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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/25/2016	.	
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The Committee on Appropriations (Gaetz) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 395.301, Florida Statutes, is amended to read:

395.301 Price transparency; itemized patient statement or bill; ~~form and content prescribed by the agency;~~ patient admission status notification.—

(1) A facility licensed under this chapter shall provide


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timely and accurate financial information and quality of service measures to prospective and actual patients of the facility, or to patients' survivors or legal guardians, as appropriate. Such information shall be provided in accordance with this section and rules adopted by the agency pursuant to this chapter and s. 408.05. Licensed facilities operating exclusively as state facilities are exempt from this subsection.

(a) Each licensed facility shall make available to the public on its website information on payments made to that facility for defined bundles of services and procedures. The payment data must be presented and searchable in accordance with, and through a hyperlink to, the system established by the agency and its vendor using the descriptive service bundles developed under s. 408.05(3)(c). At a minimum, the facility shall provide the estimated average payment received from all payors, excluding Medicaid and Medicare, for the descriptive service bundles available at that facility and the estimated payment range for such bundles. Using plain language, comprehensible to an ordinary layperson, the facility must disclose that the information on average payments and the payment ranges is an estimate of costs that may be incurred by the patient or prospective patient and that actual costs will be based on the services actually provided to the patient. The facility shall also assist the consumer in accessing his or her health insurer's or health maintenance organization's website for information on estimated copayments, deductibles, and other cost-sharing responsibilities. The facility's website must:

1. Identify and post the names and hyperlinks for direct access to the websites of all health insurers and health

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maintenance organizations for which the facility is a network provider or preferred provider.

2. Provide information to uninsured patients and insured patients whose health insurer or health maintenance organization does not include the facility as a network provider or preferred provider on the facility's financial assistance policy, including the application process, payment plans, and discounts, and the facility's charity care policy and collection procedures.

3. If applicable, notify patients and prospective patients that services may be provided in the health care facility by the facility as well as by other health care providers who may separately bill the patient and that such health care providers may or may not participate with the same health insurers or health maintenance organizations as the facility does.

4. Inform patients and prospective patients that they may request from the facility and other health care providers a more personalized estimate of charges and other information, and inform patients that they should contact each health care practitioner who will provide services in the hospital to determine with which health insurers and health maintenance organizations he or she participates as a network provider or preferred provider.

5. Provide the names, mailing addresses, and telephone numbers of the health care practitioners and medical practice groups with which it contracts to provide services in the facility and instructions on how to contact the practitioners and groups to determine the health insurers and health maintenance organizations with which they participate as a

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network provider or preferred provider.

(b)1. Upon request, and before providing any nonemergency medical services, each licensed facility shall provide a written, good faith estimate of reasonably anticipated charges by the facility for the treatment of the patient's or prospective patient's specific condition. The facility must provide the estimate in writing to the patient or prospective patient within 7 business days after the receipt of the request and is not required to adjust the estimate for any potential insurance coverage. The estimate may be based on the descriptive service bundles developed by the agency under s. 408.05(3)(c) unless the patient or prospective patient requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient. The facility shall inform the patient or prospective patient that he or she may contact his or her health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities.

2. In the estimate, the facility shall provide to the patient or prospective patient information on the facility's financial assistance policy, including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures.

3. The estimate shall clearly identify any facility fees and, if applicable, include a statement notifying the patient or prospective patient that a facility fee is included in the estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.


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4. Upon request, the facility shall notify the patient or prospective patient of any revision to the estimate.

5. In the estimate, the facility must notify the patient or prospective patient that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient, if applicable.

6. The facility shall take action to educate the public that such estimates are available upon request.

7. Failure to timely provide the estimate pursuant to this paragraph shall result in a daily fine of $1,000 until the estimate is provided to the patient or prospective patient. The total fine may not exceed $10,000.

The provision of an estimate does not preclude the actual charges from exceeding the estimate.

(c) Each facility shall make available on its website a hyperlink to the health-related data, including quality measures and statistics that are disseminated by the agency pursuant to s. 408.05. The facility shall also take action to notify the public that such information is electronically available and provide a hyperlink to the agency's website.

(d)1. Upon request, and after the patient's discharge or release from a facility, the facility must provide ~~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, 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 or bill detailing in plain language, comprehensible to an ordinary layperson, the specific nature of charges or expenses incurred by the patient.~~, which in~~ The initial statement or bill ~~billing~~ shall be provided within 7 days after the patient's discharge or release or after a request for such statement or bill, whichever is later. The initial statement or bill must contain a statement of specific services received and expenses incurred by date and provider for such items of service, enumerating in detail as prescribed by the agency 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~~. The statement or bill must also clearly identify any facility fee and explain the purpose of the fee. The statement or bill must identify each item as paid, pending payment by a third party, or pending payment by the patient and must include the amount due, if applicable. If an amount is due from the patient, a due date must be included. The initial statement or bill must direct the patient or the patient's survivor or legal guardian, as appropriate, to contact the patient's insurer or health maintenance organization regarding the patient's cost-sharing responsibilities.

2. Any subsequent statement or bill provided to a patient or to the patient's survivor or legal guardian, as appropriate, relating to the episode of care must include all of the information required by subparagraph 1., with any revisions clearly delineated.

3.~~(2)(a)~~ Each ~~such~~ statement or bill provided ~~submitted~~


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pursuant to this subsection ~~section~~:

a.~~1.~~ Must ~~May not~~ include notice ~~charges~~ of hospital-based physicians and other health care providers who bill ~~if billed~~ separately.

b.~~2.~~ May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

c.~~3.~~ Must ~~Shall~~ list drugs by brand or generic name and not refer to drug code numbers when referring to drugs of any sort.

d.~~4.~~ Must ~~Shall~~ specifically identify physical, occupational, or speech therapy treatment by ~~as to the~~ date, type, and length of treatment when such ~~therapy~~ treatment is a part of the statement or bill.

~~(b) 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.~~

(2)~~(3)~~ ~~On each itemized statement submitted pursuant to subsection (1) 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 or bill must prominently display the telephone ~~phone~~ number of the medical facility's patient liaison who is responsible for expediting the resolution of any billing dispute between the patient, or the patient's survivor or legal guardian ~~his or her representative~~, and the billing department.

