HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1329 Health Care Consumer Protection
SPONSOR(S): Health & Human Services Quality Subcommittee; Corcoran
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee	10 Y, 5 N, As CS	Poche	Calamas
2) Insurance & Banking Subcommittee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 1329 amends s. 395.107, F.S., to require ambulatory surgical centers and diagnostic-imaging centers to publish and post a schedule of medical charges for the 50 most frequently provided services and treatments at each center. The prices for medical service and treatment must be those charged to uninsured patients who pay for service or treatment by cash, check, credit card or debit card. The posting must be in a conspicuous place in the reception area of the center and comply with size and content requirements. The bill provides for a $1,000 fine, per day, for failure to comply with the law.

The bill requires certain medical practitioners to publish and distribute, in writing, a schedule of medical charges that meets the same requirements as those imposed on the centers, above. The schedule must be distributed to patients at every visit. Failure to distribute the schedule as required by law is grounds for discipline under the medical practice acts and pursuant to s. 456.072, F.S.

The bill prohibits "balance billing" by a provider for emergency care and services rendered to an insured patient during the first 24 hours if the insured patient is transported to a facility by emergency medical transportation services. "Balance billing" is also prohibited for nonemergency medical care and services if it was provided in a facility licensed under chapter 395, F.S., that has a contract with the patient's health insurer and the care or service was delivered by a provider who does not have a contract with the patient's health insurer, and the patient did not have the ability and opportunity to choose an alternate provider who has a contract with the patient's health insurer.

The bill requires specific disclosures by health insurers, facilities licensed under chapter 395, F.S., and medical professionals who provide medical care and services in those facilities to insured patients regarding contractual relationships between and among the entities and whether or not those entities will bill the insured patient directly for services rendered within the facility. The bill provides for fines and other penalties for failing to provide the requisite disclosure.

The bill makes conforming changes to statutes consistent with proposed law.

The bill has an indeterminate, possibly significant, fiscal impact on state government.

The bill provides an effective date of July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Regulation of Health Insurers and HMOs

The Office of Insurance Regulation (OIR) regulates health insurance contracts and rates under part VI of chapter 627, F.S., and health maintenance organization (HMO) contracts and rates under part I of chapter 641, F.S. The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of chapter 641, F.S.

Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate of authority and that is otherwise in compliance with the licensure provisions under part I of chapter 641, F.S., may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers.

Florida Patient's Bill of Rights and Responsibilities

In 1991, Florida enacted the Florida Patient's Bill of Rights and Responsibilities as s. 381.026, F.S.[1] 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.[2] 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
- Patient's knowledge of rights and responsibilities

Current law permits, but does not require, a primary care provider[3] to publish a schedule of medical charges provided to patients. If the primary care provider chooses to publish a schedule, it must include the prices charged to an uninsured patient paying by cash, check, credit card, or debit card.[4] The schedule must list, at least, the 50 services most frequently provided by the provider, and may group those services into three pricing levels.[5] The posting must be at least 15 square feet in size and be posted in a conspicuous place within the reception area of the provider's office.[6] If the provider posts the schedule, the provider will be exempt from one period of renewal license fees and one 2-year cycle of the continuing education requirements.[7] The schedule must remain posted at all times for the duration of active licensure within the state, as long as primary care services are provided to patients.[8] If the provider fails to continually post the schedule, he or she will be required to pay the renewal license fee that was not imposed and comply with the 2-year continuing education requirement.[9]

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[1] S. 1, Ch. 91-127, Laws of Fla. (1991).
[2] S. 381.026(3), F.S.
[3] S. 381.026(2)(d), F.S., defines "primary care provider" as a health care provider licensed under chapter 458, chapter 459, or chapter 464 who provides medical services to patients which are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[4] S. 381.026(4)(c)3., F.S.
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] S. 381.026(4)(c)4., F.S.
[9] *Id.*

Pursuant to the section relating to financial information and disclosure of financial information, a patient has the right to request certain financial information from health care providers and facilities.[10] 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.[11] Estimates are required to be written in language "comprehensible to an ordinary layperson."[12] 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.[13] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[14]

Health Care Price Transparency

In 2011, the Legislature passed CS/CS/HB 935, which was signed by the Governor.[15] The law requires an urgent care center[16] to publish and post a schedule of medical services provided and the cost of each service, grouped into three pricing levels.[17] The charges posted must be those fees charged to an uninsured patient who is paying for medical treatment by cash, check, credit card or debit card.[18] The schedule must be posted in a conspicuous place in the reception area of the office in an area of 15 square feet or more.[19] The schedule must list the 50 most frequently performed services provided by the urgent care center.[20] A primary care provider[21] (PCP) may post the same schedule of medical services provided.[22] If a PCP chooses to post a schedule of medical services, the schedule is subject to the same size and text requirements as an urgent care center.[23]

