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1
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 written
15 or electronic good faith estimate of charges to a
16 patient or prospective patient within a certain
17 timeframe; requiring a facility to provide information
18 regarding financial assistance from the facility which
19 may be available to a patient or a prospective
20 patient; providing a penalty for failing to provide an
21 estimate of charges to a patient; deleting a
22 requirement that a licensed facility not operated by
23 the state provide notice to a patient of his or her
24 right to an itemized statement or bill within a
25 certain timeframe; revising the information that must
26 be included on a patient's statement or bill;



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27 requiring that certain records be made available
28 through electronic means that comply with a specified
29 law; reducing the amount of time afforded to
30 facilities to respond to certain patient requests for
31 information; amending s. 395.107, F.S.; providing a
32 definition; making technical changes; amending s.
33 408.05, F.S.; revising requirements for the collection
34 and use of health-related data by the agency;
35 requiring the agency to contract with a vendor to
36 provide an Internet-based platform with certain
37 attributes; requiring potential vendors to have
38 certain qualifications; prohibiting the agency from
39 establishing a certain database under certain
40 circumstances; amending s. 408.061, F.S.; revising
41 requirements for the submission of health care data to
42 the agency; requiring submitted information considered
43 a trade secret to be clearly designated; amending s.
44 456.0575, F.S.; requiring a health care practitioner
45 to provide a patient upon his or her request a written
46 or electronic good faith estimate of anticipated
47 charges within a certain timeframe; setting a maximum
48 amount for total fines assessed in certain
49 disciplinary actions; creating s. 627.6385, F.S.;
50 requiring a health insurer to make available on its
51 website certain methods that a policyholder can use to
52 make estimates of certain costs and charges; providing



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53 | that an estimate does not preclude an actual cost from
54 | exceeding the estimate; requiring a health insurer to
55 | make available on its website a hyperlink to certain
56 | health information; requiring a health insurer to
57 | include certain notice; requiring a health insurer
58 | that participates in the state group health insurance
59 | plan or Medicaid managed care to provide all claims
60 | data to a contracted vendor selected by the agency by
61 | a specified date; excluding from the contributed
62 | claims data certain types of coverage; amending s.
63 | 641.54, F.S.; revising a requirement that a health
64 | maintenance organization make certain information
65 | available to its subscribers; requiring a health
66 | maintenance organization that participates in the
67 | state group health insurance plan or Medicaid managed
68 | care to provide all claims data to a contracted vendor
69 | selected by the agency by a specified date; excluding
70 | from the contributed claims data certain types of
71 | coverage; amending s. 409.967, F.S.; requiring managed
72 | care plans to provide all claims data to a contracted
73 | vendor selected by the agency; amending s. 110.123,
74 | F.S.; requiring the Department of Management Services
75 | to provide certain data to the contracted vendor for
76 | the price transparency database established by the
77 | agency; requiring a contracted vendor for the state
78 | group health insurance plan to provide claims data to



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79 the vendor selected by the agency; amending ss. 20.42,
 80 381.026, 395.602, 395.6025, 408.07, 408.18, and
 81 465.0244, F.S.; conforming provisions to changes made
 82 by the act; providing legislative intent; providing an
 83 appropriation; providing an effective date.

84
 85 Be It Enacted by the Legislature of the State of Florida:

86
 87 Section 1. Section 395.301, Florida Statutes, is amended
 88 to read:

89 395.301 Price transparency; itemized patient statement or
 90 bill; form and content prescribed by the agency; patient
 91 admission status notification.-

92 (1) A facility licensed under this chapter shall provide
 93 timely and accurate financial information and quality of service
 94 measures to patients and prospective patients of the facility,
 95 or to patients' survivors or legal guardians, as appropriate.
 96 Such information shall be provided in accordance with this
 97 section and rules adopted by the agency pursuant to this chapter
 98 and s. 408.05. Licensed facilities operating exclusively as
 99 state facilities are exempt from this subsection.