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

~~(5) In any billing for services subsequent to the initial~~

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~~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 (1).~~

~~(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.~~

~~(7) Each licensed facility not operated by the state shall provide, prior to provision of any nonemergency medical services, a written good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition upon written request of a prospective patient. The estimate shall be provided to the prospective patient within 7 business days after the receipt of the request. The estimate may be the average charges for that diagnosis related group or the average charges for that procedure. Upon request, the facility shall notify the patient of any revision to the good faith estimate. Such estimate shall not preclude the actual charges from exceeding the estimate. The facility shall place a notice in the reception area that such information is available. Failure to provide the estimate within the provisions established pursuant to this section shall result in a fine of $500 for each instance of the facility's failure to provide the~~

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~~requested information.~~

~~(8) Each licensed facility that is not operated by the state shall provide any uninsured person seeking planned nonemergency elective admission a written good faith estimate of reasonably anticipated charges for the facility to treat such person. The estimate must be provided to the uninsured person within 7 business days after the person notifies the facility and the facility confirms that the person is uninsured. The estimate may be the average charges for that diagnosis-related group or the average charges for that procedure. Upon request, the facility shall notify the person of any revision to the good faith estimate. Such estimate does not preclude the actual charges from exceeding the estimate. The facility shall also provide to the uninsured person a copy of any facility discount and charity care discount policies for which the uninsured person may be eligible. The facility shall place a notice in the reception area where such information is available. Failure to provide the estimate as required by this subsection shall result in a fine of $500 for each instance of the facility's failure to provide the requested information.~~

(3) ~~(9)~~ If a licensed facility places a patient on observation status rather than inpatient status, observation services shall be documented in the patient's discharge papers. The patient or the patient's survivor or legal guardian ~~proxy~~ shall be notified of observation services through discharge papers, which may also include brochures, signage, or other forms of communication for this purpose.

(4) ~~(10)~~ A licensed facility shall make available to a patient all records necessary for verification of the accuracy

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of the patient's statement or bill within 10 ~~30~~ business days after the request for such records. The records ~~verification information~~ must be made available in the facility's offices and through electronic means that comply with the Health Insurance Portability and Accountability Act of 1996. Such records must ~~shall~~ be available to the patient before ~~prior to~~ and after payment of the statement or bill ~~or claim~~. The facility may not charge the patient 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.

(5) ~~(11)~~ Each facility shall establish a method for reviewing and responding to questions from patients concerning the patient's itemized statement or bill. Such response shall be provided within 7 business ~~30~~ days after the date a question is received. If the patient is not satisfied with the response, the facility must provide the patient with the contact information ~~address~~ of the consumer advocate as provided in s. 627.0613 ~~agency~~ to which the issue may be sent for review.

~~(12) Each licensed facility shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration pursuant to s. 408.05(3)(k). The facility shall place a notice in the reception area that the information is available electronically and the facility's Internet website address.~~

Section 2. Section 395.107, Florida Statutes, is amended to read:

395.107 Facilities ~~Urgent care centers~~; publishing and posting schedule of charges; penalties.—

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(1) For purposes of this section, "facility" means:

(a) An urgent care center as defined in s. 395.002; or

(b) A diagnostic-imaging center operated by a hospital licensed under this chapter which is not located on the hospital's premises.

(2) A facility ~~An urgent care center~~ must publish and post a schedule of charges for the medical services offered to patients.

(3) ~~(2)~~ The schedule of charges must describe the medical services in language comprehensible to a layperson. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area and must include, but is not limited to, the 50 services most frequently provided. The schedule may group services by three price levels, listing services in each price level. The posting may be a sign, which must be at least 15 square feet in size, or may be through an electronic messaging board. If a facility ~~an urgent care center~~ is affiliated with a ~~facility~~ licensed hospital under this chapter, the schedule must include text that notifies the insured patients whether the charges for medical services received at the center will be the same as, or more than, charges for medical services received at the affiliated hospital. The text notifying the patient of the schedule of charges shall be in a font size equal to or greater than the font size used for prices and must be in a contrasting color. The text that notifies the insured patients whether the charges for medical services received at the center will be the same as, or more than, charges for medical services received at


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the affiliated hospital shall be included in all media and Internet advertisements for the center and in language comprehensible to a layperson.

(4) ~~(3)~~ The posted text describing the medical services must fill at least 12 square feet of the posting. A facility ~~center~~ may use an electronic device or messaging board to post the schedule of charges. Such a device must be at least 3 square feet, and patients must be able to access the schedule during all hours of operation of the facility ~~urgent care center~~.

(5) ~~(4)~~ A facility ~~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 facility ~~urgent care center~~ is exempt from this section.

(6) ~~(5)~~ The failure of a facility ~~an urgent care center~~ to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted.

Section 3. Section 395.3012, Florida Statutes, is created to read:

395.3012 Penalties for unconscionable prices.—

(1) The agency may impose administrative fines based on the findings of the consumer advocate’s investigation of billing complaints pursuant to s. 627.0613(6).

(2) The administrative fines for noncompliance with s. 395.301 are the greater of $2,500 per violation or double the amount of the original charges.

Section 4. Subsection (1) of section 400.487, Florida Statutes, is amended to read:

400.487 Home health service agreements; physician’s,

physician assistant's, and advanced registered nurse practitioner's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.—

(1)(a) Services provided by a home health agency must be covered by an agreement between the home health agency and the patient or the patient's legal representative specifying the home health services to be provided, the rates or charges for services paid with private funds, and the sources of payment, which may include Medicare, Medicaid, private insurance, personal funds, or a combination thereof. A home health agency providing skilled care must make an assessment of the patient's needs within 48 hours after the start of services.

(b) Every licensed home health agency shall provide upon the request of a prospective patient or his or her legal guardian a written, good faith estimate of reasonably anticipated charges for the prospective patient for services provided by the home health agency. The home health agency must provide the estimate to the requestor within 7 business days after receiving the request. The home health agency must inform the prospective patient, or his or her legal guardian, that he or she may contact the prospective patient's health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities. The home health agency must also provide information disclosing the home health agency's payment plans, discounts, and other available assistance and its collection procedures.

