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Proposed Committee Substitute by the Committee on Appropriations (Appropriations Subcommittee on Health and Human Services)

1 A bill to be entitled
2 An act relating to transparency in health care;
3 amending s. 395.301, F.S.; requiring a facility
4 licensed under ch. 395, F.S., to provide timely and
5 accurate financial information and quality of service
6 measures to certain individuals; providing an
7 exemption; requiring a licensed facility to make
8 available on its website certain information on
9 payments made to that facility for defined bundles of
10 services and procedures and other information for
11 consumers and patients; requiring that facility
12 websites provide specified information and notify and
13 inform patients or prospective patients of certain
14 information; requiring a facility to provide a
15 written, good faith estimate of charges to a patient
16 or prospective patient within a certain timeframe;
17 requiring a facility to provide information regarding
18 financial assistance from the facility which may be
19 available to a patient or a prospective patient;
20 providing a penalty for failing to provide an estimate
21 of charges to a patient; deleting a requirement that a
22 licensed facility not operated by the state provide
23 notice to a patient of his or her right to an itemized
24 statement or bill within a certain timeframe; revising
25 the information that must be included on a patient’s
26 statement or bill; requiring that certain records be
27 made available through electronic means that comply

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28 with a specified law; reducing the response time for
29 certain patient requests for information; creating s.
30 395.3012, F.S.; authorizing the Agency for Health Care
31 Administration to impose penalties based on certain
32 findings of an investigation as determined by the
33 consumer advocate; amending ss. 400.487 and 400.934,
34 F.S.; requiring home health agencies and home medical
35 equipment providers to provide upon request certain
36 written estimates of charges within a certain
37 timeframe; amending s. 408.05, F.S.; revising
38 requirements for the collection and use of health-
39 related data by the agency; requiring the agency to
40 contract with a vendor to provide an Internet-based
41 platform with certain attributes; requiring potential
42 vendors to have certain qualifications; prohibiting
43 the agency from establishing a certain database under
44 certain circumstances; amending s. 408.061, F.S.;
45 revising requirements for the submission of health
46 care data to the agency; amending s. 456.0575, F.S.;
47 requiring a health care practitioner to provide a
48 patient upon his or her request a written, good faith
49 estimate of anticipated charges within a certain
50 timeframe; amending s. 456.072, F.S.; providing that
51 the failure to comply with fair billing practices by a
52 health care practitioner is grounds for disciplinary
53 action; amending s. 627.0613, F.S.; providing that the
54 consumer advocate must represent the general public
55 before other state agencies; authorizing the consumer
56 advocate to report findings relating to certain

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57 investigations to the agency and the Department of
58 Health; authorizing the consumer advocate to have
59 access to files, records, and data of the agency and
60 the department necessary for certain investigations;
61 authorizing the consumer advocate to maintain a
62 process to receive and investigate complaints from
63 patients relating to compliance with certain billing
64 and notice requirements by licensed health care
65 facilities and practitioners; defining a term;
66 authorizing the consumer advocate to provide mediation
67 between providers and consumers relating to certain
68 matters; creating s. 627.6385, F.S.; requiring a
69 health insurer to make available on its website
70 certain methods that a policyholder can use to make
71 estimates of certain costs and charges; providing that
72 an estimate does not preclude an actual cost from
73 exceeding the estimate; requiring a health insurer to
74 make available on its website a hyperlink to certain
75 health information; requiring a health insurer to
76 include certain notice; requiring a health insurer
77 that participates in the state group health insurance
78 plan or Medicaid managed care to provide all claims
79 data to a contracted vendor selected by the agency;
80 amending s. 641.54, F.S.; revising a requirement that
81 a health maintenance organization make certain
82 information available to its subscribers; requiring a
83 health maintenance organization that participates in
84 the state group health insurance plan or Medicaid
85 managed care to provide, to the greatest extent

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86 possible, all claims data to a contracted vendor
87 selected by the agency; amending s. 409.967, F.S.;
88 requiring managed care plans to provide all claims
89 data to a contracted vendor selected by the agency;
90 amending s. 110.123, F.S.; requiring the Department of
91 Management Services to provide certain data to the
92 contracted vendor for the price transparency database
93 established by the agency; requiring a contracted
94 vendor for the state group health insurance plan to
95 provide claims data to the vendor selected by the
96 agency; amending ss. 20.42, 381.026, 395.602,
97 395.6025, 408.07, 408.18, and 465.0244, F.S.;
98 conforming provisions to changes made by the act;
99 providing an effective date.
100
101 Be It Enacted by the Legislature of the State of Florida:
102
103 Section 1. Section 395.301, Florida Statutes, is amended to
104 read:
105 395.301 Price transparency; itemized patient statement or
106 bill; ~~form and content prescribed by the agency;~~ patient
107 admission status notification.—
108 (1) A facility licensed under this chapter shall provide
109 timely and accurate financial information and quality of service
110 measures to prospective and actual patients of the facility, or
111 to patients’ survivors or legal guardians, as appropriate. Such
112 information shall be provided in accordance with this section
113 and rules adopted by the agency pursuant to this chapter and s.
114 408.05. Licensed facilities operating exclusively as state

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115 mental health treatment facilities or as mobile surgical
116 facilities are exempt from the requirements of this subsection.
117 (a) Each licensed facility shall make available to the
118 public on its website information on payments made to that
119 facility for defined bundles of services and procedures. The
120 payment data must be presented and searchable in accordance
121 with, and through a hyperlink to, the system established by the
122 agency and its vendor using the descriptive service bundles
123 developed under s. 408.05(3)(c). At a minimum, the facility
124 shall provide the estimated average payment received from all
125 payors, excluding Medicaid and Medicare, for the descriptive
126 service bundles available at that facility and the estimated
127 payment range for such bundles. Using plain language,
128 comprehensible to an ordinary layperson, the facility must
129 disclose that the information on average payments and the
130 payment ranges is an estimate of costs that may be incurred by
131 the patient or prospective patient and that actual costs will be
132 based on the services actually provided to the patient. The
133 facility shall also assist the consumer in accessing his or her
134 health insurer's or health maintenance organization's website
135 for information on estimated copayments, deductibles, and other
136 cost-sharing responsibilities. The facility's website must:
137 1. Identify and post the names of all health insurers and
138 health maintenance organizations for which the facility is a
139 network provider or preferred provider and include a hyperlink
140 to the website of each.
141 2. Provide information to uninsured patients and insured
142 patients whose health insurer or health maintenance organization
143 does not include the facility as a network provider or preferred

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144 provider on the facility's financial assistance policy,
145 including the application process, payment plans, and discounts,
146 and the facility's charity care policy and collection
147 procedures.
148 3. Notify patients or prospective patients that services
149 may be provided in the health care facility by the facility as
150 well as by other health care providers who may separately bill
151 the patient.
152 4. Inform patients or prospective patients that they may
153 request from the facility and other health care providers a more
154 personalized estimate of charges and other information.
155 (b)1. Upon request, and before providing any nonemergency
156 medical services, each licensed facility shall provide a
157 written, good faith estimate of reasonably anticipated charges
158 by the facility for the treatment of the patient's or
159 prospective patient's specific condition. The facility must
160 provide the estimate in writing to the patient or prospective
161 patient within 7 business days after the receipt of the request
162 and is not required to adjust the estimate for any potential
163 insurance coverage. The estimate may be based on the descriptive
164 service bundles developed by the agency under s. 408.05(3)(c)
165 unless the patient or prospective patient requests a more
166 personalized and specific estimate that accounts for the
167 specific condition and characteristics of the patient or
168 prospective patient. The facility shall inform the patient or
169 prospective patient that he or she may contact his or her health
170 insurer or health maintenance organization for additional
171 information concerning cost-sharing responsibilities.
172 2. In the estimate, the facility shall provide to the

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173 patient or prospective patient information on the facility's
174 financial assistance policy, including the application process,
175 payment plans, and discounts and the facility's charity care
176 policy and collection procedures.
177 3. Upon request, the facility shall notify the patient or
178 prospective patient of any revision to the estimate.
179 4. In the estimate, the facility must notify the patient or
180 prospective patient that services may be provided in the health
181 care facility by the facility as well as by other health care
182 providers that may separately bill the patient.
183 5. The facility shall take action to educate the public
184 that such estimates are available upon request.
185 6. Failure to timely provide the estimate pursuant to this
186 paragraph shall result in a fine of $500 for each instance of
187 the facility's failure to provide the requested information.
188
189 The provision of an estimate does not preclude the actual
190 charges from exceeding the estimate.
191 (c) Each facility shall make available on its website a
192 hyperlink to the health-related data, including quality measures
193 and statistics that are disseminated by the agency pursuant to
194 s. 408.05. The facility shall also take action to notify the
195 public that such information is electronically available and
196 provide a hyperlink to the agency's website.
197 (d)1. Upon request, and after the patient's discharge or
198 release from the facility, the facility must provide ~~A licensed~~
199 ~~facility not operated by the state shall notify each patient~~
200 ~~during admission and at discharge of his or her right to receive~~
201 ~~an itemized bill upon request. Within 7 days following the~~

