HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 701 w/CS Consumer Health Care Spending Protection
SPONSOR(S): Clarke and others
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 2022 (s); HB 1629 (c)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care	23 Y, 0 N w/CS	Rawlins	Collins
2) Health Access and Finance		Callaway	Cooper
3) Insurance			
4) Health Appropriations (Sub)			
5) Appropriations			

SUMMARY ANALYSIS

Currently, hospitals and ambulatory surgical centers are required to submit discharge data on a quarterly basis to the Agency for Health Care Administration (AHCA). The State Center for Health Statistics collects three types of discharge information from 261 inpatient health care facilities and Ambulatory Patient Data is collected from 526 freestanding ambulatory surgical centers, lithotripsy centers, cardiac catheterization laboratories, and short-term acute care hospitals. The data is used for information guides and research by many that are interested in the health of Florida residents.

This bill creates the "Health Care Consumer's Right to Know Act," which provides health care consumers with reliable and understandable information about facility charges and performance outcomes to assist consumers in making informed decisions about health care.

The bill requires that the number of individuals appointed to the state comprehensive health information system advisory council be expanded to include a total of 13 individuals and identifies specific representatives of the health care industry to be appointed. Specific reporting requirements for health care providers and health insurers are deleted.

The bill requires that the agency make available on its Internet website no later than October 1, 2004, and in a hard-copy format upon request, patient charge and performance outcome data for not less than 100 conditions and/or procedures and the volume of inpatient hospitalizations and/or procedures by the appropriate Medicare diagnostic related groups [ICD 9] or CPT code.

It is required that the agency website include an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. The bill specifies that public information is updated on a quarterly basis.

The agency is required to analyze and trend for comparison by and between facilities the gross charges for the 100 conditions or procedures following an adjustment to reflect changes in patient acuity, case mix, and severity of illness. This information will be posted annually on the agency website.

The agency will establish by rule the conditions and procedures to be disclosed based upon input from the State Comprehensive Health Information System Advisory Council and specify that when determining which conditions and procedures are to be disclosed.

The bill provides for an effect date of July 1, 2004.

See the “FISCAL IMPACT ON STATE GOVERNMENT” section of this analysis.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[x]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[x]	N/A[]
4. Increase personal responsibility?	Yes[x]	No[]	N/A[]
5. Empower families?	Yes[]x	No[]	N/A[]

For any principle that received a "no" above, please explain:

This bill requires an individual hospital to report specific data to the agency and the agency is required to post specific facility information on its website.

B. EFFECT OF PROPOSED CHANGES:

HB 701

This bill creates the "Health Care Consumer's Right to Know Act," which provides health care consumers with reliable and understandable information about facility charges and performance outcomes to assist consumers in making informed decisions about health care.

The bill amends the provisions of law governing the state comprehensive health information system advisory council by expanding the number of individuals appointed to the council for a total of 13 and identifying specific representatives of the health care industry to be appointed to the council. Reporting requirements for health care providers and health insurers are deleted.

The bill amends the provision of law governing hospital licensure, requiring that the agency make available on its Internet website no later than October 1, 2004, and in a hard-copy format upon request, patient charge and performance outcome data for not less than 100 conditions and/or procedures and the volume of inpatient hospitalizations and/or procedures by the appropriate Medicare diagnostic related groups [ICD 9] or CPT code.

It is required that the agency website include an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. The bill specifies that public information is updated on a quarterly basis.

The agency is required to analyze and trend for comparison by and between facilities the gross charges for the 100 conditions or procedures following an adjustment to reflect changes in patient acuity, case mix, and severity of illness. This information will be posted annually on the agency website.

The agency will establish by rule the conditions and procedures to be disclosed based upon input from the State Comprehensive Health Information System Advisory Council and specifies that when determining which conditions and procedures are to be disclosed, the council and the agency shall consider their:

- ✓ variation in costs,
- ✓ variation in outcomes and magnitude of variations, and
- ✓ other relevant information.

This data will be adjusted for case mix and severity, comparing volume of cases, patient charges, length of stay, readmission rates, complication rates, mortality rates, infection rates, and use of computerized drug order system.