Section 5. Subsection (23) is added to section 400.934, Florida Statutes, to read:

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400.934 Minimum standards.—As a requirement of licensure, home medical equipment providers shall:

(23) Provide upon the request of a prospective patient or his or her legal guardian a written, good faith estimate of reasonably anticipated charges for the prospective patient for services provided by the home medical equipment provider. The home medical equipment provider must provide the estimate to the requestor within 7 business days after receiving the request. The home medical equipment provider must inform the prospective patient, or his or her legal guardian, that he or she may contact the prospective patient's health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities. The home medical equipment provider must also provide information disclosing the home medical equipment provider's payment plans, discounts, and other available assistance and its collection procedures.

Section 6. Section 408.05, Florida Statutes, is amended to read:

408.05 Florida Center for Health Information and Transparency ~~Policy Analysis~~.—

(1) ESTABLISHMENT.—The agency shall establish and maintain a Florida Center for Health Information and Transparency to collect, compile, coordinate, analyze, index, and disseminate ~~Policy Analysis. The center shall establish 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. The center shall be staffed as ~~with public health experts, biostatisticians, information~~

~~system analysts, health policy experts, economists, and other staff~~ necessary to carry out its functions.

(2) HEALTH-RELATED DATA.—The ~~comprehensive health information system operated by the~~ Florida Center for Health Information and Transparency ~~Policy Analysis~~ shall identify ~~the best~~ available data sets, compile new data when specifically authorized, ~~data sources~~ and promote the use ~~coordinate the compilation~~ of extant health-related data and statistics. The center must maintain any data sets in existence before July 1, 2016, unless such data sets duplicate information that is readily available from other credible sources, and may ~~and purposefully~~ collect or compile data on:

~~(a) The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality.~~

~~(b) The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state.~~

~~(c) Environmental, social, and other health hazards.~~

~~(d) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status.~~

(a) ~~(c)~~ Health resources, including licensed ~~physicians, dentists, nurses, and other~~ health care practitioners ~~professionals~~, by specialty and type of practice. Such data shall include information collected by the Department of Health pursuant to ss. 458.3191 and 459.0081.

(b) Health service inventories, including ~~and~~ acute care,


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long-term care, and other institutional care facilities ~~facility supplies~~ and specific services provided by hospitals, nursing homes, home health agencies, and other licensed health care facilities.

(c) ~~(f)~~ Service utilization for licensed health care facilities ~~of health care by type of provider~~.

(d) ~~(g)~~ Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.

~~(h) Family formation, growth, and dissolution.~~

(e) ~~(i)~~ The extent of public and private health insurance coverage in this state.

(f) ~~(j)~~ Specific quality-of-care initiatives involving ~~The quality of care provided by~~ various health care providers when extant data is not adequate to achieve the objectives of the initiative.

(3) ~~COMPREHENSIVE~~ HEALTH INFORMATION TRANSPARENCY ~~SYSTEM~~.—In order to disseminate and facilitate the availability of ~~produce~~ comparable and uniform health information ~~and statistics for the development of policy recommendations~~, the agency shall perform the following functions:

(a) Collect and compile information on and coordinate the activities of state agencies involved in providing ~~the design and implementation of the comprehensive~~ health information to consumers ~~system~~.

(b) Promote data sharing through dissemination of state-collected health data by making such data available, transferable, and readily usable ~~Undertake research,~~


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~~development, and evaluation respecting the comprehensive health information system~~.

(c) Contract with a vendor to provide a consumer-friendly, Internet-based platform that allows a consumer to research the cost of health care services and procedures and allows for price comparison. The Internet-based platform must allow a consumer to search by condition or service bundles that are comprehensible to a layperson and may not require registration, a security password, or user identification. The vendor shall also establish and maintain a Florida-specific data set of health care claims information available to the public and any interested party. The agency shall actively oversee the vendor to ensure compliance with state law. The agency shall select the vendor through an invitation to negotiate. A responsive vendor must be a nonprofit research institute that is qualified under s. 1874 of the Social Security Act to receive Medicare claims data and that receives claims, payment, and patient cost-share data from multiple private insurers nationwide. By July 1, 2016, a responsive vendor must have:

1. A national database consisting of at least 15 billion claim lines of administrative claims data from multiple payors capable of being expanded by adding third-party payors, including employers with health plans covered by the Employee Retirement Income Security Act of 1974.

2. A well-developed methodology for analyzing claims data within defined service bundles.

3. A bundling methodology that is available in the public domain to allow for consistency and comparison of state and national benchmarks with local regions and specific providers.


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~~(c) Review the statistical activities of state agencies to ensure that they are consistent with the comprehensive health information system.~~

(d) Develop written agreements with local, state, and federal agencies to facilitate ~~for~~ the sharing of data related to health care ~~health-care-related data or using the facilities and services of such agencies. State agencies, local health councils, and other agencies under state contract shall assist the center in obtaining, compiling, and transferring health-care-related data maintained by state and local agencies. Written agreements must specify the types, methods, and periodicity of data exchanges and specify the types of data that will be transferred to the center~~.

(e) Establish by rule:

1. The types of data collected, compiled, processed, used, or shared.

2. Requirements for implementation of the consumer-friendly, Internet-based platform created by the contracted vendor under paragraph (c).

3. Requirements for the submission of data by insurers pursuant to s. 627.6385 and health maintenance organizations pursuant to s. 641.54 to the contracted vendor under paragraph (c).

4. Requirements governing the collection of data by the contracted vendor under paragraph (c).

5. How information is to be published on the consumer-friendly, Internet-based platform created under paragraph (c) for public use. ~~Decisions regarding center data sets should be made based on consultation with the State Consumer Health~~

~~Information and Policy Advisory Council and other public and private users regarding the types of data which should be collected and their uses. The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the agency.~~

(f) Consult with contracted vendors, the State Consumer Health Information and Policy Advisory Council, and other public and private users regarding the types of data that should be collected and the use of such data.

(g) Monitor data collection procedures and test data quality to facilitate the dissemination of data that is accurate, valid, reliable, and complete.