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202 ~~patient's discharge or release from a licensed facility not~~
203 ~~operated by the state, the licensed facility providing the~~
204 ~~service shall, upon request, submit~~ to the patient~~,~~ or to the
205 patient's survivor or legal guardian, as ~~may be~~ appropriate, an
206 itemized statement or bill detailing in plain language,
207 comprehensible to an ordinary layperson, the specific nature of
208 charges or expenses incurred by the patient.~~, which in~~ The
209 initial statement or bill ~~billing~~ shall be provided within 7
210 days after the patient's discharge or release from the facility
211 or after a request for such statement or bill, whichever is
212 later. The initial statement or bill must contain a statement of
213 specific services received and expenses incurred by date for
214 such items of service, enumerating in detail as prescribed by
215 the agency the constituent components of the services received
216 within each department of the licensed facility and including
217 unit price data on rates charged by the licensed facility~~, as~~
218 ~~prescribed by the agency~~. The statement or bill must identify
219 each item as paid, pending payment by a third party, or pending
220 payment by the patient and must include the amount due, if
221 applicable. If an amount is due from the patient, a due date
222 must be included. The initial statement or bill must inform the
223 patient or the patient's survivor or legal guardian, as
224 appropriate, to contact the patient's insurer or health
225 maintenance organization regarding the patient's cost-sharing
226 responsibilities.
227 2. Any subsequent statement or bill provided to a patient
228 or to the patient's survivor or legal guardian, as appropriate,
229 relating to the episode of care must include all of the
230 information required by subparagraph 1., with any revisions

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231 clearly delineated.
232 3.~~(2)(a)~~ Each ~~such~~ statement or bill provided ~~submitted~~
233 pursuant to this subsection ~~section~~:
234 a.~~1.~~ Must ~~May not~~ include notice ~~charges~~ of hospital-based
235 physicians and other health care providers who bill ~~if billed~~
236 separately.
237 b.~~2.~~ May not include any generalized category of expenses
238 such as “other” or “miscellaneous” or similar categories.
239 c.~~3.~~ Must ~~Shall~~ list drugs by brand or generic name and not
240 refer to drug code numbers when referring to drugs of any sort.
241 d.~~4.~~ Must ~~Shall~~ specifically identify physical,
242 occupational, or speech therapy treatment as to the date, type,
243 and length of treatment when such ~~therapy~~ treatment is a part of
244 the statement or bill.
245 ~~(b) Any person receiving a statement pursuant to this~~
246 ~~section shall be fully and accurately informed as to each charge~~
247 ~~and service provided by the institution preparing the statement.~~
248 (2)~~(3) On each itemized statement submitted pursuant to~~
249 ~~subsection (1) there shall appear the words “A FOR-PROFIT (or~~
250 ~~NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL~~
251 ~~CENTER) LICENSED BY THE STATE OF FLORIDA” or substantially~~
252 ~~similar words sufficient to identify clearly and plainly the~~
253 ~~ownership status of the licensed facility.~~ Each itemized
254 statement or bill must prominently display the telephone ~~phone~~
255 number of the medical facility’s patient liaison who is
256 responsible for expediting the resolution of any billing dispute
257 between the patient, or the patient’s survivor or legal guardian
258 ~~his or her representative~~, and the billing department.
259 ~~(4) An itemized bill shall be provided once to the~~

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260 ~~patient's physician at the physician's request, at no charge.~~
261 ~~(5) In any billing for services subsequent to the initial~~
262 ~~billing for such services, the patient, or the patient's~~
263 ~~survivor or legal guardian, may elect, at his or her option, to~~
264 ~~receive a copy of the detailed statement of specific services~~
265 ~~received and expenses incurred for each such item of service as~~
266 ~~provided in subsection (1).~~
267 ~~(6) No physician, dentist, podiatric physician, or licensed~~
268 ~~facility may add to the price charged by any third party except~~
269 ~~for a service or handling charge representing a cost actually~~
270 ~~incurred as an item of expense; however, the physician, dentist,~~
271 ~~podiatric physician, or licensed facility is entitled to fair~~
272 ~~compensation for all professional services rendered. The amount~~
273 ~~of the service or handling charge, if any, shall be set forth~~
274 ~~clearly in the bill to the patient.~~
275 ~~(7) Each licensed facility not operated by the state shall~~
276 ~~provide, prior to provision of any nonemergency medical~~
277 ~~services, a written good faith estimate of reasonably~~
278 ~~anticipated charges for the facility to treat the patient's~~
279 ~~condition upon written request of a prospective patient. The~~
280 ~~estimate shall be provided to the prospective patient within 7~~
281 ~~business days after the receipt of the request. The estimate may~~
282 ~~be the average charges for that diagnosis related group or the~~
283 ~~average charges for that procedure. Upon request, the facility~~
284 ~~shall notify the patient of any revision to the good faith~~
285 ~~estimate. Such estimate shall not preclude the actual charges~~
286 ~~from exceeding the estimate. The facility shall place a notice~~
287 ~~in the reception area that such information is available.~~
288 ~~Failure to provide the estimate within the provisions~~

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289 ~~established pursuant to this section shall result in a fine of~~
290 ~~$500 for each instance of the facility’s failure to provide the~~
291 ~~requested information.~~
292 ~~(8) Each licensed facility that is not operated by the~~
293 ~~state shall provide any uninsured person seeking planned~~
294 ~~nonemergency elective admission a written good faith estimate of~~
295 ~~reasonably anticipated charges for the facility to treat such~~
296 ~~person. The estimate must be provided to the uninsured person~~
297 ~~within 7 business days after the person notifies the facility~~
298 ~~and the facility confirms that the person is uninsured. The~~
299 ~~estimate may be the average charges for that diagnosis-related~~
300 ~~group or the average charges for that procedure. Upon request,~~
301 ~~the facility shall notify the person of any revision to the good~~
302 ~~faith estimate. Such estimate does not preclude the actual~~
303 ~~charges from exceeding the estimate. The facility shall also~~
304 ~~provide to the uninsured person a copy of any facility discount~~
305 ~~and charity care discount policies for which the uninsured~~
306 ~~person may be eligible. The facility shall place a notice in the~~
307 ~~reception area where such information is available. Failure to~~
308 ~~provide the estimate as required by this subsection shall result~~
309 ~~in a fine of $500 for each instance of the facility’s failure to~~
310 ~~provide the requested information.~~
311 <u>(3)</u>~~(9)~~ If a licensed facility places a patient on
312 observation status rather than inpatient status, observation
313 services shall be documented in the patient’s discharge papers.
314 The patient or the patient’s <u>survivor or legal guardian</u> ~~proxy~~
315 shall be notified of observation services through discharge
316 papers, which may also include brochures, signage, or other
317 forms of communication for this purpose.