The AHCA is required to make available educational information relevant to the disclosed 100 conditions and procedures, including, but not limited to, an explanation of the medical condition or procedure, potential side effects, alternative treatments and costs, and additional resources that can assist consumers in informed decision making. Information may be made available by linking consumers to credible national resources such as the National Library of Medicine.

The agency is required to study and implement by October 1, 2005, the most effective methods for public disclosure of patient charge and performance outcome data, including additional mechanisms to deliver this information to consumers, which will enhance informed decision making among consumers and health care purchasers. The agency shall also evaluate the value of disclosing additional measures that are adopted by the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, The Leapfrog Group, or a similar national entity that establishes standards to measure the performance of health care providers.

An annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives is required by October 1, 2005.

The bill amends the provisions of law governing a patient's hospital bill, requiring that hospitals provide nonemergency patients with a written estimate of charges. The facility may provide the median charges for their top 100 conditions or procedures by the appropriate Medicare diagnostic related group [ICD 9] or CPT code. The facility is required to notify the patient or other designated person of revisions to the estimate and such estimates will not prohibit the actual charges from exceeding the estimate.

The bill specifies that a facility is required to make available to a patient all records necessary for verification of the accuracy of the patient's bill within 7 business days after the request for such records prior to and after payment of the bill at no charge, with the exception of copying fees.

The facility is requires to establish an impartial method for reviewing billing disputes and provide a written response that has clear explanations within 30 days after the receipt of the dispute. All disputes will be logged and reported to the Agency.

CURRENT REPORTING REQUIRMENTS

Hospital Inpatient Data

The Hospital Inpatient Data Program within the Agency for Health Care Administration constitutes one component of the data collection activity for the State Center for Health Statistics. This section collects three types of discharge information from 261 inpatient healthcare facilities, as described below:

Acute Care Hospital and Short-term Psychiatric Inpatient Data Collection
Detailed data is collected on a quarterly basis from approximately 239 facilities in accordance with Florida Administrative Code 59E-7. The last revision of this rule became effective on January 1, 2000. For each inpatient discharged from a reporting hospital, 62 data elements are collected via computer diskette or CD-ROM.

Comprehensive Rehabilitation Inpatient Data Collection
Detailed data is collected on a quarterly basis from 14 facilities in accordance with Florida Administrative Code 59E-7.201. The reporting rule went into effect on March 31, 1994. For each inpatient discharged from a comprehensive rehabilitation hospital, 14 data elements are collected via computer diskette or CD-ROM.

Long-term Psychiatric Hospital Data Collection
Aggregate data is collected from 7 long-term psychiatric facilities on a quarterly basis. This information is transmitted via paper forms and entered manually into our information database.

For each facility in the three databases listed above, two additional steps are required to ensure the accuracy of the data. The data is processed through an editing program and the facilities are required to correct data errors. The Chief Executive Officer and Chief Financial Officer of each facility must personally certify the accuracy of their data. Both steps must be completed before the data is permanently added to the database.

Reporting Schedule

Quarter	Time Period	Data	Due Date	Final Certification Date
1st	January 1 - March 31		June 1	September 30
2nd	April 1 - June 30		September 1	December 31
3rd	July 1 - September 30		December 1	March 31 the (following year)
4th	October 1 - December 31		March 1	

The State Center for Health Statistics (SCHS) is one of AHCA's sources for health care data and consumer information. With a staff of researchers, analysts and writers, the work includes the collection and dissemination of patient data, along with technical assistance to interested parties. Databases include hospital inpatient, ambulatory outpatient, and other health-related databases.

The State Center for Health Statistics also uses the data to create detailed reports that examine health care trends and outcomes of specific diagnoses in the Health Outcome Series. In addition, the SCHS produces a variety of publications within the Consumer Awareness Series and the Florida HMO Report to assist the public in making well-informed health care decisions.

