A bill to be entitled

An act relating to consumer health care spending protection; providing a popular name; providing a purpose; amending s. 408.061, F.S.; revising a requirement for submission of health care data; amending s. 395.10973, F.S.; revising powers and duties of the Agency for Health Care Administration to include patient charge and performance outcome reporting and reporting changes in each facility's charge master; requiring the agency to provide such information to the public and implement effective methods for making public disclosure; requiring the agency to annually report findings to the Governor and Legislature; requiring the development of an auditing program for patient bills and payor claims over a certain dollar amount; providing for fines for billing errors exceeding a specified threshold; requiring the agency to adopt certain rules; amending s. 395.301, F.S.; requiring disclosure to nonemergency patients of a good faith estimate of anticipated charges; prohibiting a facility from requiring that a patient sign certain forms as a condition of admission or provision of service; providing conditions under which a patient shall not be required to pay amounts exceeding the original estimate; requiring patient notification of right to appeal charges in an itemized bill and of any interest applied to such charges; requiring the facility to disclose information necessary to verify the accuracy of the bill; requiring a method for appealing charges on the bill; requiring the facility to maintain a log of all such appeals; requiring the facility

to file annually with the agency a copy of its charge master and to disclose to the agency and the public any changes to the charge master; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. This act shall be known by the popular name the "Health Care Consumer's Right to Know Act."

Section 2. The purpose of this act is to provide health care consumers with reliable and understandable information about facility charges and performance outcomes to assist consumers in making informed decisions about health care.

Section 3. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.--

(1) The agency may require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties. Specifications for data to be collected under this section shall be developed by the agency with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data shall ~~to~~ be submitted by health care facilities quarterly for each preceding calendar quarter no later than February 1, May 1, August 1, and November 1 of each year commencing August 1, 2004. Such data shall ~~may~~ include, but are

not limited to: case-mix data, patient admission or discharge data with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information.

Section 4. Subsections (9) through (15) are added to section 395.10973, Florida Statutes, to read:

395.10973 Powers and duties of the agency.--It is the function of the agency to:

(9)(a) 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 collected from health care facilities pursuant to s. 408.061(1)(a) and (2) for not less than 100 inpatient and outpatient diagnostic and therapeutic conditions and procedures and the volume of inpatient and outpatient procedures by Medicare discharge referral experience. The website shall also provide 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. Such public data shall be updated on a quarterly basis.

(b) The agency shall establish by rule the conditions and procedures to be disclosed based upon input from the State Comprehensive Health Information System Advisory Council. 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 so that the disclosed list of conditions and procedures will assist health care consumers in differentiating between facilities when making health treatment decisions. As to each medical condition and procedure, the agency shall report current patient charges, as indicated on the facility's charge master as defined by s. 395.301(11), and performance outcomes for each licensed facility as defined in s. 395.002(17), adjusted for case mix and severity if applicable, comparing volume of cases, patient charges, length of stay, readmission rates, complication rates, mortality rates, infection rates, and use of computerized drug order systems.

(c) The agency shall make available educational information relevant to the disclosed 100 conditions and procedures pursuant to this subsection, 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 decisionmaking. Such information may be made available by linking consumers to credible national resources such as, but not limited to, the National Library of Medicine.

(10) Make available on its Internet website a copy of each facility's charge master, as defined by s. 395.301(11), for all services 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.

(11) Publicly disclose comparison information pursuant to subsections (9) and (10), including the age of the data and an explanation of the methodology used to risk-adjust the data, in language that is understandable to laypersons and accessible to consumers using an interactive query system to allow for the comparison of patient charge and performance outcome data among all licensed facilities in the state. The agency shall provide guidance to consumers on how to use this information to make informed health care decisions.

(12) Study, and implement by October 1, 2005, the most effective methods for public disclosure of patient charge and performance outcome data pursuant to subsections (9) and (10), including additional mechanisms to deliver this information to consumers, that would enhance informed decisionmaking 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, or a similar national entity that establishes standards to measure the performance of health care providers.

(13) Report its findings and recommendations pursuant to subsection (12) to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2005, and on an annual basis thereafter. The agency shall also make this annual report available to the public on its Internet website.

(14) Develop, and implement by October 1, 2004, a program to audit the accuracy of health care facility patient bills and payor claims for provider charges of $20,000 or more. Each licensed health care facility shall be audited at least once every 3 years. The audit shall establish a facility's error ratio for bill or claim errors. An error ratio of up to 5 percent is permissible. The error ratio shall be determined by dividing the number of claims and bills with violations found on a statistically valid sample of claims and bills for provider charges of $20,000 or more for the audit period by the total number of claims and bills in the sample. If the error ratio exceeds the permissible error ratio, a fine may be assessed for those claims and bill errors which exceed the error ratio in the amount of $500 per error, but not to exceed $100,000 for the noted audit period. The agency shall require a facility to refund the overpaid amount to any patient or payor who was overcharged within 30 days after the completion of the audit period.

(15) Adopt rules to implement the provisions of subsections (9)-(14) no later than July 1, 2004.