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318 (4)~~(10)~~ A licensed facility shall make available to a
319 patient all records necessary for verification of the accuracy
320 of the patient’s statement or bill within 10 ~~30~~ business days
321 after the request for such records. The records ~~verification~~
322 ~~information~~ must be made available in the facility’s offices and
323 through electronic means that comply with the Health Insurance
324 Portability and Accountability Act of 1996 (HIPAA). Such records
325 must ~~shall~~ be available to the patient before ~~prior to~~ and after
326 payment of the statement or bill ~~or claim~~. The facility may not
327 charge the patient for making such verification records
328 available; however, the facility may charge its usual fee for
329 providing copies of records as specified in s. 395.3025.
330 (5)~~(11)~~ Each facility shall establish a method for
331 reviewing and responding to questions from patients concerning
332 the patient’s itemized statement or bill. Such response shall be
333 provided within 7 business ~~30~~ days after the date a question is
334 received. If the patient is not satisfied with the response, the
335 facility must provide the patient with the address and contact
336 information of the consumer advocate as provided in s. 627.0613
337 ~~agency~~ to which the issue may be sent for review.
338 ~~(12) Each licensed facility shall make available on its~~
339 ~~Internet website a link to the performance outcome and financial~~
340 ~~data that is published by the Agency for Health Care~~
341 ~~Administration pursuant to s. 408.05(3)(k). The facility shall~~
342 ~~place a notice in the reception area that the information is~~
343 ~~available electronically and the facility’s Internet website~~
344 ~~address.~~
345 Section 2. Section 395.3012, Florida Statutes, is created
346 to read:

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347 395.3012 Penalties for unconscionable prices.—
348 (1) The agency may impose administrative fines based on the
349 findings of the consumer advocate’s investigation of billing
350 complaints pursuant to s. 627.0613(6).
351 (2) The administrative fines for noncompliance with s.
352 395.301 are the greater of $2,500 per violation or double the
353 amount of the original charges.
354 Section 3. Subsection (1) of section 400.487, Florida
355 Statutes, is amended to read:
356 400.487 Home health service agreements; physician’s,
357 physician assistant’s, and advanced registered nurse
358 practitioner’s treatment orders; patient assessment;
359 establishment and review of plan of care; provision of services;
360 orders not to resuscitate.—
361 (1)(a) Services provided by a home health agency must be
362 covered by an agreement between the home health agency and the
363 patient or the patient’s legal representative specifying the
364 home health services to be provided, the rates or charges for
365 services paid with private funds, and the sources of payment,
366 which may include Medicare, Medicaid, private insurance,
367 personal funds, or a combination thereof. A home health agency
368 providing skilled care must make an assessment of the patient’s
369 needs within 48 hours after the start of services.
370 (b) Every licensed home health agency shall provide upon
371 the request of a prospective patient or his or her legal
372 guardian a written, good faith estimate of reasonably
373 anticipated charges for the prospective patient for services
374 provided by the home health agency. The home health agency must
375 provide the estimate to the requestor within 7 business days

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376 after receiving the request. The home health agency must inform
377 the prospective patient, or his or her legal guardian, that he
378 or she may contact the prospective patient's health insurer or
379 health maintenance organization for additional information
380 concerning cost-sharing responsibilities. The home health agency
381 must also provide information disclosing the home health
382 agency's payment plans, discounts, and other available
383 assistance and its collection procedures.
384 Section 4. Subsection (23) is added to section 400.934,
385 Florida Statutes, to read:
386 400.934 Minimum standards.—As a requirement of licensure,
387 home medical equipment providers shall:
388 (23) Provide upon the request of a prospective patient or
389 his or her legal guardian a written, good faith estimate of
390 reasonably anticipated charges for the prospective patient for
391 services provided by the home medical equipment provider. The
392 home medical equipment provider must provide the estimate to the
393 requestor within 7 business days after receiving the request.
394 The home medical equipment provider must inform the prospective
395 patient, or his or her legal guardian, that he or she may
396 contact the prospective patient's health insurer or health
397 maintenance organization for additional information concerning
398 cost-sharing responsibilities. The home medical equipment
399 provider must also provide information disclosing the home
400 medical equipment provider's payment plans, discounts, and other
401 available assistance and its collection procedures.
402 Section 5. Section 408.05, Florida Statutes, is amended to
403 read:
404 408.05 Florida Center for Health Information and

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405 Transparency ~~Policy Analysis~~.—
406 (1) ESTABLISHMENT.—The agency shall establish and maintain
407 a Florida Center for Health Information and Transparency to
408 collect, compile, coordinate, analyze, index, and disseminate
409 ~~Policy Analysis. The center shall establish a comprehensive~~
410 ~~health information system to provide for the collection,~~
411 ~~compilation, coordination, analysis, indexing, dissemination,~~
412 ~~and utilization of both purposefully collected and extant~~
413 health-related data and statistics. The center shall be staffed
414 as necessary ~~with public health experts, biostatisticians,~~
415 ~~information system analysts, health policy experts, economists,~~
416 ~~and other staff necessary~~ to carry out its functions.
417 (2) HEALTH-RELATED DATA.—The ~~comprehensive health~~
418 ~~information system operated by the~~ Florida Center for Health
419 Information and Transparency ~~Policy Analysis~~ shall identify ~~the~~
420 ~~best~~ available data sets, compile new data when specifically
421 authorized, ~~data sources~~ and promote the use ~~coordinate the~~
422 ~~compilation~~ of extant health-related data and statistics. The
423 center must maintain any data sets in existence before July 1,
424 2016, unless such data sets duplicate information that is
425 readily available from other credible sources, and may ~~and~~
426 ~~purposefully~~ collect or compile data on the following:
427 ~~(a) The extent and nature of illness and disability of the~~
428 ~~state population, including life expectancy, the incidence of~~
429 ~~various acute and chronic illnesses, and infant and maternal~~
430 ~~morbidity and mortality.~~
431 ~~(b) The impact of illness and disability of the state~~
432 ~~population on the state economy and on other aspects of the~~
433 ~~well-being of the people in this state.~~

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434 ~~(c) Environmental, social, and other health hazards.~~
435 ~~(d) Health knowledge and practices of the people in this~~
436 ~~state and determinants of health and nutritional practices and~~
437 ~~status.~~
438 (a)~~(e)~~ Health resources, including licensed ~~physicians,~~
439 ~~dentists, nurses, and other~~ health care practitioners
440 ~~professionals~~, by specialty and type of practice. Such data
441 shall include information collected by the Department of Health
442 pursuant to ss. 458.3191 and 459.0081.
443 (b) Health service inventories, including ~~and~~ acute care,
444 long-term care, and other institutional care facilities ~~facility~~
445 ~~supplies~~ and specific services provided by hospitals, nursing
446 homes, home health agencies, and other licensed health care
447 facilities.
448 (c)~~(f)~~ Service utilization for licensed health care
449 facilities ~~of health care by type of provider~~.
450 (d)~~(g)~~ Health care costs and financing, including trends in
451 health care prices and costs, the sources of payment for health
452 care services, and federal, state, and local expenditures for
453 health care.
454 ~~(h) Family formation, growth, and dissolution.~~
455 (e)~~(i)~~ The extent of public and private health insurance
456 coverage in this state.
457 (f)~~(j)~~ Specific quality-of-care initiatives involving ~~The~~
458 ~~quality of care provided by~~ various health care providers when
459 extant data is not adequate to achieve the objectives of the
460 initiatives.
461 (3) ~~COMPREHENSIVE~~ HEALTH INFORMATION TRANSPARENCY ~~SYSTEM~~.—
462 In order to disseminate and facilitate the availability of

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463 ~~produce~~ comparable and uniform health information ~~and statistics~~
464 ~~for the development of policy recommendations~~, the agency shall
465 perform the following functions:
466 (a) Collect and compile information on and coordinate the
467 activities of state agencies involved in providing ~~the design~~
468 ~~and implementation of the comprehensive~~ health information to
469 consumers ~~system~~.
470 (b) Promote data sharing through dissemination of state-
471 collected health data by making such data available,
472 transferable, and readily usable ~~Undertake research,~~
473 ~~development, and evaluation respecting the comprehensive health~~
474 ~~information system~~.
475 (c) Contract with a vendor to provide a consumer-friendly,
476 Internet-based platform that allows a consumer to research the
477 cost of health care services and procedures and allows for price
478 comparison. The Internet-based platform must allow a consumer to
479 search by condition or service bundles that are comprehensible
480 to an ordinary layperson and may not require registration, a
481 security password, or user identification. The vendor must be a
482 nonprofit research institute that is qualified under s. 1874 of
483 the Social Security Act to receive Medicare claims data and that
484 receives claims data from multiple private insurers nationwide.
485 The vendor must have:
486 1. A national database consisting of at least 15 billion
487 claim lines of administrative claims data from multiple payors
488 capable of being expanded by adding third-party payors,
489 including employers with health plans covered by the Employee
490 Retirement Income Security Act of 1974 (ERISA).
491 2. A well-developed methodology for analyzing claims data

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492 within defined service bundles.
493 3. A bundling methodology that is available in the public
494 domain to allow for consistency and comparison of state and
495 national benchmarks with local regions and specific providers.
496 ~~(c) Review the statistical activities of state agencies to~~
497 ~~ensure that they are consistent with the comprehensive health~~
498 ~~information system.~~
499 (d) Develop written agreements with local, state, and
500 federal agencies to facilitate ~~for~~ the sharing of data related
501 to health care ~~health-care-related data or using the facilities~~
502 ~~and services of such agencies. State agencies, local health~~
503 ~~councils, and other agencies under state contract shall assist~~
504 ~~the center in obtaining, compiling, and transferring health-~~
505 ~~care-related data maintained by state and local agencies.~~
506 ~~Written agreements must specify the types, methods, and~~
507 ~~periodicity of data exchanges and specify the types of data that~~
508 ~~will be transferred to the center~~.
509 (e) Establish by rule the types of data collected,
510 compiled, processed, used, or shared. ~~Decisions regarding center~~
511 ~~data sets should be made based on consultation with the State~~
512 ~~Consumer Health Information and Policy Advisory Council and~~
513 ~~other public and private users regarding the types of data which~~
514 ~~should be collected and their uses. The center shall establish~~
515 ~~standardized means for collecting health information and~~
516 ~~statistics under laws and rules administered by the agency.~~
517 (f) Consult with contracted vendors, the State Consumer
518 Health Information and Policy Advisory Council, and other public
519 and private users regarding the types of data that should be
520 collected and the use of such data.