Hospital data includes detailed patient data collected from acute care hospitals, short-term psychiatric hospitals, and comprehensive rehabilitation hospitals. It also includes aggregate data collected from long-term psychiatric hospitals. The specific data elements being reported quarterly are:

ITEM	FIELD NAME	LENGTH	POSITION	DATA TYPE	
1.	REPORTING YEAR	4	01 - 04	N	
2.	REPORTING QUARTER	1	05	N	
3.	HOSPITAL NUMBER	8	06 - 13	N	
4.	TYPE OF ADMISSION	1	14	N	
5.	SOURCE OF ADMISSION	2	15 - 16	N	
6.	DISCHARGE STATUS	2	17 - 18	N	
7.	PATIENT RACE	1	19	N	
8.	PATIENT SEX	1	20	N	
9.	ZIPCODE	5	21 - 25	N	
10.	PRINCIPAL DIAGNOSIS CODE	5	26 - 30	A/N	
11.	SECONDARY DIAGNOSIS CODES	5	31 - 75	A/N	OCCURS 09 TIMES
12.	PRINCIPAL PROCEDURE CODE	4	76 - 79	A/N	
13.	SECONDARY PROCEDURE CODES	4	80 - 115	A/N	OCCURS 09 TIMES
14.	PRINCIPAL PAYER	1	116	A/N	
15.	CHARGES BY REVENUE	7	117 - 284	N	OCCURS 24 TIMES

16.TOTAL GROSS CHARGES	8	285 - 292	N	
17.ATTENDING PHYSICIAN ID	11	293 - 303	A/N	
18.OPERATING PHYSICIAN ID	11	304 - 314	A/N	
19.DRG CODE	3	315 - 317	N	
20. R-DRG CODE * (If Available)	4	318 - 321	N	
21. A-DRG CODE * (If Available)	3	322 - 324	N	
22. SEVERITY OF ILLNESS (APR-DRG) * (If Available)	1	325	N	
23. RISK OF MORTALITY (APR-DRG) * (If Available)	1	326	N	
24. PATIENT AGE AT ADMISSION	3	327 - 329	N	
25. LENGTH OF STAY	4	330 - 333	N	
26. DAY OF WEEK ADMITTED (1 = MONDAY)	1	334	N	
27.DAYS TO PROCEDURE	4	335 - 338	N	
28.PATIENT COUNTY (Florida Only)	2	339 - 340	A/N	
29.PATIENT STATE OF RESIDENCE	2	341 - 342	A/N	
30.ATTENDING PHYSICIAN UPIN * (If Available)	6	343 - 348	A/N	
31.OPERATING PHYSICIAN UPIN * (If Available)	6	349 - 354	A/N	

Ambulatory Patient Data

Ambulatory Patient Data is collected from 526 freestanding ambulatory surgical centers, lithotripsy centers, cardiac catheterization laboratories, and short-term acute care hospitals. The data is used for information guides and research by many that are interested in the health of Florida residents.

Ambulatory patient data is submitted in accordance with section 408.062, Florida Statutes, and Chapter 59B-9, Florida Administrative Code. Data is collected on ambulatory surgeries, radiological services, *lithotripsy, and cardiac catheterization from facilities that have 200 or more patient visits as defined in the administrative code. A patient visit is a face to face encounter between a provider and patient who is not formally admitted as an inpatient in an acute care hospital setting and who is not treated in the emergency room. These events must have a procedure that involves a valid Current Procedural Terminology (CPT) code occurring within the following ranges: 10000 through 69999, 93500 through 93599, and 77000 through 77999. Data is collected on ninety-eight data fields, including patient demographic information, hospital identifying information, payer information, charges, procedures, and diagnosis information. Once the data is edited, it is certified by the reporting facilities' Chief Executive Officer and Chief Financial Officer as accurate and permanently added to our database.

DATA ELEMENT	**DESCRIPTION**
1. Record Identification Number	A unique twelve-digit code for each record.
2. Report Year	The four-digit year.
3. Report Quarter	Single-digit representing the quarter. 1 - January through March 2 - April through June 3 - July through September 4 - October through December
4. AHCA Facility Identification Number	The eight-digit identification number assigned by the agency for reporting purposes.
5. Patient's Race	A single-digit code for identification of the patient's racial/ethnic background. 1 - American Indian/Eskimo/Aleut 2 - Asian/Pacific Islander 3 - Black 4 - White 5 - White Hispanic 6 - Black Hispanic