~~(f) Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data. The agency shall periodically review ongoing health care data collections of the Department of Health and other state agencies to determine if the collections are being conducted in accordance with the established minimum sets of data.~~

~~(g) Establish advisory standards to ensure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations.~~

~~(h) Prescribe standards for the publication of health-care-related data reported pursuant to this section which ensure the reporting of accurate, valid, reliable, complete, and comparable data. Such standards should include advisory warnings to users of the data regarding the status and quality of any data~~


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~~reported by or available from the center.~~

(h) ~~(i)~~ Develop ~~Prescribe standards for the maintenance and preservation of the center's data. This should include~~ methods for archiving data, retrieval of archived data, and data editing and verification.

~~(j) Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests.~~

(i) ~~(k)~~ Make ~~Develop, in conjunction with the State Consumer Health Information and Policy Advisory Council, and implement a long-range plan for making~~ available health care quality measures ~~and financial data~~ that will allow consumers to compare outcomes and other performance measures for health care services. ~~The health care quality measures and financial data the agency must make available include, but are not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall update the plan and report on the status of its implementation annually. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:~~

~~1. Make available patient-safety indicators, inpatient quality indicators, and performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The terms "patient-safety indicators" and~~

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~~"inpatient quality indicators" have the same meaning as that ascribed by the Centers for Medicare and Medicaid Services, an accrediting organization whose standards incorporate comparable regulations required by this state, or a national entity that establishes standards to measure the performance of health care providers, or by other states. The agency shall determine which conditions, procedures, health care quality measures, and patient charge data to disclose based upon input from the council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which health care quality measures to disclose, the agency:~~

~~a. Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable.~~

~~b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, an accrediting organization whose standards incorporate comparable regulations required by this state, the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.~~

~~When determining which patient charge data to disclose, the agency shall include such measures as the average of~~

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~~undiscounted charges on frequently performed procedures and preventive diagnostic procedures, the range of procedure charges from highest to lowest, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others.~~

~~2. Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to chapter 627 or chapter 641. The agency shall determine which health care quality measures and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health plans shall make available to the agency such data or information that is not currently reported to the agency or the office.~~

~~3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the State Consumer Health Information and Policy Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include~~

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~~such additional information as is determined necessary to ensure that the website enhances informed decisionmaking among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider.~~

~~4. Publish on its website undiscounted charges for no fewer than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures.~~

~~(4) TECHNICAL ASSISTANCE.—~~

~~(a) The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the center. The center shall also provide the following additional technical assistance services:~~

~~1. Establish procedures identifying the circumstances under which, the places at which, the persons from whom, and the methods by which a person may secure data from the center, including procedures governing requests, the ordering of requests, timeframes for handling requests, and other procedures necessary to facilitate the use of the center's data. To the extent possible, the center should provide current data timely in response to requests from public or private agencies.~~

~~2. Provide assistance to data sources and users in the areas of database design, survey design, sampling procedures, statistical interpretation, and data access to promote improved health-care-related data sets.~~

~~3. Identify health care data gaps and provide technical assistance to other public or private organizations for meeting~~

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~~documented health care data needs.~~

~~4. Assist other organizations in developing statistical abstracts of their data sets that could be used by the center.~~

~~5. Provide statistical support to state agencies with regard to the use of databases maintained by the center.~~

~~6. To the extent possible, respond to multiple requests for information not currently collected by the center or available from other sources by initiating data collection.~~

~~7. Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center.~~

~~8. Respond to requests for data which are not available in published form by initiating special computer runs on data sets available to the center.~~

~~9. Monitor innovations in health information technology, informatics, and the exchange of health information and maintain a repository of technical resources to support the development of a health information network.~~

~~(b) The agency shall administer, manage, and monitor grants to not-for-profit organizations, regional health information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or training projects to advance the development of a health information network. Any grant contract shall be evaluated to ensure the effective outcome of the health information project.~~

~~(c) The agency shall initiate, oversee, manage, and evaluate the integration of health care data from each state agency that collects, stores, and reports on health care issues~~

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~~and make that data available to any health care practitioner through a state health information network.~~

~~(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.—The center shall provide for the widespread dissemination of data which it collects and analyzes. The center shall have the following publication, reporting, and special study functions:~~

~~(a) The center shall publish and make available periodically to agencies and individuals health statistics publications of general interest, including health plan consumer reports and health maintenance organization member satisfaction surveys; publications providing health statistics on topical health policy issues; publications that provide health status profiles of the people in this state; and other topical health statistics publications.~~

(j) ~~(b) The center shall publish,~~ Make available~~, and disseminate, promptly and as widely as practicable,~~ the results of special health surveys, health care research, and health care evaluations conducted or supported under this section. ~~Any publication by the center must include a statement of the limitations on the quality, accuracy, and completeness of the data.~~

~~(c) The center shall provide indexing, abstracting, translation, publication, and other services leading to a more effective and timely dissemination of health care statistics.~~

~~(d) The center shall be responsible for publishing and disseminating an annual report on the center's activities.~~

~~(e) The center shall be responsible, to the extent resources are available, for conducting a variety of special studies and surveys to expand the health care information and~~


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~~statistics available for health policy analyses, particularly for the review of public policy issues. The center shall develop a process by which users of the center's data are periodically surveyed regarding critical data needs and the results of the survey considered in determining which special surveys or studies will be conducted. The center shall select problems in health care for research, policy analyses, or special data collections on the basis of their local, regional, or state importance; the unique potential for definitive research on the problem; and opportunities for application of the study findings.~~

(4) ~~(6)~~ PROVIDER DATA REPORTING.—This section does not confer on the agency the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law. The agency may not establish an all-payor claims database or a comparable database without express legislative authority.

(5) ~~(7)~~ BUDGET; FEES.—

(a) ~~The Legislature intends that funding for the Florida Center for Health Information and Policy Analysis be appropriated from the General Revenue Fund.~~

~~(b)~~ The Florida Center for Health Information and Transparency ~~Policy Analysis~~ may apply for and receive and accept grants, gifts, and other payments, including property and services, from any governmental or other public or private entity or person and make arrangements as to the use of same, including the undertaking of special studies and other projects relating to health-care-related topics. Funds obtained pursuant


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to this paragraph may not be used to offset annual appropriations from the General Revenue Fund.

(b) ~~(c)~~ The center may charge such reasonable fees for services as the agency prescribes by rule. The established fees may not exceed the reasonable cost for such services. Fees collected may not be used to offset annual appropriations from the General Revenue Fund.