100 (a) Each licensed facility shall make available to the
 101 public on its website information on payments made to that
 102 facility for defined bundles of services and procedures. The
 103 payment data must be presented and searchable in accordance
 104 with, and through a hyperlink to, the system established by the



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105 agency and its vendor using the descriptive service bundles
106 developed under s. 408.05(3)(c). At a minimum, the facility
107 shall provide the estimated average payment received from all
108 payors, excluding Medicaid and Medicare, for the descriptive
109 service bundles available at that facility and the estimated
110 payment range for such bundles. Using plain language,
111 comprehensible to an ordinary layperson, the facility must
112 disclose that the information on average payments and the
113 payment ranges is an estimate of costs that may be incurred by
114 the patient or prospective patient and that actual costs will be
115 based on the services actually provided to the patient. The
116 facility's website must:

117 1. Provide information to prospective patients on the
118 facility's financial assistance policy, including the
119 application process, payment plans, and discounts, and the
120 facility's charity care policy and collection procedures.

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

127 3. Inform patients and prospective patients that they may
128 request from the facility and other health care providers a more
129 personalized estimate of charges and other information, and
130 inform patients that they should contact each health care



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131 practitioner who will provide services in the hospital to
132 determine the health insurers and health maintenance
133 organizations with which the health care practitioner
134 participates as a network provider or preferred provider.

135 4. Provide the names, mailing addresses, and telephone
136 numbers of the health care practitioners and medical practice
137 groups with which it contracts to provide services in the
138 facility and instructions on how to contact the practitioners
139 and groups to determine the health insurers and health
140 maintenance organizations with which they participate as network
141 providers or preferred providers.

142 (b)1. Upon request, and before providing any nonemergency
143 medical services, each licensed facility shall provide in
144 writing or by electronic means a good faith estimate of
145 reasonably anticipated charges by the facility for the treatment
146 of the patient's or prospective patient's specific condition.
147 The facility must provide the estimate to the patient or
148 prospective patient within 7 business days after the receipt of
149 the request and is not required to adjust the estimate for any
150 potential insurance coverage. The estimate may be based on the
151 descriptive service bundles developed by the agency under s.
152 408.05(3)(c) unless the patient or prospective patient requests
153 a more personalized and specific estimate that accounts for the
154 specific condition and characteristics of the patient or
155 prospective patient. The facility shall inform the patient or
156 prospective patient that he or she may contact his or her health



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157 | insurer or health maintenance organization for additional
158 | information concerning cost-sharing responsibilities.

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

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

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

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

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

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



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183
184 The provision of an estimate does not preclude the actual
185 charges from exceeding the estimate.

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

192 (d)1. Upon request, and after the patient's discharge or
193 release from a facility, the facility must provide ~~A licensed~~
194 ~~facility not operated by the state shall notify each patient~~
195 ~~during admission and at discharge of his or her right to receive~~
196 ~~an itemized bill upon request. Within 7 days following the~~
197 ~~patient's discharge or release from a licensed facility not~~
198 ~~operated by the state, the licensed facility providing the~~
199 ~~service shall, upon request, submit to the patient, or to the~~
200 ~~patient's survivor or legal guardian, as may be appropriate, an~~
201 ~~itemized statement or a bill detailing in plain language,~~
202 ~~comprehensible to an ordinary layperson, the specific nature of~~
203 ~~charges or expenses incurred by the patient, which in The~~
204 ~~initial statement or bill billing shall be provided within 7~~
205 ~~days after the patient's discharge or release or after a request~~
206 ~~for such statement or bill, whichever is later. The initial~~
207 ~~statement or bill must contain a statement of specific services~~
208 ~~received and expenses incurred by date and provider for such~~



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209 items of service, enumerating in detail as prescribed by the
210 agency the constituent components of the services received
211 within each department of the licensed facility and including
212 unit price data on rates charged by the licensed facility, ~~as~~
213 ~~prescribed by the agency.~~ The statement or bill must also
214 clearly identify any facility fee and explain the purpose of the
215 fee. The statement or bill must identify each item as paid,
216 pending payment by a third party, or pending payment by the
217 patient, and must include the amount due, if applicable. If an
218 amount is due from the patient, a due date must be included. The
219 initial statement or bill must direct the patient or the
220 patient's survivor or legal guardian, as appropriate, to contact
221 the patient's insurer or health maintenance organization
222 regarding the patient's cost-sharing responsibilities.