	7 - Other 8 - No Response
6. Patient's Sex	A single-digit code. 1 - Male 2 - Female 3 - Unknown (Starting with 1/02 data)
7. Patient's Zip Code	A five-digit code of the patient's permanent address Zip code. These codes are included unless the patient's residence is outside of Florida or resides in an area within the state where the population is less than 500 people. 00000 - Unknown Zip Codes 00008 - Other States and Territories 00009 - Not a U.S. resident 00011 Masked Zip Code 32000 to 32499 00012 Masked Zip Code 32500 to 32999 00013 Masked Zip Code 33000 to 33499 00014 Masked Zip Code 33500 to 33999 00015 Masked Zip Code 34000 to 34499 00016 Masked Zip Code 34500 to 34999 00007 - Homeless (Start 1/02, formerly 22222)
8. Principal Payer Code	A single-character, alpha code. A - Medicare B - Medicare HMO C - Medicaid D - Medicaid HMO E - Commercial Insurance F - Commercial HMO G - Commercial PPO H - Workers' Compensation I - CHAMPUS J - VA K - Other State/Local Govt. L - Self pay (no third party coverage) M - Other N - Charity O - Kidcare (Starting 1/03)
9. Principal Diagnosis Code	ICD-9-CM code. Principal diagnosis is the condition established after study, this code is the chief indicator to be used for occasioning the admission of the patient to the facility. Decimal is not included. The decimal in diagnosis codes is implied between the third and fourth digit.
10. Primary Procedure Code	CPT codes between **10000-69999, 77000-77999** and **93500-93599**. Primary procedure is the procedure for which the patient was primarily admitted to the facility. **(Note: 77000-77999, not collected after 1/03)**
11. Primary Procedure Modifier Code (1)	The CPT two-digit modifier code for the primary procedure (optional field). *Available in 1999+*
12. Primary Procedure Modifier Code (2)	The CPT two-digit modifier code (optional field). *Available in 1999+*
13. Attending/Referring Physician ID	The physician having primary responsibility referring or ordering the procedure. Out of State Physicians - Physician's home state two letters Abbreviation and 9's (e.g. NY9999999)

	Non US Physicians - XX999999999 Unavailable/Unknown - ZZ999999999 Military physicians not licensed in FL - US999999999
14. Attending/Referring Physician UPIN	The attending/referring physician's *Unique Physician Identification Number* (blank as of 1/02).
15. Operating Physician ID	The physician having primary responsibility in performing the procedure. Must be a Florida Licensed Physician.
16. Operating Physician UPIN	The performing physician's Unique Physician Identification Number (blank as of 1/02).
17. Total Charges	Sum of individual charges rounded to the nearest dollar. Up to eight digits.
18. Radiology Professional Fee Indicator	One-digit field indicating whether or not professional fees for radiology services are in included. 1 - Yes 2 - No
19. Radiation therapy visits	This field indicates the total number of visits involved with this event if the primary procedure code is **between 77000-77999**. If the primary procedure code *is not* between 77000-77999, this field will default to 01. **(Note: 77000-77999, not collected after 1/03, field blank)**
20. Principal Procedure Code	ICD-9-CM (Volume III) procedure code. Decimal is not included. The decimal is implied between the third and fourth digit. (Available 1999+, optional field)
21. Patient Status	A two-digit code representing the patient's discharge status from the facility (Optional field, available 1999+, required field starting 1/03, only 01, 02, 03, and 04 valid choices, 05, 06, 07, 08, 20 deleted)
	01 - Home 02 - To a short term general hospital 03 - To a skilled nursing facility 04 - To an intermediate care facility 05 - To another type of institution 06 - Home under care of home health care 07 - Left facility against medical advice (AMA) 08 - Home on IV medications 20 – Expired
22. Patient's Age	Patient's age on date of procedure.
23. Procedure Day of Week	One-digit field indicating day of week procedure was performed. 1 - Monday 2 - Tuesday 3 - Wednesday 4 - Thursday 5 - Friday 6 - Saturday 7 - Sunday
24. Patient's County	County of residence. Florida patients only. The patient's ZIP code is used to reference the U.S. Postal Service database. When a ZIP code crosses county lines, the county code will contain the code of the county in which the greatest portion of that ZIP code lays. 99 - Unknown or non-Florida patient.