A health care provider or health care facility is required to provide a reasonable estimate of charges for non-emergency medical treatment to a patient.[24] The law also requires that the estimate comply with posted charges for medical treatment.[25]

Section 408.05, F.S. requires the AHCA to establish the Florida Center for Health Information and Policy Analysis (the Center).[26] The Center was required to create "a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics."[27] Specifically, the Center makes available to consumers health care quality measures and financial data of physicians, health care facilities, and other entities to enable the comparison of health care services.[28] The database includes certain health care quality measures such as average patient charges, the average of undiscounted charges on frequently performed procedures and preventive diagnostic procedures, and a range of charges for procedures from highest to lowest.[29]

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[10] S. 381.026(4)(c), F.S.
[11] S. 381.026(4)(c)3., F.S.
[12] *Id.*
[13] *Id.*
[14] S. 381.026(4)(c)5., F.S.
[15] *See* Chapter 2011-122, Laws of Fla.
[16] S. 395.002(30), F.S., defines "urgent care center" as a facility or clinic that provides immediate but not emergent ambulatory medical care to patients with or without an appointment. It does not include the emergency department of a hospital.
[17] S. 395.107, F.S.
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *See supra* at FN 3.
[22] S. 381.026(4)(c)3., F.S.
[23] *Id.*
[24] S. 381.026(4)(c)5., F.S.
[25] *Id.*
[26] S. 408.05, F.S.
[27] S. 408.05(1), F.S.
[28] S. 408.05(3)(k), F.S.
[29] S. 408.05(3)(k)1., F.S.; *see also* 2009 Hospital Financial Data, AHCA, data compiled September 2, 2010- available at http://ahca.myflorida.com/MCHQ/CON_FA/Publications/index.shtml (includes the most recent financial data for hospitals, including costs of daily hospital services, ambulatory services, and other total patient charges); *see also*

Balance Billing

"Balance billing" is the term given to the practice of a provider of medical care or treatment, such as a physician or hospital, seeking to collect payment from an insured patient or HMO subscriber, the amount of which is beyond the co-payment and deductible outlined in the health insurance plan or HMO contract. Essentially, the provider seeks to collect the total fee charged to a patient from the patient after the terms of the insurance plan or contract is applied to the total fee. Florida law prohibits balance billing of HMO subscribers.[30] Florida law also provides that AHCA may impose a fine on a hospital for balance billing an HMO subscriber[31], the amount of which is to be determined under section 641.52(5), F.S.[32].

There is no prohibition against balance billing of a patient covered by a health insurer subject to regulation under chapter 627, F.S.

Effect of Proposed Changes

Price Transparency

The bill requires an ambulatory surgical center[33] and a diagnostic-imaging center[34] to comply with the provisions of s. 395.107, F.S. The bill amends the definition of "urgent care center" to include a facility or organization that operates three or more locations, does not require an appointment to receive medical treatment, and holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided. Each center is required to post a schedule of charges for the 50 most frequently provided medical services in a conspicuous location in the reception area of the center. The schedule must include the price charged to an uninsured patient paying for the service by cash, check, credit card or debit card. Prices for medical services may be grouped into three pricing levels. The posted scheduled must be at least 15 square feet in size. In lieu of a sign, the bill permits the centers listed in s. 395.107, F.S., to use an electronic device to post the schedule of medical charges. The device must measure at least 22" by 33" in size and be accessible to all consumers during business hours.

The schedule of charges for medical services posted by an urgent care center, ambulatory surgical center, and a diagnostic-imaging center 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. The bill also requires the text of the schedule of medical charges to fill at least 12 square feet of the total 15 square feet area of the posted schedule.

The bill exempts an urgent care center that is operated and used exclusively for employees and dependents of employees of the business that owns, or contracts to operate, the urgent care center from the posting requirements of s. 395.107, F.S., outlined above.

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http://www.floridahealthfinder.gov/CompareCare/CompareFacilities.aspx (provides the range of charges for specific procedures at various facilities throughout Florida, broken down by category, condition or procedure, and age group).

[30] S. 641.3154, F.S.

[31] S. 395.1065(2)(c), F.S.

[32] S. 641.52(5), F.S. ,provides AHCA with the authority to suspend an HMO's authority to enroll new members, revoke the health care provider certificate, and assess fines for willful and non-willful violations not to exceed $2,500 and $20,000, respectively, with caps on the aggregate amount of fines assessed.