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

228 3.(2)(a) Each such statement or bill provided submitted
229 pursuant to this subsection section:

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

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



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

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

242 ~~(b) Any person receiving a statement pursuant to this~~
243 ~~section shall be fully and accurately informed as to each charge~~
244 ~~and service provided by the institution preparing the statement.~~

245 ~~(2)(3) On each itemized statement submitted pursuant to~~
246 ~~subsection (1) there shall appear the words "A FOR-PROFIT (or~~
247 ~~NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL~~
248 ~~CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially~~
249 ~~similar words sufficient to identify clearly and plainly the~~
250 ~~ownership status of the licensed facility. Each itemized~~
251 ~~statement~~ or bill must prominently display the telephone ~~phone~~
252 number of the medical facility's patient liaison who is
253 responsible for expediting the resolution of any billing dispute
254 between the patient, or the patient's survivor or legal guardian
255 ~~his or her representative,~~ and the billing department.

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

258 ~~(5) In any billing for services subsequent to the initial~~
259 ~~billing for such services, the patient, or the patient's~~
260 ~~survivor or legal guardian, may elect, at his or her option, to~~



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261 ~~receive a copy of the detailed statement of specific services~~
262 ~~received and expenses incurred for each such item of service as~~
263 ~~provided in subsection (1).~~

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

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



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287 ~~\$500 for each instance of the facility's failure to provide the~~
288 ~~requested information.~~

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

308 ~~(3)(9)~~ (3) If a licensed facility places a patient on
309 observation status rather than inpatient status, observation
310 services shall be documented in the patient's discharge papers.
311 The patient or the patient's survivor or legal guardian ~~proxy~~
312 shall be notified of observation services through discharge



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313 papers, which may also include brochures, signage, or other
314 forms of communication for this purpose.

315 ~~(4)-(10)~~ A licensed facility shall make available to a
316 patient all records necessary for verification of the accuracy
317 of the patient's statement or bill within 10 ~~30~~ business days
318 after the request for such records. The records ~~verification~~
319 ~~information~~ must be made available in the facility's offices and
320 through electronic means that comply with the Health Insurance
321 Portability and Accountability Act of 1996, 42 U.S.C. s. 1320d,
322 as amended. Such records must ~~shall~~ be available to the patient
323 before ~~prior to~~ and after payment of the statement or bill ~~or~~
324 ~~claim~~. The facility may not charge the patient for making such
325 verification records available; however, the facility may charge
326 its usual fee for providing copies of records as specified in s.
327 395.3025.

328 ~~(5)-(11)~~ Each facility shall establish a method for
329 reviewing and responding to questions from patients concerning
330 the patient's itemized statement or bill. Such response shall be
331 provided within 7 business ~~30~~ days after the date a question is
332 received. If the patient is not satisfied with the response, the
333 facility must provide the patient with the contact information
334 ~~address~~ of the agency to which the issue may be sent for review.

