavirus pandemic).[20]

Despite inconclusive evidence on the effectiveness of benchmarks, states are still pursuing this policy with the hope that it will work as intended. The impacts of policy changes are rarely seen immediately and over time, states will be able to evaluate and tailor their benchmark programs to better fit their environment. Furthermore, the continuous data collection for the benchmark will enable states to identify sectors that drive cost growth and can tailor interventions to address those factors and curtail costs.

POLICY IN ACTION: HEALTHCARE COST GROWTH BENCHMARK

Connecticut's benchmarking approach is novel in that it uses the state's Healthcare Affordability Index to estimate the policy's impact on the number of Connecticut households that will have access to quality healthcare coverage and be able to meet their basic economic needs.[21] An initial study conducted prior to implementation found that adherence to a cost growth benchmark would grant more than 14,000 additional households access to affordable healthcare (a six percent increase compared to the number of households with adequate income to afford healthcare expenses in 2019). The impact of the cost growth benchmark is projected to be even greater among households that purchase coverage through the insurance Marketplace, with over 30 percent more of these households having adequate income to afford healthcare.[22]

Notably, Connecticut's benchmark includes targets for increased primary care spending as part of its strategy.[23] The goal of this initiative is to divert more resources towards primary care to avoid more expensive and complex care needs of preventable conditions.

RECOMMENDATION:

- ***Establish a Cost Growth Benchmark:*** Though evidence on the effectiveness of cost growth benchmarks under varying conditions is still emerging, states are increasingly considering this strategy as a tool to rein in healthcare spending growth. Including enforcement mechanisms may increase the likelihood of the benchmark's success and quality benchmarks can help ensure that efforts to reduce healthcare cost growth do not negatively impact health outcomes. Additionally, annual reports that detail how healthcare spending changed over the years and within different sectors of the healthcare system can enable regulators and policymakers to identify sectors with large spending increases and implement targeted actions to constrain cost growth. These types of reports can also be produced on their own to assess healthcare spending.[24] Commissioning a report specifically within Florida's healthcare market can be used to identify cost drivers and targeted policy interventions.

  Additionally, policymakers should consider establishing an affordability index for Florida households, as Connecticut has. Doing so will enable policymakers to evaluate the effects of various healthcare policies and reforms (including, but not limited to, a cost growth benchmark) on Florida households' ability to maintain quality healthcare coverage along with meeting their basic economic needs.

STRENGTHEN PRICE TRANSPARENCY TOOLS

It is well established that prices for the same healthcare service can differ significantly across providers—even within the same geographic area.[25] Yet, it is extremely difficult for consumers and policymakers to get reliable information about this pricing landscape. Contrary to popular belief, transparency tools have generally not been successful when it comes to incentivizing consumers to compare services and shop for the best price.[26] This failure stems from tools that don't contain the types of actionable information consumers need and from the fact that some consumers don't view healthcare as a shoppable commodity. Moreover, many healthcare services are not shoppable, such as those provided in emergency situations and settings that lack a selection of treatments or providers.[27]

While "shopping" by patients is unlikely to drive down excess prices,[28] transparent pricing data can be used by researchers, payers, regulators and legislators to identify outliers and embrace targeted solutions such as reference pricing, strategic network construction and rate setting, though success will depend on the level of provider competition in the market. For maximum impact, healthcare price transparency tools should be: free; publicly available; reflect negotiated rates; display prices that are treatment- and provider-specific; and pair pricing information with reliable quality metrics.[29]

Florida established a price transparency tool, Florida Health Price Finder, in 2019 that displays negotiated rates for hundreds of healthcare services, as well as the national, state and county average prices for the service. The tool also includes information on what to expect during the service, how to prepare for the service and provides recommended questions to ask the provider about the service.

Recommendations:

- ***Include Both Negotiated and Chargemaster Rates for Services:*** Currently, Florida's price transparency tool only provides an average cost estimate based on all claims provided by the insurers that participate in the state's APCD. Providing only the negotiated rates can be a disadvantage for those without insurance coverage. Over 12 percent of Florida residents were uninsured in 2020.[30] Additionally, including both negotiated rates and chargemaster rates paid by consumers will further assist policymakers in identifying providers that are charging outlier rates.
- ***Break Down Price Information by Insurer:*** In its current form, Florida's price transparency tool provides average prices for specific procedures, based on all of its claims data. Including insurer-specific price averages can help consumers more accurately estimate their expenses.