[33] S. 395.002(3), F.S., defines "ambulatory surgical center", in part, as a "facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital."

[34] "Diagnostic-imaging center" is defined in section 1 of the bill as a free-standing outpatient facility that provides specialized services for diagnosis of a disease by examination and also provides radiological services.

In situations in which the care center is affiliated with a facility licensed under chapter 395, F.S.,[35] the schedule of medical charges must include a statement, in a font which is the same size as other text on schedule and in a contrasting color, explaining whether charges for medical care received at the care center will be the same as, or more than, the charges for medical care received at the facility licensed under chapter 395. The statement must be included in all advertisements for the care facility and must be in language comprehensible to a layperson. This provision provides for transparency of medical facility charges so that a consumer, who may choose to seek treatment at a care center rather than the emergency room, assuming that the cost of care at the center is lower than the cost of care at an emergency room, is fully informed about the cost of care and can choose the option that best fits the consumer's budget.

The bill amends the Florida Patient's Bill of Rights and Responsibilities[36] to require allopathic physicians and osteopathic physicians to publish, in writing, a schedule of medical charges. The schedule must meet all of the requirements contained in s. 395.107, F.S. The schedule must be given to patients at each visit. The bill allows a physician to also post the schedule of medical charges pursuant to the same provisions observed by urgent care centers in s. 395.107, F.S. The bill also permits a physician to use an electronic device, measuring at least 22" by 33" in size, to post the schedule of medical charges. For a primary care provider who voluntarily publishes and maintains a schedule of medical charges from July 1, 2011 to June 30, 2012, in accordance with chapter 2011-122, Laws of Florida, the bill grants a one-time exemption from the costs of renewing a license and a one-time exemption from one cycle of compliance with continuing education requirements under the applicable practice act.

The bill imposes a fine of $1,000, per day, on an urgent care center, ambulatory surgical center, or diagnostic-imaging center that fails to post the schedule of medical charges. The failure of a practitioner to publish and distribute a schedule of medical charges is deemed grounds for discipline under s. 456.072(1), F.S., and subjects the offending practitioner to discipline under the applicable practice act and s. 456.072(2), F.S.[37]

Balance Billing Prohibition

The bill prohibits provider balance billing of an insured by a provider for emergency care and services for the first 24 hours if the insured was transported to a facility by emergency medical transportation services, as defined by s. 945.6041(1)(a), F.S.[38] Further, provider balance billing of an insured for nonemergency medical care and services is prohibited if the care or service is provided in a facility licensed under chapter 395, F.S., which has a contract with the health insurer, and the care or service is provided by a provider who does not have a contract with the health insurer, and the insured had no ability and opportunity to choose an alternate provider who has a contract with the health insurer. This provision addresses the situation in which a patient maintains health insurance, seeks treatment from a covered hospital entity, is treated by providers within the hospital who do not have a contract with the patient's insurer, and the patient has no ability to choose a contracted provider. The patient is negatively impacted by a contractual situation, or lack thereof, over which he or she has no control or input. This provision allows the patient to avoid charges for medical care over and above that which is covered by the patient's health insurance coverage.

[35] S. 395.002(12), F.S., (hospital); s. 395.002(3), F.S., (ambulatory surgical center); s. 395.002(21), F.S., (mobile surgical facility); s. 395.002(28), F.S., (specialty hospital).
[36] S. 381.026, F.S.
[37] Possible disciplinary action includes, but is not limited to, suspension or revocation of license, administrative fine, license probation, or other corrective action.
[38] S. 945.6041(1)(a), F.S., defines "emergency medical transportation services" as including, but not limited to, services rendered by ambulances, emergency medical services vehicles, and air ambulances as those terms are defined in s. 401.23, F.S.; within that section, an "ambulance" or "emergency medical services vehicle" is defined as any privately or publicly owned land or water vehicle that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, land or water transportation of sick or injured persons requiring or likely to require medical attention during transport; an "air ambulance" is defined as any fixed-wing or rotary-wing aircraft used for, or intended to be used for, air transportation of sick or injured persons requiring or likely to require medical attention during transport.

Balance Billing Transparency

The bill creates s. 627.6385, F.S., requiring health insurers, hospitals, and medical providers to disclose contractual relationships among the parties and to disclose, in advance of the provision of medical care or services, whether or not the patient will be balance billed as a result of the contractual relationship, or lack thereof, among the insurer, hospital, and medical provider. The bill provides transparency in the billing process and allows the health care consumer to make an informed choice regarding his or her medical treatment.