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521 (g) Monitor data collection procedures and test data
522 quality to facilitate the dissemination of data that is
523 accurate, valid, reliable, and complete.
524 ~~(f) Establish minimum health-care-related data sets which~~
525 ~~are necessary on a continuing basis to fulfill the collection~~
526 ~~requirements of the center and which shall be used by state~~
527 ~~agencies in collecting and compiling health-care-related data.~~
528 ~~The agency shall periodically review ongoing health care data~~
529 ~~collections of the Department of Health and other state agencies~~
530 ~~to determine if the collections are being conducted in~~
531 ~~accordance with the established minimum sets of data.~~
532 ~~(g) Establish advisory standards to ensure the quality of~~
533 ~~health statistical and epidemiological data collection,~~
534 ~~processing, and analysis by local, state, and private~~
535 ~~organizations.~~
536 ~~(h) Prescribe standards for the publication of health-care-~~
537 ~~related data reported pursuant to this section which ensure the~~
538 ~~reporting of accurate, valid, reliable, complete, and comparable~~
539 ~~data. Such standards should include advisory warnings to users~~
540 ~~of the data regarding the status and quality of any data~~
541 ~~reported by or available from the center.~~
542 (h) ~~(i)~~ Develop ~~Prescribe standards for the maintenance and~~
543 ~~preservation of the center's data. This should include~~ methods
544 for archiving data, retrieval of archived data, and data editing
545 and verification.
546 ~~(j) Ensure that strict quality control measures are~~
547 ~~maintained for the dissemination of data through publications,~~
548 ~~studies, or user requests.~~
549 (i) ~~(k)~~ Make ~~Develop, in conjunction with the State Consumer~~

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550 ~~Health Information and Policy Advisory Council, and implement a~~
551 ~~long-range plan for making~~ available health care quality
552 measures ~~and financial data~~ that will allow consumers to compare
553 outcomes and other performance measures for health care
554 services. ~~The health care quality measures and financial data~~
555 ~~the agency must make available include, but are not limited to,~~
556 ~~pharmaceuticals, physicians, health care facilities, and health~~
557 ~~plans and managed care entities. The agency shall update the~~
558 ~~plan and report on the status of its implementation annually.~~
559 ~~The agency shall also make the plan and status report available~~
560 ~~to the public on its Internet website. As part of the plan, the~~
561 ~~agency shall identify the process and timeframes for~~
562 ~~implementation, barriers to implementation, and recommendations~~
563 ~~of changes in the law that may be enacted by the Legislature to~~
564 ~~eliminate the barriers. As preliminary elements of the plan, the~~
565 ~~agency shall:~~
566 ~~1. Make available patient-safety indicators, inpatient~~
567 ~~quality indicators, and performance outcome and patient charge~~
568 ~~data collected from health care facilities pursuant to s.~~
569 ~~408.061(1)(a) and (2). The terms "patient-safety indicators" and~~
570 ~~"inpatient quality indicators" have the same meaning as that~~
571 ~~ascribed by the Centers for Medicare and Medicaid Services, an~~
572 ~~accrediting organization whose standards incorporate comparable~~
573 ~~regulations required by this state, or a national entity that~~
574 ~~establishes standards to measure the performance of health care~~
575 ~~providers, or by other states. The agency shall determine which~~
576 ~~conditions, procedures, health care quality measures, and~~
577 ~~patient charge data to disclose based upon input from the~~
578 ~~council. When determining which conditions and procedures are to~~

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~~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 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~~

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608 ~~disclose, based upon input from the council. When determining~~
609 ~~which data to disclose, the agency shall consider information~~
610 ~~that may be required by either individual or group purchasers to~~
611 ~~assess the value of the product, which may include membership~~
612 ~~satisfaction, quality of care, current enrollment or membership,~~
613 ~~coverage areas, accreditation status, premium costs, plan costs,~~
614 ~~premium increases, range of benefits, copayments and~~
615 ~~deductibles, accuracy and speed of claims payment, credentials~~
616 ~~of physicians, number of providers, names of network providers,~~
617 ~~and hospitals in the network. Health plans shall make available~~
618 ~~to the agency such data or information that is not currently~~
619 ~~reported to the agency or the office.~~
620 ~~3. Determine the method and format for public disclosure of~~
621 ~~data reported pursuant to this paragraph. The agency shall make~~
622 ~~its determination based upon input from the State Consumer~~
623 ~~Health Information and Policy Advisory Council. At a minimum,~~
624 ~~the data shall be made available on the agency's Internet~~
625 ~~website in a manner that allows consumers to conduct an~~
626 ~~interactive search that allows them to view and compare the~~
627 ~~information for specific providers. The website must include~~
628 ~~such additional information as is determined necessary to ensure~~
629 ~~that the website enhances informed decisionmaking among~~
630 ~~consumers and health care purchasers, which shall include, at a~~
631 ~~minimum, appropriate guidance on how to use the data and an~~
632 ~~explanation of why the data may vary from provider to provider.~~
633 ~~4. Publish on its website undiscounted charges for no fewer~~
634 ~~than 150 of the most commonly performed adult and pediatric~~
635 ~~procedures, including outpatient, inpatient, diagnostic, and~~
636 ~~preventative procedures.~~

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637 ~~(4) TECHNICAL ASSISTANCE.—~~
638 ~~(a) The center shall provide technical assistance to~~
639 ~~persons or organizations engaged in health planning activities~~
640 ~~in the effective use of statistics collected and compiled by the~~
641 ~~center. The center shall also provide the following additional~~
642 ~~technical assistance services:~~
643 ~~1. Establish procedures identifying the circumstances under~~
644 ~~which, the places at which, the persons from whom, and the~~
645 ~~methods by which a person may secure data from the center,~~
646 ~~including procedures governing requests, the ordering of~~
647 ~~requests, timeframes for handling requests, and other procedures~~
648 ~~necessary to facilitate the use of the center's data. To the~~
649 ~~extent possible, the center should provide current data timely~~
650 ~~in response to requests from public or private agencies.~~
651 ~~2. Provide assistance to data sources and users in the~~
652 ~~areas of database design, survey design, sampling procedures,~~
653 ~~statistical interpretation, and data access to promote improved~~
654 ~~health-care-related data sets.~~
655 ~~3. Identify health care data gaps and provide technical~~
656 ~~assistance to other public or private organizations for meeting~~
657 ~~documented health care data needs.~~
658 ~~4. Assist other organizations in developing statistical~~
659 ~~abstracts of their data sets that could be used by the center.~~
660 ~~5. Provide statistical support to state agencies with~~
661 ~~regard to the use of databases maintained by the center.~~
662 ~~6. To the extent possible, respond to multiple requests for~~
663 ~~information not currently collected by the center or available~~
664 ~~from other sources by initiating data collection.~~
665 ~~7. Maintain detailed information on data maintained by~~