25. Patient's State	The patient's state of residence. The patient's ZIP code is used to reference the U.S. Postal Service Standard state or territory. XX - Unknown state of residence.
26. Pharmacy Charges	Total amount associated with pharmacy charges rounded to the nearest dollar.
27. Med/Surgical Supply Charges	Total amount associated with medical and surgical supplies rounded to the nearest dollar.
28. Radiation Oncology Charges	Total amount associated with oncology charges rounded to the nearest dollar.
29. Laboratory Charges	Total amount associated with laboratory charges rounded to the nearest dollar.
30. CT Scan Charges	Total amount associated with CAT rounded to the nearest dollar.
31. Operating Room Charges	Total amount associated with operating room charges rounded to the nearest dollar.
32. Anesthesia Charges	Total amount associated with anesthesia charges rounded to the nearest dollar.
33. MRI Charges	Total amount associated with MRI charges rounded to the nearest dollar.
34. Recovery Room Charges	Total amount associated with recovery room charges rounded to the nearest dollar.
35. Treatment/Observation Room Charges	Total amount associated with treatment and observation charges rounded to the nearest dollar. *Available 1999+*
36. Other Charges	Total amount associated with other charges that do not fit into the other categories rounded to the nearest dollar.
37 - 40 Other Diagnosis Code	Up to four secondary diagnosis codes (ICD-9-CM). Decimal is not included. Decimal implied between the third and fourth digit.
41 - 82 Other Procedure Codes, Modifier 1, Modifier 2 (Repeats 14 times)	
	Other Procedure Codes Up to fourteen secondary procedures (CPT or HCPCS). Other Procedure Modifier Code (1). The CPT or HCPCS two-digit modifier code (optional field *available 1999+).* Other Procedure Modifier Code (2) **.** The CPT or HCPCS two-digit modifier code (optional field *available 1999+).*

Fines

Pursuant to 59E-7.013, Florida Administrative Code, a hospital which refuses to file, fails to timely file, or files false or incomplete reports or other information required to be filed under the provisions of s. 408.08(13), F.S., other Florida Law, or rules adopted thereunder, is subject to administrative penalties. Failure to comply with reporting requirements will also result in the referral of a hospital to the Agency's Bureau of Health Facility Regulation. In addition, any hospital which is delinquent for a reporting deficiency shall be subject to a fine of $100 per day of violation for the first violation, $350 per day of violation for the second violation, and $1000 per day of violation for the third and all subsequent violations. Violations will be considered those activities which necessitate the issuance of an administrative complaint by the agency unless the administrative complaint is withdrawn or final order dismissing the administrative complaint is entered.

Limitations of Current Systems

Although the agency publishes consumer friendly information from the required data submission, the agency does not publish readmission rates, complication rates, mortality rates, infection rates, and use of computerized drug order systems.

Data collected pursuant to 408.061, F.S. does not include information about computerized drug order systems or hospital acquired infections. The data specifications in 59B-9.010 through 59B-9.020, F.A.C. and 59E-7.011 through 59E-7.016, F.A.C. do not require that facilities report complications. However, some complications are reported as a secondary diagnosis if space is available on the discharge record. According to AHCA, it is not known whether readmissions are reported separately or combined into one discharge record.

Deaths occurring during the hospital stay are included in the data collected and published with the following disclaimer, "Discharge status does not measure the quality of care in a hospital." Data collected pursuant to 408.061.061, F.S. does not contain all the information necessary to determine risk of mortality. The data does not include all diagnoses if space is unavailable on the discharge record. The data does not include laboratory and radiology test results, other clinical information contained in the medical record, medical history, do not resuscitate orders, and physician notes that are necessary to fully evaluate risk.

Section 395.301, F.S., specifies that a licensed facility not operated by the state shall submit to the patient an itemized bill upon request within 7 days following release from the licensed facility, and the itemized bill may not include charges of hospital-based physicians if billed separately.

According to AHCA, it is current procedure that when the agency receives a request for assistance from a patient regarding a bill received from a licensed facility, the agency acts to facilitate communication between the facility and patient by requesting a written explanation from the facility.

Comprehensive Health Information System (CHIS) Advisory Council

The State Comprehensive Health Information System (CHIS) Advisory Council advises Agency staff regarding health information and statistics, pursuant to s. 408.05(8) F.S.

The CHIS has assisted in the development of the consumer publications *Choosing A Quality Health Plan: Florida HMO Report* and *Understanding Prescription Drug Costs*. The CHIS has participated in a project to increase awareness and disseminate information on local and state programs combating health disparities. The CHIS has also encouraged the continued expansion of the Agency's consumer-oriented web site, www.FloridaHealthStat.com.