The bill requires each health insurer operating within the state to disclose to the insured if a facility licensed under chapter 395, F.S., contracts with medical providers that do not have a contractual relationship with the insurer. This information must be available on the insurer website and must be distributed to each insured.

The bill requires a facility licensed under chapter 395, F.S., to disclose to a patient, at the time the patient is admitted to the facility for non-emergent care or schedules medical care or treatment, which providers will treat the patient and which of those providers do not have a contractual relationship with the patient's insurer. The disclosure must include notice to the patient that the providers without a contractual relationship with the patient's insurer may bill the patient directly for services rendered within the facility. The notice must:

- Be limited to the providers reasonably expected to treat the insured, based on the medical care or treatment scheduled by the insured. For example, if the insured is scheduled to undergo a heart catheterization, the notice will apply to the anesthesiologist and the cardiologist scheduled to treat the insured. The notice will not apply to an oncologist or obstetrician, as those providers cannot be reasonably expected to provide treatment to the insured undergoing a cardiac procedure;
- Be in writing;
- Include the name, address, and telephone number of each provider; and
- Direct the insured to contact each provider to determine if the insured will be billed directly by the provider.

Failure to provide disclosure to the insured as required by this provision of the bill results in a $500 fine, per occurrence, to be imposed by the AHCA, pursuant to the provisions of s. 408.813, F.S.[39] If, during an episode of non-emergent treatment or care, the patient's condition becomes emergent in nature, the disclosure provisions applicable to the facility and to the providers that treat the patient do not apply.

Lastly, a medical provider, treating patients in a hospital entity who is not under contract with an insured's health insurer must disclose in writing, prior to providing care, whether the insured will be billed directly by the provider for care or treatment rendered in the facility. If the provider will directly bill the patient, the provider must give the patient an estimate of the medical charges to be billed. If the actual charges billed directly to the claimant exceed the estimate by 200% or more, the patient is not responsible for payment of those fees and the provider cannot balance bill the patient. Failure to provide the written disclosure to the insured exempts the insured from liability for any charges for services rendered by the provider. The bill does specify that the insured will be responsible for any applicable co-payments or deductibles as outlined by his or her health insurance plan.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.002, F.S., relating to definitions.
Section 2: Amends s. 395.107, F.S., relating to urgent care centers; publishing and posting schedule of charges.
Section 3: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.

[39] S. 408.813, F.S., authorizes AHCA to impose administrative fines as a penalty for violations of the Health Care Licensing Procedures Act (Part II of Chapter 408, F.S.), authorizing statutes, or applicable rules.

Section 4: Amends s. 627.6131, F.S., relating to payment of claims.
Section 5: Creates s. 627.6385, F.S., relating to hospital and provider transparency; duty to inform.
Section 6: Amends s. 383.50, F.S., relating to treatment of surrendered newborn infant.
Section 7: Amends s. 390.011, F.S., relating to definitions.
Section 8: Amends s. 394.4787, F.S., relating to definition; ss. 394.4786, 394.4787, 394.4788, and 394.4789.
Section 9: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 10: Amends s. 395.602, F.S., relating to rural hospitals.
Section 11: Amends s. 395.701, F.S., relating to annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.
Section 12: Amends s. 408.051, F.S., relating to Florida Electronic Health Records Exchange Act.
Section 13: Amends s. 409.905, F.S., relating to mandatory Medicaid services.
Section 14: Amends s. 409.97, F.S., relating to state and local Medicaid partnerships.
Section 15: Amends s. 409.975, F.S., relating to managed care plan accountability.
Section 16: Amends s. 468.505, F.S., relating to exemptions; exceptions.
Section 17: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; claims.
Section 18: Amends s. 766.118, F.S., relating to determination of noneconomic damages.
Section 19: Amends s. 766.316, F.S., relating to notice to obstetrical patients of participation in the plan.
Section 20: Amends s. 812.014, F.S., relating to theft.
Section 21: Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The AHCA may collect fines from urgent care centers, ambulatory surgical centers, and diagnostic-imaging centers which fail to publish and post the schedule of medical charges provided to patients at the center. The Department of Health (DOH) may collect fines from medical practitioners who fail to publish and distribute a schedule of medical charges to patients. Lastly, AHCA may also collect fines from facilities licensed under chapter 395, F.S., that fail to provide the requisite disclosure to an insured regarding whether or not providers may bill the insured directly for care and service rendered within the facility. The amount of fines that will be collected will not be known until compliance with the law by all parties can be determined. As a result, the impact of the collection of fines on revenue is indeterminate at this time. Such fines will likely offset the increased workload to enforce the provisions of the bill.