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666 ~~other local, state, federal, and private agencies in order to~~
667 ~~advise those who use the center of potential sources of data~~
668 ~~which are requested but which are not available from the center.~~
669 ~~8. Respond to requests for data which are not available in~~
670 ~~published form by initiating special computer runs on data sets~~
671 ~~available to the center.~~
672 ~~9. Monitor innovations in health information technology,~~
673 ~~informatics, and the exchange of health information and maintain~~
674 ~~a repository of technical resources to support the development~~
675 ~~of a health information network.~~
676 ~~(b) The agency shall administer, manage, and monitor grants~~
677 ~~to not-for-profit organizations, regional health information~~
678 ~~organizations, public health departments, or state agencies that~~
679 ~~submit proposals for planning, implementation, or training~~
680 ~~projects to advance the development of a health information~~
681 ~~network. Any grant contract shall be evaluated to ensure the~~
682 ~~effective outcome of the health information project.~~
683 ~~(c) The agency shall initiate, oversee, manage, and~~
684 ~~evaluate the integration of health care data from each state~~
685 ~~agency that collects, stores, and reports on health care issues~~
686 ~~and make that data available to any health care practitioner~~
687 ~~through a state health information network.~~
688 ~~(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.—The center~~
689 ~~shall provide for the widespread dissemination of data which it~~
690 ~~collects and analyzes. The center shall have the following~~
691 ~~publication, reporting, and special study functions:~~
692 ~~(a) The center shall publish and make available~~
693 ~~periodically to agencies and individuals health statistics~~
694 ~~publications of general interest, including health plan consumer~~

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695 ~~reports and health maintenance organization member satisfaction~~
696 ~~surveys; publications providing health statistics on topical~~
697 ~~health policy issues; publications that provide health status~~
698 ~~profiles of the people in this state; and other topical health~~
699 ~~statistics publications.~~
700 (j) ~~(b)~~ ~~The center shall publish,~~ Make available~~, and~~
701 ~~disseminate, promptly and as widely as practicable,~~ the results
702 of special health surveys, health care research, and health care
703 evaluations conducted or supported under this section. ~~Any~~
704 ~~publication by the center must include a statement of the~~
705 ~~limitations on the quality, accuracy, and completeness of the~~
706 ~~data.~~
707 ~~(c) The center shall provide indexing, abstracting,~~
708 ~~translation, publication, and other services leading to a more~~
709 ~~effective and timely dissemination of health care statistics.~~
710 ~~(d) The center shall be responsible for publishing and~~
711 ~~disseminating an annual report on the center's activities.~~
712 ~~(e) The center shall be responsible, to the extent~~
713 ~~resources are available, for conducting a variety of special~~
714 ~~studies and surveys to expand the health care information and~~
715 ~~statistics available for health policy analyses, particularly~~
716 ~~for the review of public policy issues. The center shall develop~~
717 ~~a process by which users of the center's data are periodically~~
718 ~~surveyed regarding critical data needs and the results of the~~
719 ~~survey considered in determining which special surveys or~~
720 ~~studies will be conducted. The center shall select problems in~~
721 ~~health care for research, policy analyses, or special data~~
722 ~~collections on the basis of their local, regional, or state~~
723 ~~importance; the unique potential for definitive research on the~~

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724 ~~problem; and opportunities for application of the study~~
725 ~~findings.~~
726 (4) ~~(6)~~ PROVIDER DATA REPORTING.—This section does not
727 confer on the agency the power to demand or require that a
728 health care provider or professional furnish information,
729 records of interviews, written reports, statements, notes,
730 memoranda, or data other than as expressly required by law. The
731 agency may not establish an all-payor claims database or a
732 comparable database without express legislative authority.
733 (5) ~~(7)~~ BUDGET; FEES.—
734 (a) The Legislature intends that funding for the Florida
735 Center for Health Information and Transparency ~~Policy Analysis~~
736 be appropriated from the General Revenue Fund.
737 (b) The Florida Center for Health Information and
738 Transparency ~~Policy Analysis~~ may apply for and receive and
739 accept grants, gifts, and other payments, including property and
740 services, from any governmental or other public or private
741 entity or person and make arrangements as to the use of same,
742 including the undertaking of special studies and other projects
743 relating to health-care-related topics. Funds obtained pursuant
744 to this paragraph may not be used to offset annual
745 appropriations from the General Revenue Fund.
746 (c) The center may charge such reasonable fees for services
747 as the agency prescribes by rule. The established fees may not
748 exceed the reasonable cost for such services. Fees collected may
749 not be used to offset annual appropriations from the General
750 Revenue Fund.
751 (6) ~~(8)~~ STATE CONSUMER HEALTH INFORMATION AND POLICY
752 ADVISORY COUNCIL.—

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753 (a) There is established in the agency the State Consumer
754 Health Information and Policy Advisory Council to assist the
755 center ~~in reviewing the comprehensive health information system,~~
756 ~~including the identification, collection, standardization,~~
757 ~~sharing, and coordination of health-related data, fraud and~~
758 ~~abuse data, and professional and facility licensing data among~~
759 ~~federal, state, local, and private entities and to recommend~~
760 ~~improvements for purposes of public health, policy analysis, and~~
761 ~~transparency of consumer health care information~~. The council
762 <u>consists</u> ~~shall consist~~ of the following members:
763 1. An employee of the Executive Office of the Governor, to
764 be appointed by the Governor.
765 2. An employee of the Office of Insurance Regulation, to be
766 appointed by the director of the office.
767 3. An employee of the Department of Education, to be
768 appointed by the Commissioner of Education.
769 4. Ten persons, to be appointed by the Secretary of Health
770 Care Administration, representing other state and local
771 agencies, state universities, business and health coalitions,
772 local health councils, professional health-care-related
773 associations, consumers, and purchasers.
774 (b) Each member of the council shall be appointed to serve
775 for a term of 2 years following the date of appointment~~, except~~
776 ~~the term of appointment shall end 3 years following the date of~~
777 ~~appointment for members appointed in 2003, 2004, and 2005~~. A
778 vacancy shall be filled by appointment for the remainder of the
779 term, and each appointing authority retains the right to
780 reappoint members whose terms of appointment have expired.
781 (c) The council may meet at the call of its chair, at the

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782 request of the agency, or at the request of a majority of its
783 membership, but the council must meet at least quarterly.
784 (d) Members shall elect a chair and vice chair annually.
785 (e) A majority of the members constitutes a quorum, and the
786 affirmative vote of a majority of a quorum is necessary to take
787 action.
788 (f) The council shall maintain minutes of each meeting and
789 shall make such minutes available to any person.
790 (g) Members of the council shall serve without compensation
791 but shall be entitled to receive reimbursement for per diem and
792 travel expenses as provided in s. 112.061.
793 (h) The council's duties and responsibilities include, but
794 are not limited to, the following:
795 1. To develop a mission statement, goals, and a plan of
796 action for the identification, collection, standardization,
797 sharing, and coordination of health-related data across federal,
798 state, and local government and private sector entities.
799 2. To develop a review process to ensure cooperative
800 planning among agencies that collect or maintain health-related
801 data.
802 3. To create ad hoc issue-oriented technical workgroups on
803 an as-needed basis to make recommendations to the council.
804 (7) ~~(9)~~ APPLICATION TO OTHER AGENCIES. ~~Nothing in~~ This
805 section does not ~~shall~~ limit, restrict, affect, or control the
806 collection, analysis, release, or publication of data by any
807 state agency pursuant to its statutory authority, duties, or
808 responsibilities.
809 Section 6. Subsection (1) of section 408.061, Florida
810 Statutes, is amended to read:

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811 408.061 Data collection; uniform systems of financial
812 reporting; information relating to physician charges;
813 confidential information; immunity.—
814 (1) The agency shall require the submission by health care
815 facilities, health care providers, and health insurers of data
816 necessary to carry out the agency's duties and to facilitate
817 transparency in health care pricing data and quality measures.
818 Specifications for data to be collected under this section shall
819 be developed by the agency and applicable contract vendors, with
820 the assistance of technical advisory panels including
821 representatives of affected entities, consumers, purchasers, and
822 such other interested parties as may be determined by the
823 agency.
824 (a) Data submitted by health care facilities, including the
825 facilities as defined in chapter 395, shall include, but are not
826 limited to: case-mix data, patient admission and discharge data,
827 hospital emergency department data which shall include the
828 number of patients treated in the emergency department of a
829 licensed hospital reported by patient acuity level, data on
830 hospital-acquired infections as specified by rule, data on
831 complications as specified by rule, data on readmissions as
832 specified by rule, with patient and provider-specific
833 identifiers included, actual charge data by diagnostic groups or
834 other bundled groupings as specified by rule, financial data,
835 accounting data, operating expenses, expenses incurred for
836 rendering services to patients who cannot or do not pay,
837 interest charges, depreciation expenses based on the expected
838 useful life of the property and equipment involved, and
839 demographic data. The agency shall adopt nationally recognized