Section 5. Section 395.301, Florida Statutes, is amended to read:

395.301 Itemized patient bill; form and content prescribed by the agency.--

(1) A licensed facility as defined in s. 395.002(17) shall disclose to each patient, prior to treatment being rendered or admission in a nonemergency situation, a written good faith estimate of the reasonably anticipated charges generally required for the facility to treat the patient's condition. Such

facility shall also disclose other common, less costly treatments for the medical condition, including, but not limited to, outpatient services or drug therapies. In the event of any unanticipated complications, the licensed facility may charge the patient, or a third-party payor acting on behalf of the patient, for additional treatment, services, or supplies rendered in connection with the complication if such charges are itemized on the patient billing statement.

(2) A licensed facility shall not, as a condition of admission or the provision of service, require a patient to sign any form that requires or binds the patient or the patient's third-party payor to make an unspecified or unlimited financial payment to the facility or to waive the patient's right to appeal charges billed. A facility may require a financial commitment from a patient or the patient's payor only if the facility provides a prior written good faith estimate pursuant to this section. The facility shall notify the patient or payor of any revision to the good faith estimate in a timely manner. Except for unanticipated complications, if the facility makes a revision to the estimate that exceeds the lesser of 20 percent of the original estimate or $1,000, the patient or payor shall not be required to pay any amount over the original estimate.

(3)~~(1)~~ A licensed facility not operated by the state shall notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. Within 7 days following the patient's discharge or release from a licensed facility not operated by the state, or within 7 days after the earliest date on ~~at~~ which the loss or expense from the service may be determined, the licensed facility providing the

service shall, upon request, submit to the patient, or to the patient's survivor or legal guardian, as may be appropriate, an itemized statement detailing in language comprehensible to an ordinary layperson the specific nature of charges or expenses incurred by the patient, which in the initial billing shall contain a statement of specific services received and expenses incurred for such 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 by the licensed facility, as prescribed by the agency.

(4)~~(2)~~ Each ~~such~~ statement submitted pursuant to subsection (3):

(a) May not include charges of hospital-based physicians if billed separately.

(b) May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

(c) Shall list drugs by brand or generic name and not refer to drug code numbers when referring to drugs of any sort.

(d) Shall specifically identify therapy treatment as to the date, type, and length of treatment when therapy treatment is a part of the statement. Any person receiving a statement pursuant to this section shall be fully and accurately informed as to each charge and service provided by the institution preparing the statement.

(e) Shall conspicuously display notice of the right of a patient, or a third-party payor acting on behalf of the patient, to appeal any of the charges in the bill and whether interest

will be charged on the amount not covered by a third-party payor and the interest rate charged, if applicable.

(5)~~(3)~~ On each ~~such~~ itemized statement submitted pursuant to subsection (3), there shall appear the words "A FOR-PROFIT (or NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially similar words sufficient to identify clearly and plainly the ownership status of the licensed facility. Each itemized statement must prominently display the phone number of the medical facility's patient liaison who is responsible for expediting the resolution of any billing dispute between the patient, or his or her representative, and the billing department.

(6)~~(4)~~ An itemized bill shall be provided once to the patient's physician at the physician's request, at no charge.

(7)~~(5)~~ In any billing for services subsequent to the initial billing for such services, the patient, or the patient's survivor or legal guardian, may elect, at his or her option, to receive a copy of the detailed statement of specific services received and expenses incurred for each such item of service as provided in subsection (3)~~(1)~~.

(8)~~(6)~~ No physician, dentist, podiatric physician, or licensed facility may add to the price charged by any third party except for a service or handling charge representing a cost actually incurred as an item of expense; however, the physician, dentist, podiatric physician, or licensed facility is entitled to fair compensation for all professional services rendered. The amount of the service or handling charge, if any, shall be set forth clearly in the bill to the patient.

(9) A licensed facility shall make available to a patient, or a third-party payor acting on behalf of the patient, records necessary for verification of the accuracy of the patient's bill or payor's claim related to such patient's bill within 3 business days after the request for such records. The verification information must be made available in the facility's offices. Such records shall be available to the patient or payor prior to and after payment of the bill or claim. The facility may not charge the patient or payor for making such verification records available; however, the facility may charge its usual fee for providing copies of records as specified in s. 395.3025.

(10) A patient, or a third-party payor acting on behalf of the patient, has the right to appeal any charges in a facility's bill. A facility shall establish an impartial method for reviewing billing appeals and provide a written decision, with a clear explanation of the grounds for the decision, to the patient or payor making the appeal and to the agency within 30 days after the receipt of the appeal. A facility shall maintain a complete and accurate log of all appeals and shall report to the agency the number of appeals, the total of the charges subject to appeal, and a summary of the dispositions of the appeals no later than January 1 of each year.

(11) A licensed facility shall file with the agency no later than January 1 of each year a copy of its charge master. A facility must include an estimate of the percentage increase in its gross revenue due to any price increase or decrease in its charge master during the previous 12-month period. For purposes of this section, the term "charge master" means a uniform

schedule of charges represented by the facility as its gross billed charge for a given service or item, regardless of payor type.

(12) A licensed facility shall report to the agency and provide public notice on its Internet website, or by other electronic means, and in its public reception areas any proposed change to its charge master 30 days prior to implementing such changes. The notice must separately identify the amount and percent by which a charge is being reduced or increased. The licensed facility must include on such notice an explanation developed by the agency as to how the public may use the information in the selection of a health care facility.

Section 6. This act shall take effect July 1, 2004.