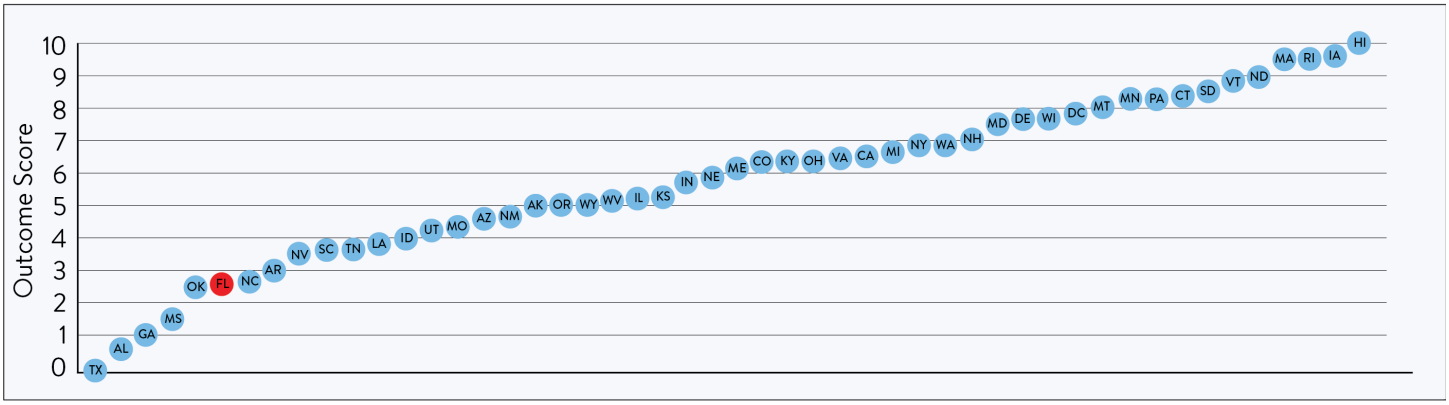
POLICY IN ACTION: PRICE TRANSPARENCY TOOL

New Hampshire's price transparency tool—NHHealthCost—was instrumental in driving down prices charged by a major hospital within the state. Prior to 2010, payments to the state's most expensive hospital exceeded those of its competitors by nearly 50 percent. The state's largest insurer had been unable to decrease prices due to the hospital's prominent reputation and loyal patient base, however, evidence of excessive prices—made public on the state's price transparency website—enabled the insurer to brand the hospital as a pricing outlier, garner public support and negotiate lower prices. Market observers testified that, despite limited public awareness of the price transparency tool, publicly identifying high-priced providers shifted the balance of power towards the state's insurers and narrowed price variation over time.[31]

MAKE OUT-OF-POCKET COSTS AFFORDABLE

Surveys have found that half of Floridians (51%) are not very confident that they can pay for their usual healthcare services, with 45 percent saying they or a family member have sacrificed some form of healthcare due to cost. Surveys also show that many Floridians look to their elected officials to improve the affordability of coverage and care.[32] While Florida has taken some initial steps to make out-of-pocket costs affordable for its residents, such as enacting comprehensive surprise medical bill protections, the state performs poorly in terms of the percent of residents who went without needed care due to cost compared to other states (see figure below). Areas for improvement that state policymakers should consider are outlined below.

State Score Comparison: Make Out-of-Pocket Costs Affordable
Outcome Scores



Notes: The 'Making Out-of-Pocket Costs Affordable' outcome measure is based on the percent of adults who could not get needed medical care due to cost, using data from a State Health Access Data Assistance Center analysis of 2019 Behavioral Risk Factor Surveillance System (BRFSS) survey data. Scores are based on how well each state performs relative to the highest-performing state. The higher the score, the lower the percentage of adults who could not get needed medical care due to cost—Florida's score of 2.6 indicates a higher percentage of adults who could not get needed medical care due to cost. NJ is not included in this chart because data on affordability burdens was not available for this state.

Source: State Health Access Data Assistance Center

PROTECT PATIENTS FROM SURPRISE OUT-OF-NETWORK MEDICAL BILLS

A 2022 survey conducted by Perry Undem found that more than one-third (36%) of Floridians say that surprise medical bills (SMBs) are their most frustrating healthcare cost.[33] SMBs include any medical bill for which a health insurer paid less than the patient expected. One form of SMB receiving a lot of attention is when a patient receives a bill from an out-of-network provider that would have been difficult for them to avoid; for example, in emergency situations or when care is provided by an out-of-network provider at an in-network hospital.