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840 risk adjustment methodologies or software consistent with the
841 standards of the Agency for Healthcare Research and Quality and
842 as selected by the agency for all data submitted as required by
843 this section. Data may be obtained from documents such as, but
844 not limited to: leases, contracts, debt instruments, itemized
845 patient statements or bills, medical record abstracts, and
846 related diagnostic information. Reported data elements shall be
847 reported electronically in accordance with rule 59E-7.012,
848 Florida Administrative Code. Data submitted shall be certified
849 by the chief executive officer or an appropriate and duly
850 authorized representative or employee of the licensed facility
851 that the information submitted is true and accurate.
852 (b) Data to be submitted by health care providers may
853 include, but are not limited to: professional organization and
854 specialty board affiliations, Medicare and Medicaid
855 participation, types of services offered to patients, actual
856 charges to patients as specified by rule, amount of revenue and
857 expenses of the health care provider, and such other data which
858 are reasonably necessary to study utilization patterns. Data
859 submitted shall be certified by the appropriate duly authorized
860 representative or employee of the health care provider that the
861 information submitted is true and accurate.
862 (c) Data to be submitted by health insurers may include,
863 but are not limited to: claims, payments to health care
864 facilities and health care providers as specified by rule,
865 premium, administration, and financial information. Data
866 submitted shall be certified by the chief financial officer, an
867 appropriate and duly authorized representative, or an employee
868 of the insurer that the information submitted is true and

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869 accurate.
870 (d) Data required to be submitted by health care
871 facilities, health care providers, or health insurers may ~~shall~~
872 not include specific provider contract reimbursement
873 information. However, such specific provider reimbursement data
874 shall be reasonably available for onsite inspection by the
875 agency as is necessary to carry out the agency's regulatory
876 duties. Any such data obtained by the agency as a result of
877 onsite inspections may not be used by the state for purposes of
878 direct provider contracting and are confidential and exempt from
879 ~~the provisions of~~ s. 119.07(1) and s. 24(a), Art. I of the State
880 Constitution.
881 (e) A requirement to submit data shall be adopted by rule
882 if the submission of data is being required of all members of
883 any type of health care facility, health care provider, or
884 health insurer. Rules are not required, however, for the
885 submission of data for a special study mandated by the
886 Legislature or when information is being requested for a single
887 health care facility, health care provider, or health insurer.
888 Section 7. Section 456.0575, Florida Statutes, is amended
889 to read:
890 456.0575 Duty to notify patients.—
891 (1) Every licensed health care practitioner shall inform
892 each patient, or an individual identified pursuant to s.
893 765.401(1), in person about adverse incidents that result in
894 serious harm to the patient. Notification of outcomes of care
895 that result in harm to the patient under this section shall not
896 constitute an acknowledgment of admission of liability, nor can
897 such notifications be introduced as evidence.

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898 (2) Every licensed health care practitioner must provide
899 upon request by a patient, before providing any nonemergency
900 medical services in a facility licensed under chapter 395, a
901 written, good faith estimate of reasonably anticipated charges
902 to treat the patient's condition at the licensed facility. The
903 health care practitioner must provide the estimate to the
904 patient within 7 business days after receiving the request and
905 is not required to adjust the estimate for any potential
906 insurance coverage. The health care practitioner must inform the
907 patient that he or she may contact his or her health insurer or
908 health maintenance organization for additional information
909 concerning cost-sharing responsibilities. The health care
910 practitioner must provide information to uninsured patients and
911 insured patients for whom the practitioner is not a network
912 provider or preferred provider which discloses the
913 practitioner's financial assistance policy, including the
914 application process, payment plans, discounts, and other
915 available assistance; the practitioner's charity care policy;
916 and the practitioner's collection procedures. Such estimate does
917 not preclude the actual charges from exceeding the estimate.
918 Failure to provide the estimate in accordance with this
919 subsection, without good cause, within the 7 business days shall
920 result in disciplinary action against the health care
921 practitioner and a fine of $500 for each instance of the
922 practitioner's failure to provide the requested estimate.
923 Section 8. Paragraph (oo) is added to subsection (1) of
924 section 456.072, Florida Statutes, to read:
925 456.072 Grounds for discipline; penalties; enforcement.—
926 (1) The following acts shall constitute grounds for which

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927 the disciplinary actions specified in subsection (2) may be
928 taken:
929 (oo) Failure to comply with fair billing practices pursuant
930 to s. 627.0613(6).
931 Section 9. Section 627.0613, Florida Statutes, is amended
932 to read:
933 627.0613 Consumer advocate.—The Chief Financial Officer
934 must appoint a consumer advocate who must represent the general
935 public of the state before the department, ~~and~~ the office, and
936 other state agencies, as required by this section. The consumer
937 advocate must report directly to the Chief Financial Officer,
938 but is not otherwise under the authority of the department or of
939 any employee of the department. The consumer advocate has such
940 powers as are necessary to carry out the duties of the office of
941 consumer advocate, including, but not limited to, the powers to:
942 (1) Recommend to the department or office, by petition, the
943 commencement of any proceeding or action; appear in any
944 proceeding or action before the department or office; or appear
945 in any proceeding before the Division of Administrative Hearings
946 relating to subject matter under the jurisdiction of the
947 department or office.
948 (2) Report to the Agency for Health Care Administration and
949 to the Department of Health any findings resulting from
950 investigation of unresolved complaints concerning the billing
951 practices of any health care facility licensed under chapter 395
952 or any health care practitioner subject to chapter 456.
953 (3) ~~(2)~~ Have access to and use of all files, records, and
954 data of the department or office.
955 (4) Have access to any files, records, and data of the

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956 Agency for Health Care Administration and the Department of
957 Health which are necessary for the investigations authorized by
958 subsection (6).
959 (5) ~~(3)~~ Examine rate and form filings submitted to the
960 office, hire consultants as necessary to aid in the review
961 process, and recommend to the department or office any position
962 deemed by the consumer advocate to be in the public interest.
963 (6) Maintain a process for receiving and investigating
964 complaints from insured and uninsured patients of health care
965 facilities licensed under chapter 395 and health care
966 practitioners subject to chapter 456 concerning billing
967 practices. Investigations by the office of the consumer advocate
968 shall be limited to determining compliance with the following
969 requirements:
970 (a) The patient was informed before a nonemergency
971 procedure of expected payments related to the procedure as
972 provided in s. 395.301, contact information for health insurers
973 or health maintenance organizations to determine specific cost-
974 sharing responsibilities, and the expected involvement in the
975 procedure of other providers who may bill independently.
976 (b) The patient was informed of policies and procedures to
977 qualify for discounted charges.
978 (c) The patient was informed of collection procedures and
979 given the opportunity to participate in an extended payment
980 schedule.
981 (d) The patient was given a written, personal, and itemized
982 estimate upon request as provided in ss. 395.301 and 456.0575.
983 (e) The statement or bill delivered to the patient was
984 accurate and included all information required pursuant to s.

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985 395.301.
986 (f) The billed amounts were fair charges. As used in this
987 paragraph, the term “fair charges” means the common and frequent
988 range of charges for patients who are similarly situated
989 requiring the same or similar medical services.
990 (7) Provide mediation between providers and patients to
991 resolve billing complaints and negotiate arrangements for
992 extended payment schedules.
993 (8)~~(4)~~ Prepare an annual budget for presentation to the
994 Legislature by the department, which budget must be adequate to
995 carry out the duties of the office of consumer advocate.
996 Section 10. Section 627.6385, Florida Statutes, is created
997 to read:
998 627.6385 Disclosures to policyholders; calculations of cost
999 sharing.—
1000 (1) Each health insurer shall make available on its
1001 website:
1002 (a) A method for policyholders to estimate their
1003 copayments, deductibles, and other cost-sharing responsibilities
1004 for health care services and procedures. Such method of making
1005 an estimate shall be based on service bundles established
1006 pursuant to s. 408.05(3)(c). Estimates do not preclude the
1007 actual copayment, coinsurance percentage, or deductible,
1008 whichever is applicable, from exceeding the estimate.
1009 1. Estimates shall be calculated according to the policy
1010 and known plan usage during the coverage period.
1011 2. Estimates shall be made available based on providers
1012 that are in-network or out-of-network.
1013 3. A policyholder must be able to create estimates by any