(6) ~~(8)~~ STATE CONSUMER HEALTH INFORMATION AND POLICY ADVISORY COUNCIL.—

(a) There is established in the agency the State Consumer Health Information and Policy Advisory Council to assist the center ~~in reviewing the comprehensive health information system, including the identification, collection, standardization, sharing, and coordination of health-related data, fraud and abuse data, and professional and facility licensing data among federal, state, local, and private entities and to recommend improvements for purposes of public health, policy analysis, and transparency of consumer health care information~~. The council consists ~~shall consist~~ of the following members:

1. An employee of the Executive Office of the Governor, to be appointed by the Governor.

2. An employee of the Office of Insurance Regulation, to be appointed by the director of the office.

3. An employee of the Department of Education, to be appointed by the Commissioner of Education.

4. Ten persons, to be appointed by the Secretary of Health Care Administration, representing other state and local agencies, state universities, business and health coalitions, local health councils, professional health-care-related


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associations, consumers, and purchasers.

(b) Each member of the council shall be appointed to serve for a term of 2 years following the date of appointment~~, except the term of appointment shall end 3 years following the date of appointment for members appointed in 2003, 2004, and 2005~~. A vacancy shall be filled by appointment for the remainder of the term, and each appointing authority retains the right to reappoint members whose terms of appointment have expired.

(c) The council may meet at the call of its chair, at the request of the agency, or at the request of a majority of its membership, but the council must meet at least quarterly.

(d) Members shall elect a chair and vice chair annually.

(e) A majority of the members constitutes a quorum, and the affirmative vote of a majority of a quorum is necessary to take action.

(f) The council shall maintain minutes of each meeting and shall make such minutes available to any person.

(g) Members of the council shall serve without compensation but shall be entitled to receive reimbursement for per diem and travel expenses as provided in s. 112.061.

(h) The council's duties and responsibilities include, but are not limited to, the following:

1. To develop a mission statement, goals, and a plan of action for the identification, collection, standardization, sharing, and coordination of health-related data across federal, state, and local government and private sector entities.

2. To develop a review process to ensure cooperative planning among agencies that collect or maintain health-related data.


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3. To create ad hoc issue-oriented technical workgroups on an as-needed basis to make recommendations to the council.

(7)~~(9)~~ APPLICATION TO OTHER AGENCIES.~~—Nothing in~~ This section does not ~~shall~~ limit, restrict, affect, or control the collection, analysis, release, or publication of data by any state agency pursuant to its statutory authority, duties, or responsibilities.

Section 7. 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 shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties and to facilitate transparency in health care pricing data and quality measures. Specifications for data to be collected under this section shall be developed by the agency and applicable contract vendors, 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 submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to: case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on

complications as specified by rule, data on readmissions as specified by rule, with patient and provider-specific identifiers included, actual charge data by diagnostic groups or other bundled groupings as specified by rule, 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. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, and related diagnostic information. Reported data elements shall be reported electronically in accordance with rule 59E-7.012, Florida Administrative Code. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

(b) Data to be submitted by health care providers may include, but are not limited to: professional organization and specialty board affiliations, Medicare and Medicaid participation, types of services offered to patients, actual charges to patients as specified by rule, amount of revenue and expenses of the health care provider, and such other data which are reasonably necessary to study utilization patterns. Data submitted shall be certified by the appropriate duly authorized


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representative or employee of the health care provider that the information submitted is true and accurate.

(c) Data to be submitted by health insurers may include, but are not limited to: claims, payments to health care facilities and health care providers as specified by rule, premium, administration, and financial information. Data submitted shall be certified by the chief financial officer, an appropriate and duly authorized representative, or an employee of the insurer that the information submitted is true and accurate. Information that is considered a trade secret under s. 812.081 shall be clearly designated.

(d) Data required to be submitted by health care facilities, health care providers, or health insurers may ~~shall~~ not include specific provider contract reimbursement information. However, such specific provider reimbursement data shall be reasonably available for onsite inspection by the agency as is necessary to carry out the agency's regulatory duties. Any such data obtained by the agency as a result of onsite inspections may not be used by the state for purposes of direct provider contracting and are confidential and exempt from ~~the provisions of~~ s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(e) A requirement to submit data shall be adopted by rule if the submission of data is being required of all members of any type of health care facility, health care provider, or health insurer. Rules are not required, however, for the submission of data for a special study mandated by the Legislature or when information is being requested for a single health care facility, health care provider, or health insurer.

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Section 8. Section 456.0575, Florida Statutes, is amended to read:

456.0575 Duty to notify patients.—

(1) Every licensed health care practitioner shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section does ~~shall~~ not constitute an acknowledgment of admission of liability, nor can such notifications be introduced as evidence.

(2) Every licensed health care practitioner must provide upon request by a patient, before providing any nonemergency medical services in a facility licensed under chapter 395, a written, good faith estimate of reasonably anticipated charges to treat the patient's condition at the facility. The health care practitioner must provide the estimate to the patient within 7 business days after receiving the request and is not required to adjust the estimate for any potential insurance coverage. The health care practitioner must inform the patient that he or she may contact his or her health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities. The health care practitioner must provide information to uninsured patients and insured patients for whom the practitioner is not a network provider or preferred provider which discloses the practitioner's financial assistance policy, including the application process, payment plans, discounts, or other available assistance, and the practitioner's charity care policy and collection procedures. Such estimate does not preclude the actual charges from exceeding the


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estimate. Failure to provide the estimate in accordance with this subsection, without good cause, shall result in disciplinary action against the health care practitioner and a daily fine of $500 until the estimate is provided to the patient. The total fine may not exceed $5,000.

Section 9. Paragraph (oo) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(oo) Failure to comply with fair billing practices pursuant to s. 627.0613(6).

Section 10. Section 627.0613, Florida Statutes, is amended to read:

627.0613 Consumer advocate.—The Chief Financial Officer must appoint a consumer advocate who must represent the general public of the state before the department, ~~and~~ the office, and other state agencies, as required by this section. The consumer advocate must report directly to the Chief Financial Officer, but is not otherwise under the authority of the department or of any employee of the department. The consumer advocate has such powers as are necessary to carry out the duties of the office of consumer advocate, including, but not limited to, the powers to:

(1) Recommend to the department or office, by petition, the commencement of any proceeding or action; appear in any proceeding or action before the department or office; or appear in any proceeding before the Division of Administrative Hearings relating to subject matter under the jurisdiction of the

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department or office.