335 ~~(12)~~ ~~Each licensed facility shall make available on its~~
336 ~~Internet website a link to the performance outcome and financial~~
337 ~~data that is published by the Agency for Health Care~~
338 ~~Administration pursuant to s. 408.05(3)(k). The facility shall~~



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339 ~~place a notice in the reception area that the information is~~
340 ~~available electronically and the facility's Internet website~~
341 ~~address.~~

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

344 395.107 Facilities ~~Urgent care centers~~; publishing and
345 posting schedule of charges; penalties.—

346 (1) For purposes of this section, the term "facility"
347 means:

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

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

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

355 (3) ~~(2)~~ The schedule of charges must describe the medical
356 services in language comprehensible to a layperson. The schedule
357 must include the prices charged to an uninsured person paying
358 for such services by cash, check, credit card, or debit card.
359 The schedule must be posted in a conspicuous place in the
360 reception area and must include, but is not limited to, the 50
361 services most frequently provided. The schedule may group
362 services by three price levels, listing services in each price
363 level. The posting may be a sign, which must be at least 15
364 square feet in size, or may be through an electronic messaging



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365 board. If a facility ~~an urgent care center~~ is affiliated with a
366 ~~facility~~ licensed hospital under this chapter, the schedule must
367 include text that notifies the insured patients whether the
368 charges for medical services received at the center will be the
369 same as, or more than, charges for medical services received at
370 the affiliated hospital. The text notifying the patient of the
371 schedule of charges shall be in a font size equal to or greater
372 than the font size used for prices and must be in a contrasting
373 color. The text that notifies the insured patients whether the
374 charges for medical services received at the center will be the
375 same as, or more than, charges for medical services received at
376 the affiliated hospital shall be included in all media and
377 Internet advertisements for the center and in language
378 comprehensible to a layperson.

379 ~~(4)-(3)~~ The posted text describing the medical services
380 must fill at least 12 square feet of the posting. A facility
381 ~~center~~ may use an electronic device or messaging board to post
382 the schedule of charges. Such a device must be at least 3 square
383 feet, and patients must be able to access the schedule during
384 all hours of operation of the facility ~~urgent care center~~.

385 ~~(5)-(4)~~ A facility ~~An urgent care center~~ that is operated
386 and used exclusively for employees and the dependents of
387 employees of the business that owns or contracts for the
388 facility ~~urgent care center~~ is exempt from this section.

389 ~~(6)-(5)~~ The failure of a facility ~~an urgent care center~~ to
390 publish and post a schedule of charges as required by this



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391 section shall result in a fine of not more than \$1,000, per day,
392 until the schedule is published and posted.

393 Section 3. Section 408.05, Florida Statutes, is amended to
394 read:

395 408.05 Florida Center for Health Information and
396 Transparency Policy Analysis.—

397 (1) ESTABLISHMENT.—The agency shall establish and maintain
398 a Florida Center for Health Information and Transparency to
399 collect, compile, coordinate, analyze, index, and disseminate
400 ~~Policy Analysis. The center shall establish a comprehensive~~
401 ~~health information system to provide for the collection,~~
402 ~~compilation, coordination, analysis, indexing, dissemination,~~
403 ~~and utilization of both purposefully collected and extant~~
404 health-related data and statistics. The center shall be staffed
405 as with public health experts, biostatisticians, information
406 system analysts, health policy experts, economists, and other
407 staff necessary to carry out its functions.

408 (2) HEALTH-RELATED DATA.—The ~~comprehensive health~~
409 ~~information system operated by the Florida Center for Health~~
410 Information and Transparency Policy Analysis shall identify the
411 ~~best~~ available data sets, compile new data when specifically
412 authorized, data sources and promote the use ~~coordinate the~~
413 ~~compilation~~ of extant health-related data and statistics. The
414 center must maintain any data sets in existence before July 1,
415 2016, unless such data sets duplicate information that is
416 readily available from other credible sources, and may and



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417 ~~purposefully~~ collect or compile data on:

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

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

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

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

429 ~~(a)-(e)~~ Health resources, including licensed physicians,
430 dentists, nurses, and other health care practitioners
431 professionals, by specialty and type of practice. Such data must
432 include information collected by the Department of Health
433 pursuant to ss. 458.3191 and 459.0081.