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1014 combination of the service bundles established pursuant to s.
1015 408.05(3)(c) or by a specified provider or a comparison of
1016 providers.
1017 (b) A method for policyholders to estimate their
1018 copayments, deductibles, and other cost-sharing responsibilities
1019 based on a personalized estimate of charges received from a
1020 facility pursuant to s. 395.301 or a practitioner pursuant to s.
1021 456.0575.
1022 (c) A hyperlink to the health information, including, but
1023 not limited to, service bundles and quality of care information,
1024 which is disseminated by the Agency for Health Care
1025 Administration pursuant to s. 408.05(3).
1026 (2) Each health insurer shall include in every policy
1027 delivered or issued for delivery to any person in the state or
1028 in materials provided as required by s. 627.64725 notice that
1029 the information required by this section is available
1030 electronically and the address of the website where the
1031 information can be accessed.
1032 (3) Each health insurer that participates in the state
1033 group health insurance plan created pursuant to s. 110.123 or
1034 Medicaid managed care pursuant to part IV of chapter 409 shall
1035 provide all claims data to the fullest extent possible to the
1036 contracted vendor selected by the Agency for Health Care
1037 Administration under s. 408.05(3)(c).
1038 Section 11. Subsection (6) of section 641.54, Florida
1039 Statutes, is amended, present subsection (7) of that section is
1040 redesignated as subsection (8) and amended, and a new subsection
1041 (7) is added to that section, to read:
1042 641.54 Information disclosure.—

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1043 (6) Each health maintenance organization shall make
1044 available to its subscribers on its website or by request the
1045 estimated copayment ~~copay~~, coinsurance percentage, or
1046 deductible, whichever is applicable, for any covered services as
1047 described by the searchable bundles established on a consumer-
1048 friendly, Internet-based platform pursuant to s. 408.05(3)(c) or
1049 as described in a personalized estimate received from a facility
1050 pursuant to s. 395.301 or a practitioner pursuant to s.
1051 456.0575, the status of the subscriber's maximum annual out-of-
1052 pocket payments for a covered individual or family, and the
1053 status of the subscriber's maximum lifetime benefit. Such
1054 estimate does ~~shall~~ not preclude the actual copayment ~~copay~~,
1055 coinsurance percentage, or deductible, whichever is applicable,
1056 from exceeding the estimate.
1057 (7) Each health maintenance organization that participates
1058 in the state group health insurance plan created pursuant to s.
1059 110.123 or Medicaid managed care pursuant to part IV of chapter
1060 409 shall provide all claims data to the fullest extent possible
1061 to the contracted vendor selected by the Agency for Health Care
1062 Administration under s. 408.05(3)(c).
1063 (8)~~(7)~~ Each health maintenance organization shall make
1064 available on its ~~Internet~~ website a hyperlink ~~link~~ to the health
1065 information ~~performance outcome and financial data~~ that is
1066 disseminated ~~published~~ by the Agency for Health Care
1067 Administration pursuant to s. 408.05(3) ~~s. 408.05(3)(k)~~ and
1068 shall include in every policy delivered or issued for delivery
1069 to any person in the state or any materials provided as required
1070 by s. 627.64725 notice that such information is available
1071 electronically and the address of its Internet website.

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1072 Section 12. Paragraph (n) is added to subsection (2) of
1073 section 409.967, Florida Statutes, to read:
1074 409.967 Managed care plan accountability.—
1075 (2) The agency shall establish such contract requirements
1076 as are necessary for the operation of the statewide managed care
1077 program. In addition to any other provisions the agency may deem
1078 necessary, the contract must require:
1079 (n) *Transparency.*—Managed care plans shall comply with ss.
1080 627.6385(3) and 641.54(7).
1081 Section 13. Paragraph (d) of subsection (3) of section
1082 110.123, Florida Statutes, is amended to read:
1083 110.123 State group insurance program.—
1084 (3) STATE GROUP INSURANCE PROGRAM.—
1085 (d)1. Notwithstanding ~~the provisions of~~ chapter 287 and the
1086 authority of the department, for the purpose of protecting the
1087 health of, and providing medical services to, state employees
1088 participating in the state group insurance program, the
1089 department may contract to retain the services of professional
1090 administrators for the state group insurance program. The agency
1091 shall follow good purchasing practices of state procurement to
1092 the extent practicable under the circumstances.
1093 2. Each vendor in a major procurement, and any other vendor
1094 if the department deems it necessary to protect the state's
1095 financial interests, shall, at the time of executing any
1096 contract with the department, post an appropriate bond with the
1097 department in an amount determined by the department to be
1098 adequate to protect the state's interests but not higher than
1099 the full amount estimated to be paid annually to the vendor
1100 under the contract.

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1101 3. Each major contract entered into by the department
1102 pursuant to this section shall contain a provision for payment
1103 of liquidated damages to the department for material
1104 noncompliance by a vendor with a contract provision. The
1105 department may require a liquidated damages provision in any
1106 contract if the department deems it necessary to protect the
1107 state's financial interests.
1108 4. Section ~~The provisions of s.~~ 120.57(3) applies ~~apply~~ to
1109 the department's contracting process, except:
1110 a. A formal written protest of any decision, intended
1111 decision, or other action subject to protest shall be filed
1112 within 72 hours after receipt of notice of the decision,
1113 intended decision, or other action.
1114 b. As an alternative to any provision of s. 120.57(3), the
1115 department may proceed with the bid selection or contract award
1116 process if the director of the department sets forth, in
1117 writing, particular facts and circumstances which demonstrate
1118 the necessity of continuing the procurement process or the
1119 contract award process in order to avoid a substantial
1120 disruption to the provision of any scheduled insurance services.
1121 5. The department shall make arrangements as necessary to
1122 provide claims data of the state group health insurance plan to
1123 the contracted vendor selected by the Agency for Health Care
1124 Administration pursuant to s. 408.05(3)(c).
1125 6. Each contracted vendor for the state group health
1126 insurance plan shall provide claims data to the fullest extent
1127 possible to the vendor selected by the Agency for Health Care
1128 Administration pursuant to s. 408.05(3)(c).
1129 Section 14. Subsection (3) of section 20.42, Florida

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1130 Statutes, is amended to read:
1131 20.42 Agency for Health Care Administration.—
1132 (3) The department shall be the chief health policy and
1133 planning entity for the state. The department is responsible for
1134 health facility licensure, inspection, and regulatory
1135 enforcement; investigation of consumer complaints related to
1136 health care facilities and managed care plans; the
1137 implementation of the certificate of need program; the operation
1138 of the Florida Center for Health Information and Transparency
1139 ~~Policy Analysis~~; the administration of the Medicaid program; the
1140 administration of the contracts with the Florida Healthy Kids
1141 Corporation; the certification of health maintenance
1142 organizations and prepaid health clinics as set forth in part
1143 III of chapter 641; and any other duties prescribed by statute
1144 or agreement.
1145 Section 15. Paragraph (c) of subsection (4) of section
1146 381.026, Florida Statutes, is amended to read:
1147 381.026 Florida Patient's Bill of Rights and
1148 Responsibilities.—
1149 (4) RIGHTS OF PATIENTS.—Each health care facility or
1150 provider shall observe the following standards:
1151 (c) *Financial information and disclosure.*—
1152 1. A patient has the right to be given, upon request, by
1153 the responsible provider, his or her designee, or a
1154 representative of the health care facility full information and
1155 necessary counseling on the availability of known financial
1156 resources for the patient's health care.
1157 2. A health care provider or a health care facility shall,
1158 upon request, disclose to each patient who is eligible for

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1159 Medicare, before treatment, whether the health care provider or
1160 the health care facility in which the patient is receiving
1161 medical services accepts assignment under Medicare reimbursement
1162 as payment in full for medical services and treatment rendered
1163 in the health care provider's office or health care facility.
1164 3. A primary care provider may publish a schedule of
1165 charges for the medical services that the provider offers to
1166 patients. The schedule must include the prices charged to an
1167 uninsured person paying for such services by cash, check, credit
1168 card, or debit card. The schedule must be posted in a
1169 conspicuous place in the reception area of the provider's office
1170 and must include, but is not limited to, the 50 services most
1171 frequently provided by the primary care provider. The schedule
1172 may group services by three price levels, listing services in
1173 each price level. The posting must be at least 15 square feet in
1174 size. A primary care provider who publishes and maintains a
1175 schedule of charges for medical services is exempt from the
1176 license fee requirements for a single period of renewal of a
1177 professional license under chapter 456 for that licensure term
1178 and is exempt from the continuing education requirements of
1179 chapter 456 and the rules implementing those requirements for a
1180 single 2-year period.
1181 4. If a primary care provider publishes a schedule of
1182 charges pursuant to subparagraph 3., he or she must continually
1183 post it at all times for the duration of active licensure in
1184 this state when primary care services are provided to patients.
1185 If a primary care provider fails to post the schedule of charges
1186 in accordance with this subparagraph, the provider shall be
1187 required to pay any license fee and comply with any continuing