(2) Report to the Agency for Health Care Administration and to the Department of Health any findings resulting from investigation of unresolved complaints concerning the billing practices of any health care facility licensed under chapter 395 or any health care practitioner subject to chapter 456.

(3) ~~(2)~~ Have access to and use of all files, records, and data of the department or office.

(4) Have access to any files, records, and data of the Agency for Health Care Administration and the Department of Health which are necessary for the investigations authorized by subsection (6).

(5) ~~(3)~~ Examine rate and form filings submitted to the office, hire consultants as necessary to aid in the review process, and recommend to the department or office any position deemed by the consumer advocate to be in the public interest.

(6) Maintain a process for receiving and investigating complaints from insured and uninsured patients of health care facilities licensed under chapter 395 and health care practitioners subject to chapter 456 concerning billing practices. Investigations by the office of the consumer advocate shall be limited to determining compliance with the following requirements:

(a) The patient was informed before a nonemergency procedure of expected payments related to the procedure as provided in s. 395.301, contact information for health insurers or health maintenance organizations to determine specific cost-sharing responsibilities, and the expected involvement in the procedure of other providers who may bill independently.

(b) The patient was informed of policies and procedures to qualify for discounted charges.

(c) The patient was informed of collection procedures and given the opportunity to participate in an extended payment schedule.

(d) The patient was given a written, personal, and itemized estimate upon request as provided in ss. 395.301 and 456.0575.

(e) The statement or bill delivered to the patient was accurate and included all information required pursuant to s. 395.301.

(f) The billed amounts were fair charges. As used in this paragraph, the term "fair charges" means the common and frequent range of charges for patients who are similarly situated requiring the same or similar medical services.

(7) Provide mediation between providers and patients to resolve billing complaints and negotiate arrangements for extended payment schedules.

(8)~~(4)~~ Prepare an annual budget for presentation to the Legislature by the department, which budget must be adequate to carry out the duties of the office of consumer advocate.

Section 11. Section 627.6385, Florida Statutes, is created to read:

627.6385 Disclosures to policyholders; calculations of cost sharing.—

(1) Each health insurer shall make available on its website:

(a) A method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities for health care services and procedures. Such method of making

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an estimate shall be based on service bundles established pursuant to s. 408.05(3)(c). Estimates do not preclude the actual copayment, coinsurance percentage, or deductible, whichever is applicable, from exceeding the estimate.

1. Estimates shall be calculated according to the policy and known plan usage during the coverage period.

2. Estimates shall be made available based on providers that are in-network and out-of-network.

3. A policyholder must be able to create estimates by any combination of the service bundles established pursuant to s. 408.05(3)(c), by a specified provider, or a comparison of providers.

(b) A method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities based on a personalized estimate of charges received from a facility pursuant to s. 395.301 or a practitioner pursuant to s. 456.0575.

(c) A hyperlink to the health information, including, but not limited to, service bundles and quality of care information, which is disseminated by the Agency for Health Care Administration pursuant to s. 408.05(3).

(2) Each health insurer shall include in every policy delivered or issued for delivery to any person in the state or in materials provided as required by s. 627.64725 notice that the information required by this section is available electronically and the address of the website where the information can be accessed.

(3) Each health insurer that participates in the state group health insurance plan created under s. 110.123 or Medicaid

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managed care pursuant to part IV of chapter 409 shall contribute all claims data from Florida policyholders held by the insurer and its affiliates to the contracted vendor selected by the Agency for Health Care Administration under s. 408.05(3)(c). Each insurer and its affiliates may not contribute claims data to the contracted vendor which reflect the following types of coverage:

(a) Coverage only for accident, or disability income insurance, or any combination thereof.

(b) Coverage issued as a supplement to liability insurance.

(c) Liability insurance, including general liability insurance and automobile liability insurance.

(d) Workers' compensation or similar insurance.

(e) Automobile medical payment insurance.

(f) Credit-only insurance.

(g) Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

(h) Limited scope dental or vision benefits.

(i) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(j) Coverage only for a specified disease or illness.

(k) Hospital indemnity or other fixed indemnity insurance.

(l) Medicare supplemental health insurance as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under chapter 55 of Title 10 U.S.C., and similar supplemental coverage provided to supplement coverage under a group health plan.

Section 12. Subsection (6) of section 641.54, Florida Statutes, is amended, present subsection (7) of that section is


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redesignated as subsection (8) and amended, and a new subsection (7) is added to that section, to read:

641.54 Information disclosure.—

(6) Each health maintenance organization shall make available to its subscribers on its website or by request the estimated copayment ~~copay~~, coinsurance percentage, or deductible, whichever is applicable, for any covered services as described by the searchable bundles established on a consumer-friendly, Internet-based platform pursuant to s. 408.05(3)(c) or as described by a personalized estimate received from a facility pursuant to s. 395.301 or a practitioner pursuant to s. 456.0575, the status of the subscriber's maximum annual out-of-pocket payments for a covered individual or family, and the status of the subscriber's maximum lifetime benefit. Such estimate does ~~shall~~ not preclude the actual copayment ~~copay~~, coinsurance percentage, or deductible, whichever is applicable, from exceeding the estimate.

(7) Each health maintenance organization that participates in the state group health insurance plan created under s. 110.123 or Medicaid managed care pursuant to part IV of chapter 409 shall contribute all claims data from Florida subscribers held by the organization and its affiliates to the contracted vendor selected by the Agency for Health Care Administration under s. 408.05(3)(c). Each health maintenance organization and its affiliates may not contribute claims data to the contracted vendor which reflect the following types of coverage:

(a) Coverage only for accident, or disability income insurance, or any combination thereof.

(b) Coverage issued as a supplement to liability insurance.

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(c) Liability insurance, including general liability insurance and automobile liability insurance.

(d) Workers' compensation or similar insurance.

(e) Automobile medical payment insurance.

(f) Credit-only insurance.

(g) Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

(h) Limited scope dental or vision benefits.

(i) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(j) Coverage only for a specified disease or illness.