2. Expenditures:

AHCA will be responsible for confirming compliance with the law by urgent care centers, ambulatory surgical centers, diagnostic-imaging centers, and facilities licensed under chapter 395, F.S., and for imposing and collecting applicable fines. AHCA may experience a recurring increase in workload associated with confirming compliance with the law by urgent care centers, ambulatory surgical centers, and diagnostic-imaging centers. AHCA may also experience a recurring increase in workload associated with confirming that facilities licensed under chapter 395, F.S., are complying with the disclosure provisions of the bill. It is anticipated that current resources are adequate to absorb the increase in workload.[40] AHCA will incur non-recurring costs for rulemaking, which

[40] Telephone conference between AHCA staff and Health and Human Services Quality Subcommittee staff on January 23, 2012.

current budget authority is adequate to absorb.[41] The budgetary impact on AHCA for the increase in workload, if it exists, is indeterminate at this time.

Medical practitioner boards housed within DOH, or DOH itself, will be responsible for confirming compliance with the law by the specified medical practitioners subject to the statute proposed in the bill, and for imposing and collecting applicable fines. DOH may experience a recurring increase in workload associated with additional complaints and investigations due to non-compliance. It is anticipated that current resources are adequate to absorb the increase in workload.[42] DOH will incur non-recurring costs for rulemaking, which current budget authority is adequate to absorb.[43] The budgetary impact on the DOH for the increase in workload, if it exists, is indeterminate at this time.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Urgent care centers, ambulatory surgical centers, diagnostic-imaging centers, facilities licensed under chapter 395, F.S., and certain medical professionals, all of which are subject to the statutes proposed by this bill, may be required to pay fines for failing to comply with the law. The fines could be, in some cases, significant.

The centers will incur costs associated with publishing and posting the schedule of medical charges. Licensed facilities under chapter 395, F.S., and medical providers will incur costs associated with preparing and distributing the requisite disclosures to patients regarding the status of contractual relationships among each other and with insurers. Health insurers will incur costs associated with posting information on their websites regarding the contractual relationships between hospitals within the insurer's network and the medical professionals that provide care and services at those hospitals, as well as the costs associated with ensuring that the information on the website is up to date. Lastly, insurers may incur costs associated with distributing the information to their insureds in a manner other than through the website.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

[41] *Id.*
[42] E-mail correspondence between DOH staff and Health and Human Services Quality Subcommittee staff on January 23, 2012 (on file with the Subcommittee).
[43] *Id.*

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The AHCA and the DOH have appropriate rule-making authority sufficient to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 25, 2012, the Health and Human Services Quality Subcommittee adopted a strike-all amendment to HB 1329. The strike-all made the following changes to the bill:

- Made the publishing and distributing of a schedule of medical charges applicable only to physicians licensed under chapter 458, F.S., or chapter 459, F.S., and removed reference to chiropractors and podiatrists;
- Moved the requirements of physicians for publishing and distributing a schedule of medical charges from s. 395.107, F.S., to s. 381.026, F.S.;
- Amended the definition to "urgent care center" to include a facility or organization that maintains three or more locations, does not require an appointment for medical care, and holds itself out to the general public, in any manner, to be an urgent care center;
- Permitted a center, subject to the provisions of s. 395.107, F.S., to use an electronic device to post the schedule of medical charges;
- Required the electronic device to measure at least 22" by 33" in size and to be accessible to consumers during business hours;
- Exempted from the provisions of s. 395.107, F.S., an urgent care center that is operated and used exclusively for employees and the dependents of employees of the business that owns or contracts for the center;
- Made a violation of the provisions of s. 381.026, F.S., by a physician licensed under chapter 458, F.S., or chapter 459, F.S., grounds for discipline pursuant to s. 456.072, F.S.
- Made an insurer solely liable for fees of a provider for the first 24 hours of emergency care and treatment if the insured patient was transported to the facility for said treatment by emergency medical transportation services;
- Removed the requirement that a facility licensed under chapter 395, F.S., include in its disclosure to the insured a direction to the insured that he or she contact providers, prior to the delivery of care or service, to determine whether each provider will directly bill the insured for services rendered within the facility; and
- Made the disclosure requirements in s. 627.6385, F.S., inapplicable to a facility licensed under chapter 395, F.S., and a provider if, during an episode of non-emergent treatment, the patient's condition becomes emergent.

The bill was reported favorably as a committee substitute. The analysis reflects the committee substitute.