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1188 education requirements for which an exemption was received.
1189 5. A health care provider or a health care facility shall,
1190 upon request, furnish a person, before the provision of medical
1191 services, a reasonable estimate of charges for such services.
1192 The health care provider or the health care facility shall
1193 provide an uninsured person, before the provision of a planned
1194 nonemergency medical service, a reasonable estimate of charges
1195 for such service and information regarding the provider's or
1196 facility's discount or charity policies for which the uninsured
1197 person may be eligible. Such estimates by a primary care
1198 provider must be consistent with the schedule posted under
1199 subparagraph 3. Estimates shall, to the extent possible, be
1200 written in language comprehensible to an ordinary layperson.
1201 Such reasonable estimate does not preclude the health care
1202 provider or health care facility from exceeding the estimate or
1203 making additional charges based on changes in the patient's
1204 condition or treatment needs.
1205 6. Each licensed facility<u>, except a facility operating</u>
1206 <u>exclusively as a state mental health treatment facility or as a</u>
1207 <u>mobile surgical facility,</u> ~~not operated by the state~~ shall make
1208 available to the public on its Internet website or by other
1209 electronic means a description of and a <u>hyperlink</u> ~~link~~ to the
1210 <u>health information</u> ~~performance outcome and financial data~~ that
1211 is <u>disseminated</u> ~~published~~ by the agency pursuant to <u>s. 408.05(3)</u>
1212 ~~s. 408.05(3)(k)~~. The facility shall place a notice in the
1213 reception area that such information is available electronically
1214 and the website address. The licensed facility may indicate that
1215 the pricing information is based on a compilation of charges for
1216 the average patient and that each patient's <u>statement or</u> bill

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1217 may vary from the average depending upon the severity of illness
1218 and individual resources consumed. The licensed facility may
1219 also indicate that the price of service is negotiable for
1220 eligible patients based upon the patient’s ability to pay.
1221 7. A patient has the right to receive a copy of an itemized
1222 statement or bill upon request. A patient has a right to be
1223 given an explanation of charges upon request.
1224 Section 16. Paragraph (e) of subsection (2) of section
1225 395.602, Florida Statutes, is amended to read:
1226 395.602 Rural hospitals.—
1227 (2) DEFINITIONS.—As used in this part, the term:
1228 (e) “Rural hospital” means an acute care hospital licensed
1229 under this chapter, having 100 or fewer licensed beds and an
1230 emergency room, which is:
1231 1. The sole provider within a county with a population
1232 density of up to 100 persons per square mile;
1233 2. An acute care hospital, in a county with a population
1234 density of up to 100 persons per square mile, which is at least
1235 30 minutes of travel time, on normally traveled roads under
1236 normal traffic conditions, from any other acute care hospital
1237 within the same county;
1238 3. A hospital supported by a tax district or subdistrict
1239 whose boundaries encompass a population of up to 100 persons per
1240 square mile;
1241 4. A hospital with a service area that has a population of
1242 up to 100 persons per square mile. As used in this subparagraph,
1243 the term “service area” means the fewest number of zip codes
1244 that account for 75 percent of the hospital’s discharges for the
1245 most recent 5-year period, based on information available from

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1246 the hospital inpatient discharge database in the Florida Center
1247 for Health Information and Transparency ~~Policy Analysis~~ at the
1248 agency; or
1249 5. A hospital designated as a critical access hospital, as
1250 defined in s. 408.07.
1251
1252 Population densities used in this paragraph must be based upon
1253 the most recently completed United States census. A hospital
1254 that received funds under s. 409.9116 for a quarter beginning no
1255 later than July 1, 2002, is deemed to have been and shall
1256 continue to be a rural hospital from that date through June 30,
1257 2021, if the hospital continues to have up to 100 licensed beds
1258 and an emergency room. An acute care hospital that has not
1259 previously been designated as a rural hospital and that meets
1260 the criteria of this paragraph shall be granted such designation
1261 upon application, including supporting documentation, to the
1262 agency. A hospital that was licensed as a rural hospital during
1263 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
1264 rural hospital from the date of designation through June 30,
1265 2021, if the hospital continues to have up to 100 licensed beds
1266 and an emergency room.
1267 Section 17. Section 395.6025, Florida Statutes, is amended
1268 to read:
1269 395.6025 Rural hospital replacement facilities.—
1270 Notwithstanding ~~the provisions of~~ s. 408.036, a hospital defined
1271 as a statutory rural hospital in accordance with s. 395.602, or
1272 a not-for-profit operator of rural hospitals, is not required to
1273 obtain a certificate of need for the construction of a new
1274 hospital located in a county with a population of at least

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1275 15,000 but no more than 18,000 and a density of fewer ~~less~~ than
1276 30 persons per square mile, or a replacement facility, provided
1277 that the replacement, or new, facility is located within 10
1278 miles of the site of the currently licensed rural hospital and
1279 within the current primary service area. As used in this
1280 section, the term “service area” means the fewest number of zip
1281 codes that account for 75 percent of the hospital’s discharges
1282 for the most recent 5-year period, based on information
1283 available from the hospital inpatient discharge database in the
1284 Florida Center for Health Information and Transparency ~~Policy~~
1285 ~~Analysis~~ at the Agency for Health Care Administration.
1286 Section 18. Subsection (43) of section 408.07, Florida
1287 Statutes, is amended to read:
1288 408.07 Definitions.—As used in this chapter, with the
1289 exception of ss. 408.031-408.045, the term:
1290 (43) “Rural hospital” means an acute care hospital licensed
1291 under chapter 395, having 100 or fewer licensed beds and an
1292 emergency room, and which is:
1293 (a) The sole provider within a county with a population
1294 density of no greater than 100 persons per square mile;
1295 (b) An acute care hospital, in a county with a population
1296 density of no greater than 100 persons per square mile, which is
1297 at least 30 minutes of travel time, on normally traveled roads
1298 under normal traffic conditions, from another acute care
1299 hospital within the same county;
1300 (c) A hospital supported by a tax district or subdistrict
1301 whose boundaries encompass a population of 100 persons or fewer
1302 per square mile;
1303 (d) A hospital with a service area that has a population of

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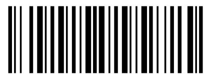
1304 100 persons or fewer per square mile. As used in this paragraph,
1305 the term “service area” means the fewest number of zip codes
1306 that account for 75 percent of the hospital’s discharges for the
1307 most recent 5-year period, based on information available from
1308 the hospital inpatient discharge database in the Florida Center
1309 for Health Information and Transparency ~~Policy Analysis~~ at the
1310 Agency for Health Care Administration; or
1311 (e) A critical access hospital.
1312
1313 Population densities used in this subsection must be based upon
1314 the most recently completed United States census. A hospital
1315 that received funds under s. 409.9116 for a quarter beginning no
1316 later than July 1, 2002, is deemed to have been and shall
1317 continue to be a rural hospital from that date through June 30,
1318 2015, if the hospital continues to have 100 or fewer licensed
1319 beds and an emergency room. An acute care hospital that has not
1320 previously been designated as a rural hospital and that meets
1321 the criteria of this subsection shall be granted such
1322 designation upon application, including supporting
1323 documentation, to the Agency for Health Care Administration.
1324 Section 19. Paragraph (a) of subsection (4) of section
1325 408.18, Florida Statutes, is amended to read:
1326 408.18 Health Care Community Antitrust Guidance Act;
1327 antitrust no-action letter; market-information collection and
1328 education.—
1329 (4)(a) Members of the health care community who seek
1330 antitrust guidance may request a review of their proposed
1331 business activity by the Attorney General’s office. In
1332 conducting its review, the Attorney General’s office may seek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1333 whatever documentation, data, or other material it deems
1334 necessary from the Agency for Health Care Administration, the
1335 Florida Center for Health Information and Transparency ~~Policy~~
1336 ~~Analysis~~, and the Office of Insurance Regulation of the
1337 Financial Services Commission.
1338 Section 20. Section 465.0244, Florida Statutes, is amended
1339 to read:
1340 465.0244 Information disclosure.—Every pharmacy shall make
1341 available on its ~~Internet~~ website a hyperlink ~~link~~ to the health
1342 information ~~performance outcome and financial data~~ that is
1343 disseminated ~~published~~ by the Agency for Health Care
1344 Administration pursuant to s. 408.05(3) ~~s. 408.05(3)(k)~~ and
1345 shall place in the area where customers receive filled
1346 prescriptions notice that such information is available
1347 electronically and the address of its Internet website.
1348 Section 21. This act shall take effect July 1, 2016.