(k) Hospital indemnity or other fixed indemnity insurance.

(l) Medicare supplemental health insurance as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under chapter 55 of Title 10 U.S.C., and similar supplemental coverage provided to supplement coverage under a group health plan.

(8)~~(7)~~ Each health maintenance organization shall make available on its ~~Internet~~ website a hyperlink ~~link~~ to the health information ~~performance outcome and financial data~~ that is disseminated ~~published~~ by the Agency for Health Care Administration pursuant to s. 408.05(3) ~~s. 408.05(3)(k)~~ and shall include in every policy delivered or issued for delivery to any person in the state or in ~~any~~ materials provided as required by s. 627.64725 notice that such information is available electronically and the address of its ~~Internet~~ website.

Section 13. Paragraph (n) is added to subsection (2) of section 409.967, Florida Statutes, to read:


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409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(n) *Transparency.*—Managed care plans shall comply with ss. 627.6385(3) and 641.54(7).

Section 14. Paragraph (d) of subsection (3) of section 110.123, Florida Statutes, is amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

(d)1. Notwithstanding ~~the provisions of~~ chapter 287 and the authority of the department, for the purpose of protecting the health of, and providing medical services to, state employees participating in the state group insurance program, the department may contract to retain the services of professional administrators for the state group insurance program. The agency shall follow good purchasing practices of state procurement to the extent practicable under the circumstances.

2. Each vendor in a major procurement, and any other vendor if the department deems it necessary to protect the state's financial interests, shall, at the time of executing any contract with the department, post an appropriate bond with the department in an amount determined by the department to be adequate to protect the state's interests but not higher than the full amount estimated to be paid annually to the vendor under the contract.

3. Each major contract entered into by the department pursuant to this section shall contain a provision for payment


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of liquidated damages to the department for material noncompliance by a vendor with a contract provision. The department may require a liquidated damages provision in any contract if the department deems it necessary to protect the state's financial interests.

4. Section ~~The provisions of s.~~ 120.57(3) applies ~~apply~~ to the department's contracting process, except:

a. A formal written protest of any decision, intended decision, or other action subject to protest shall be filed within 72 hours after receipt of notice of the decision, intended decision, or other action.

b. As an alternative to any provision of s. 120.57(3), the department may proceed with the bid selection or contract award process if the director of the department sets forth, in writing, particular facts and circumstances that ~~which~~ demonstrate the necessity of continuing the procurement process or the contract award process in order to avoid a substantial disruption to the provision of any scheduled insurance services.

5. The department shall make arrangements as necessary to contribute claims data of the state group health insurance plan to the contracted vendor selected by the Agency for Health Care Administration pursuant to s. 408.05(3)(c).

6. Each contracted vendor for the state group health insurance plan shall contribute Florida claims data to the contracted vendor selected by the Agency for Health Care Administration pursuant to s. 408.05(3)(c).

Section 15. Subsection (3) of section 20.42, Florida Statutes, is amended to read:

20.42 Agency for Health Care Administration.—


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(3) The department shall be the chief health policy and planning entity for the state. The department is responsible for health facility licensure, inspection, and regulatory enforcement; investigation of consumer complaints related to health care facilities and managed care plans; the implementation of the certificate of need program; the operation of the Florida Center for Health Information and Transparency ~~Policy Analysis~~; the administration of the Medicaid program; the administration of the contracts with the Florida Healthy Kids Corporation; the certification of health maintenance organizations and prepaid health clinics as set forth in part III of chapter 641; and any other duties prescribed by statute or agreement.

Section 16. Paragraph (c) of subsection (4) of section 381.026, Florida Statutes, is amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(4) RIGHTS OF PATIENTS.—Each health care facility or provider shall observe the following standards:

(c) *Financial information and disclosure.*—

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.

2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, before treatment, whether the health care provider or the health care facility in which the patient is receiving


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medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.

3. A primary care provider may publish a schedule of charges for the medical services that the provider offers to patients. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area of the provider's office and must include, but is not limited to, the 50 services most frequently provided by the primary care provider. The schedule may group services by three price levels, listing services in each price level. The posting must be at least 15 square feet in size. A primary care provider who publishes and maintains a schedule of charges for medical services is exempt from the license fee requirements for a single period of renewal of a professional license under chapter 456 for that licensure term and is exempt from the continuing education requirements of chapter 456 and the rules implementing those requirements for a single 2-year period.

4. If a primary care provider publishes a schedule of charges pursuant to subparagraph 3., he or she must continually post it at all times for the duration of active licensure in this state when primary care services are provided to patients. If a primary care provider fails to post the schedule of charges in accordance with this subparagraph, the provider shall be required to pay any license fee and comply with any continuing education requirements for which an exemption was received.

5. A health care provider or a health care facility shall,


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upon request, furnish a person, before the provision of medical services, a reasonable estimate of charges for such services. The health care provider or the health care facility shall provide an uninsured person, before the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding the provider's or facility's discount or charity policies for which the uninsured person may be eligible. Such estimates by a primary care provider must be consistent with the schedule posted under subparagraph 3. Estimates shall, to the extent possible, be written in language comprehensible to an ordinary layperson. Such reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

6. Each licensed facility, except a facility operating exclusively as a state facility, ~~not operated by the state~~ shall make available to the public on its ~~Internet~~ website or by other electronic means a description of and a hyperlink ~~link~~ to the health information ~~performance outcome and financial data~~ that is disseminated ~~published~~ by the agency pursuant to s. 408.05(3) ~~s. 408.05(3)(k)~~. The facility shall place a notice in the reception area that such information is available electronically and the website address. The licensed facility may indicate that the pricing information is based on a compilation of charges for the average patient and that each patient's statement or bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the price of service is negotiable for


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eligible patients based upon the patient's ability to pay.

7. A patient has the right to receive a copy of an itemized statement or bill upon request. A patient has a right to be given an explanation of charges upon request.

Section 17. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part, the term:

(e) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons per square mile;

4. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency ~~Policy Analysis~~ at the agency; or

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5. A hospital designated as a critical access hospital, as defined in s. 408.07.