The federal No Surprises Act (NSA), passed in 2020, aims to address this issue by prohibiting balance billing in most insurance plans nationwide effective January 2022. The NSA protects consumers from cost-sharing beyond the normal in-network amount when a patient receives emergency services by an out-of-network facility or provider (including air ambulances) or when out-of-network providers at in-network facilities provide nonemergency services.[34] However, the NSA does not wholly protect consumers from balance billing, leaving loopholes like ground ambulance rides that are susceptible to a balance bill.

As previously stated, Florida passed comprehensive surprise medical bill protections in 2012 that apply to HMOs[35] and additional protections in 2016 that apply to PPOs.[36] The 2012 law that applies to HMOs is very broad and provides

generous protections for consumers. However, the 2016 law that applies to PPOs is more narrow in scope. Florida's balance billing protections do not apply to ground ambulances for PPO enrollees, non-emergency services for PPO enrollees who have "the ability and opportunity to choose" an in-network provider and enrollees in self-funded plans (however, enrollees in self-funded plans are protected under the NSA).[37] Despite the comprehensive designation (as identified by the Commonwealth Fund),[38] opportunities for Florida to improve its SMB protections remain—seventy-one percent of ground ambulance rides in Florida charged to commercial insurance plans in 2018 had the potential for surprise medical billing, indicating that many Florida residents are still vulnerable to a surprise bill.[39]

Recommendation:

- ***Broaden Surprise Medical Bill Protections for Ground Ambulance Services to Include PPO Enrollees:*** PPO enrollees in Florida continue to be at risk for a surprise medical bill for an ambulance service. Florida should expand their balance billing protections for ground ambulances to include residents enrolled in a PPO plan.

WAIVE OR REDUCE COST-SHARING FOR HIGH-VALUE SERVICES

Failure to receive high-value care like flu vaccines and certain cancer screenings not only worsens health outcomes but can result in higher spending on medical care in the future.[40] Reducing financial barriers by waiving or reducing cost-sharing for specific high-value services is one way states can encourage the utilization of high-value care.

Across the country, the most common area of action states took in 2020 was capping costs for high-value prescription drugs, particularly insulin. Florida has done some work in this area, including passing legislation to import prescription drugs from Canada in 2019. At the time of this writing, the state is in the process of working with Canadian sellers to establish an importation program. It is important to note, however, that imported drugs would only be available for the Florida Medicaid program and other public payers, such as the Department of Corrections, and certain types of drugs are banned from importation, including insulin.[41] Additional bills introduced in the Senate to cap the cost-sharing amount for covered prescription insulin drugs at $100 per month died in committee in 2021[42] and 2022.[43]

Recommendations:

- ***Explore Other Avenues to Subsidize Insulin and Other High-Value Prescription Drugs:*** State approaches to increase the affordability of and access to high-value prescription drugs can take many forms. Some states have taken legislative action to cap the out-of-pocket cost of high-value drugs for some or all state residents, while others offer pre-deductible coverage through standardized plans on the exchange (see Policy in Action box below). While recent state efforts have focused almost exclusively on insulin, Florida should consider capping cost-sharing for other high-value drugs, such as specialty drugs used to treat HIV and hepatitis, as well.
- ***Establish Spending Targets for High-Value Services:*** A few states have established minimum spending targets for service categories like primary care and behavioral healthcare in an effort to increase utilization of and investment in high-value care. Florida should consider adopting minimum spending targets for these service categories, either in coordination with or independently of a cost growth benchmark designed to constrain annual healthcare spending growth across sectors.