The Florida Health Stat website provides consumers with a wide array of information from the online "Florida Hospital Service Guide" to the Rx Saver. In the Florida Hospital Services Guide 2003 provides consumers with information on hospitalizations for selected conditions and also information on specialized services available at Florida hospitals. The Rx Saver hotlink provides consumer with a link to an online comparison shopping web site which focuses on prescription drugs, health, wellness, and beauty products. The site provides consumers with the necessary information and services to help save money on prescription and drug store item purchases.

The CHIS meets four or more times each year at the AHCA offices in Tallahassee or various locations in the state. Meetings are noticed in the Florida Administrative Weekly and open to the public.

C. SECTION DIRECTORY:

Section 1. Provides a popular name.

Section 2. Provides the purpose of the act.

Section 3. Amends s. 408.05, F.S., revises membership of the State Comprehensive Health Information System Advisory Council.

Section 4. Amends s. 408.061, F.S., revises a requirement for submission of health care data; and requires the council to assist the Agency for Health Care Administration in developing specifications for data collection.

Section 5. Amends s. 408.08, F.S., conforms provisions to changes made by the act.

Section 6. Amends s. 395.10973, F.S., revises powers and duties of the agency to include patient charge and performance outcome reporting; requires the agency to provide such information to the public and implement effective methods for making public disclosure; requires the agency to annually report findings to the Governor and Legislature; and requires the agency to adopt certain rules.

Section 7. Amends s. 395.301, F.S., requires disclosure to nonemergency patients of a good faith estimate of anticipated charges; revises the timeframe in which to provide a statement of itemized expenses to a patient; requires the facility to disclose information necessary to verify the accuracy of the bill; requires the facility to establish a method for reviewing billing disputes; and requires the facility to maintain a log of all such disputes and report certain information annually to the agency.

Section 8. Provides that the act shall take effect on July 1, 2004.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Based on the justification provided by AHCA for the fiscal impact of the bill as originally filed, one may assume that the provisions of this act may be accomplished with the addition of 2 FTEs. However, at the time of this analysis, AHCA had not provided a revised fiscal impact.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Employers and the general population may benefit from additional information about licensed hospital and ambulatory surgical center prices

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides the Agency for Health Care Administration with specific rule-making authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 17, 2004, the Committee on Health Care considered HB 701 with a strike all amendment and reported the bill favorably with a committee substitute. The amendment differs from the original bill in that the provisions that moved forward due dates for licensed health care facilities to report data specified in 59B-9.010 through 59B-9.020, F.A.C. and 59E-7.011 through 59E-7.016, F.A.C. were removed due to concerns raised regarding facilities having to adjust their internal procedures to meet the new schedule.

Other issues deleted from the original bill include provisions that:

- ✓ Requires the agency to add to its website a copy of each licensed facility's uniform schedule of gross charges ("charge master") and information on any percentage increase in each facility's gross revenue due to any price increase or decrease in its charge master during the previous 12-month period.
- ✓ Requires the agency to audit the accuracy of health care facility bills and payer claims for provider charges of $20,000 or more, and requires facilities to refund the overpaid amount to any patient or payer who was overcharged within 30 days after the completion of the audit period. The agency will promulgate rules to implement the audit program and refund procedures.
- ✓ Prohibits facilities from charging more than the lesser of $1000 or 20 percent above the original estimate unless unanticipated complications occur.
- ✓ Requires licensed facilities to provide public notice of any proposed change to the facility's uniform schedule of gross charges 30 days prior to implementing their respective Internet websites and in public reception areas.

According to AHCA, the fiscal impact of the bill as originally filed was $1,317,104 for FY 04-05 and $2,130,400 for FY 05-06 with non-recurring expenditures of $30,652 in FY 04-05 and recurring expenditures of $1,286,452 and $2,130,400 in FY 05-06. The changes in the bill, as incorporated by the amendment, will lessen this fiscal impact greatly. Based on the justification provided by AHCA for the fiscal impact of the bill as originally filed, one may assume that the provision of this act may be accomplished with the addition of 2 FTEs.

The bill analysis is written to the bill as amended.