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 18. Section 395.6025, Florida Statutes, is amended to read:

395.6025 Rural hospital replacement facilities.—Notwithstanding ~~the provisions of~~ s. 408.036, a hospital defined as a statutory rural hospital in accordance with s. 395.602, or a not-for-profit operator of rural hospitals, is not required to obtain a certificate of need for the construction of a new hospital located in a county with a population of at least 15,000 but no more than 18,000 and a density of fewer ~~less~~ than 30 persons per square mile, or a replacement facility, provided that the replacement, or new, facility is located within 10


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miles of the site of the currently licensed rural hospital and within the current primary service area. As used in this section, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency ~~Policy Analysis~~ at the Agency for Health Care Administration.

Section 19. Subsection (43) of section 408.07, Florida Statutes, is amended to read:

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(43) "Rural hospital" means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county;

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the


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most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency ~~Policy Analysis~~ at the Agency for Health Care Administration; or

(e) A critical access hospital.

Population densities used in this subsection must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this subsection shall be granted such designation upon application, including supporting documentation, to the Agency for Health Care Administration.

Section 20. Paragraph (a) of subsection (4) of section 408.18, Florida Statutes, is amended to read:

408.18 Health Care Community Antitrust Guidance Act; antitrust no-action letter; market-information collection and education.—

(4)(a) Members of the health care community who seek antitrust guidance may request a review of their proposed business activity by the Attorney General’s office. In conducting its review, the Attorney General’s office may seek whatever documentation, data, or other material it deems necessary from the Agency for Health Care Administration, the Florida Center for Health Information and Transparency ~~Policy~~

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~~Analysis~~, and the Office of Insurance Regulation of the Financial Services Commission.

Section 21. Section 465.0244, Florida Statutes, is amended to read:

465.0244 Information disclosure.—Every pharmacy shall make available on its ~~Internet~~ website a hyperlink ~~link~~ to the health information ~~performance outcome and financial data~~ that is disseminated ~~published~~ by the Agency for Health Care Administration pursuant to s. 408.05(3) ~~s. 408.05(3)(k)~~ and shall place in the area where customers receive filled prescriptions notice that such information is available electronically and the address of its Internet website.

Section 22. This act is intended to promote health care price and quality transparency to enable consumers to make informed choices on health care treatment and improve competition in the health care market. Persons or entities required to submit, receive, or publish data under this act are acting pursuant to state requirements contained therein and are exempt from state antitrust laws.

Section 23. This act shall take effect July 1, 2016.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to transparency in health care; amending s. 395.301, F.S.; requiring a facility licensed under ch. 395, F.S., to provide timely and


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accurate financial information and quality of service measures to certain individuals; providing an exemption; requiring a licensed facility to make available on its website certain information on payments made to that facility for defined bundles of services and procedures and other information for consumers and patients; requiring that facility websites provide specified information and notify and inform patients or prospective patients of certain information; requiring a facility to provide a written, good faith estimate of charges to a patient or prospective patient within a certain timeframe; requiring a facility to provide information regarding financial assistance from the facility which may be available to a patient or a prospective patient; providing a penalty for failing to provide an estimate of charges to a patient; deleting a requirement that a licensed facility not operated by the state provide notice to a patient of his or her right to an itemized statement or bill within a certain timeframe; revising the information that must be included on a patient's statement or bill; requiring that certain records be made available through electronic means that comply with a specified law; reducing the response time for certain patient requests for information; amending s. 395.107, F.S.; providing a definition; making technical changes; creating s. 395.3012, F.S.; authorizing the Agency for Health Care Administration to impose penalties based on certain findings of an


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investigation as determined by the consumer advocate; amending ss. 400.487 and 400.934, F.S.; requiring home health agencies and home medical equipment providers to provide upon request certain written estimates of charges within a certain timeframe; amending s. 408.05, F.S.; revising requirements for the collection and use of health-related data by the agency; requiring the agency to contract with a vendor to provide an Internet-based platform with certain attributes; requiring potential vendors to have certain qualifications; prohibiting the agency from establishing a certain database under certain circumstances; amending s. 408.061, F.S.; revising requirements for the submission of health care data to the agency; requiring submitted information considered a trade secret to be clearly designated; amending s. 456.0575, F.S.; requiring a health care practitioner to provide a patient upon his or her request a written, good faith estimate of anticipated charges within a certain timeframe; setting a maximum amount for total fines assessed in certain disciplinary actions; amending s. 456.072, F.S.; providing that the failure to comply with fair billing practices by a health care practitioner is grounds for disciplinary action; amending s. 627.0613, F.S.; providing that the consumer advocate must represent the general public before other state agencies; authorizing the consumer advocate to report findings relating to certain investigations to the agency and the Department of


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Health; authorizing the consumer advocate to have access to files, records, and data of the agency and the department necessary for certain investigations; authorizing the consumer advocate to maintain a process to receive and investigate complaints from patients relating to compliance with certain billing and notice requirements by licensed health care facilities and practitioners; defining a term; authorizing the consumer advocate to provide mediation between providers and consumers relating to certain matters; creating s. 627.6385, F.S.; requiring a health insurer to make available on its website certain methods that a policyholder can use to make estimates of certain costs and charges; providing that an estimate does not preclude an actual cost from exceeding the estimate; requiring a health insurer to make available on its website a hyperlink to certain health information; requiring a health insurer to include certain notice; requiring a health insurer that participates in the state group health insurance plan or Medicaid managed care to provide all claims data to a contracted vendor selected by the agency; excluding from the contributed claims data certain types of coverage; amending s. 641.54, F.S.; revising a requirement that a health maintenance organization make certain information available to its subscribers; requiring a health maintenance organization that participates in the state group health insurance plan or Medicaid managed care to provide all claims data to


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a contracted vendor selected by the agency; excluding from the contributed claims data certain types of coverage;; amending s. 409.967, F.S.; requiring managed care plans to provide all claims data to a contracted vendor selected by the agency; amending s. 110.123, F.S.; requiring the Department of Management Services to provide certain data to the contracted vendor for the price transparency database established by the agency; requiring a contracted vendor for the state group health insurance plan to provide claims data to the vendor selected by the agency; amending ss. 20.42, 381.026, 395.602, 395.6025, 408.07, 408.18, and 465.0244, F.S.; conforming provisions to changes made by the act; providing legislative intent; providing an effective date.