POLICY IN ACTION: SUBSIDIZING HIGH-VALUE PRESCRIPTION DRUGS

Utah's Insulin Savings Program allows any resident to purchase insulin at wholesale prices through the state and public employee plan.[44,45]

New Mexico passed legislation to cap copays and out-of-pocket expenses for insulin at $25 for a 30-day supply (the lowest price cap in the country) and established an advisory group to study the cost of prescription drugs for New Mexico consumers and make recommendations on increasing accessibility.[46] In 2022, New Mexico established a Healthcare Affordability Fund that will invest in healthcare affordability initiatives for lower- and middle-income residents, such as reducing premiums and out-of-pocket costs.[47]

Texas passed a law in 2021 that caps the cost-sharing of a 30-day supply of insulin to $25, regardless of the amount or type of insulin needed to fill an enrollee of a state-regulated health plan's prescription.[48] Another Texas law instructs state officials to develop a drug savings program that would give uninsured individuals a discounted rate on insulin purchases.[49]

In 2021, **Oregon** passed a law to limit cost-sharing of insulin for health plans offered on the state exchange to $75 for a 30-day supply or $225 for a 90-day supply.[50] The law further excludes such coverage from deductibles imposed by health plans.[51]

Delaware, Louisiana and **Maryland** cap cost-sharing for specialty drugs—such as those to treat HIV and hepatitis—at $150 for a 30-day supply.[52]

Beginning in 2023, **Massachusetts'** ConnectorCare plans (available to residents earning up to 300 percent of the Federal Poverty Level) will eliminate cost-sharing for medications used to treat conditions that disproportionately affect communities of color, including diabetes, asthma, coronary artery disease and hypertension.[53] Also beginning in 2023, the **District of Columbia** will eliminate cost-sharing for prescription drugs and other medical services required for the treatment and maintenance of conditions that disproportionately affect District residents of color in standard plan designs for Marketplace plans. Plan year 2023 will eliminate cost-sharing for diabetes services, with other conditions under consideration for future plan years.[54]

POLICY IN ACTION: SPENDING TARGETS FOR HIGH-VALUE SERVICES

Part of **Connecticut's** cost growth benchmark includes spending targets for increasing primary care spending to account for 10 percent of total healthcare expenditures by 2025.[55]

Rhode Island's affordability standards (enacted in 2010) require commercial insurers to invest more in primary care providers and services and encourage primary care practices to transform into patient-centered medical homes. A 2019 study focusing on Rhode Islands' affordability standards found that quarterly primary care coordination spending increased by $21 per commercially insured enrollee, total spending growth decreased (the reduction in fee-for-service spending on patient care was greater than the increase in non-fee-for-service spending related to primary care) and that quality measures were either unaffected or improved.[56]

INCREASE PROTECTIONS AGAINST SHORT-TERM, LIMITED-DURATION PLANS

In response to rising insurance costs, some people turn to Short-Term, Limited-Duration (STLD) health plans, which offer lower monthly premiums compared to ACA-compliant plans. These plans are not required to provide the standard ACA protections for non-group coverage and, therefore, typically offer poor coverage, can reject/charge higher rates for women and people with pre-existing conditions and pose significant financial risks for consumers. Though the term limit of these plans was capped at three months in 2016 under the Obama administration, the Trump administration extended the limit to 364 days with an option to extend the policy to 36 months in 2018.[57]

Florida, like many states, has no protections against STLD plans beyond the federal minimum, which limit the initial plan term limit to 364 days and cap the maximum duration to 36 months, leaving residents vulnerable to the financial harms these plans can cause.

Recommendation:

- ***Enact Protections Against STLD Plans:*** Florida should implement consumer protections against STLD plans. States have established a variety of protections to reduce consumer harm from STLD plans, including prohibiting gender rating, prohibiting pre-existing condition exclusions or waiting periods, requiring coverage for essential health benefits, limiting the term limit and banning the sale of STLD plans in the state altogether.

CONCLUSION

While Florida has taken some actions to improve healthcare affordability for its residents, the state has ample opportunity to improve. Because healthcare affordability is a multi-faceted issue, interventions will ultimately be needed across multiple affordability domains—including expanding coverage, reducing out-of-pocket costs, curbing excess prices and reducing the provision of low-value care—in order to eliminate healthcare affordability problems for all. In the absence of Florida policymakers' willingness to explore opportunities for expanding coverage (the primary means through which most U.S. residents finance their care), this brief presents opportunities for Florida to make progress in two other high-impact areas—curbing excess prices in the system and reducing out-of-pocket costs for consumers. Policymakers should consider the recommended strategies in light of emerging evidence that close to half of Florida adults are unable to afford healthcare costs.

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With support from Arnold Ventures and the Robert Wood Johnson Foundation, the Healthcare Value Hub provides free, timely information about the policies and practices that address high healthcare costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all Americans by applying research-based and field-tested solutions that transform our systems of health and healthcare.

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