434 (b) Health service inventories, including and acute care,
435 long-term care, and other institutional care facilities facility
436 supplies and specific services provided by hospitals, nursing
437 homes, home health agencies, and other licensed health care
438 facilities.

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

441 ~~(d)-(g)~~ Health care costs and financing, including trends
442 in health care prices and costs, the sources of payment for



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443 health care services, and federal, state, and local expenditures
 444 for health care.

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

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

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

452 (3) ~~COMPREHENSIVE HEALTH INFORMATION~~ TRANSPARENCY SYSTEM.—

453 In order to disseminate and facilitate the availability of
 454 ~~produce~~ comparable and uniform health information ~~and statistics~~
 455 ~~for the development of policy recommendations,~~ the agency shall
 456 perform the following functions:

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

461 (b) Promote data sharing through dissemination of state-
 462 collected health data by making such data available,
 463 transferable, and readily usable ~~Undertake research,~~
 464 ~~development, and evaluation respecting the comprehensive health~~
 465 ~~information system.~~

466 (c) Contract with a vendor to provide a consumer-friendly,
 467 Internet-based platform that allows a consumer to research the
 468 cost of health care services and procedures and allows for price



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469 comparison. The Internet-based platform must allow a consumer to
470 search by condition or service bundles that are comprehensible
471 to a layperson and may not require registration, a security
472 password, or user identification. The vendor shall also
473 establish and maintain a Florida-specific data set of health
474 care claims information available to the public and any
475 interested party. The agency shall actively oversee the vendor
476 to ensure compliance with state law. The vendor may not be owned
477 or operated by any health plan, health insurer, health
478 maintenance organization, or any entity authorized to provide
479 health care coverage in any state or any director, employee, or
480 other person who has the ability to direct or control a health
481 plan, health insurer, health maintenance organization, or any
482 entity authorized to provide health care coverage in any state.
483 The vendor must be qualified under s. 1874 of the Social
484 Security Act, 42 U.S.C. 1395kk, to receive Medicare claims data
485 and receive claims, payment, and patient cost-share data from
486 multiple private insurers nationwide. The agency shall select
487 the vendor through a competitive procurement process. By October
488 1, 2016, a responsive vendor shall have:

489 1. A national database consisting of at least 15 billion
490 claim lines of administrative claims data from multiple payors
491 capable of being expanded by adding claims data, directly or
492 through arrangements with extant data sources, from other third-
493 party payors, including employers with health plans covered by
494 the Employee Retirement Income Security Act of 1974 when those



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495 employers choose to participate.

496 2. A well-developed methodology for analyzing claims data
497 within defined service bundles that are understandable by the
498 general public.

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

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

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

515 (e) Establish by rule:

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

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



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

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

527 5. How information is to be published on the consumer-
528 friendly, Internet-based platform created under paragraph (c)
529 for public use ~~Decisions regarding center data sets should be~~
530 ~~made based on consultation with the State Consumer Health~~
531 ~~Information and Policy Advisory Council and other public and~~
532 ~~private users regarding the types of data which should be~~
533 ~~collected and their uses. The center shall establish~~
534 ~~standardized means for collecting health information and~~
535 ~~statistics under laws and rules administered by the agency.~~

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

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

543 ~~(f) Establish minimum health care related data sets which~~
544 ~~are necessary on a continuing basis to fulfill the collection~~
545 ~~requirements of the center and which shall be used by state~~
546 ~~agencies in collecting and compiling health care related data.~~



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547 ~~The agency shall periodically review ongoing health care data~~
548 ~~collections of the Department of Health and other state agencies~~
549 ~~to determine if the collections are being conducted in~~
550 ~~accordance with the established minimum sets of data.~~

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

555 ~~(h) Prescribe standards for the publication of health-~~
556 ~~care-related data reported pursuant to this section which ensure~~
557 ~~the reporting of accurate, valid, reliable, complete, and~~
558 ~~comparable data. Such standards should include advisory warnings~~
559 ~~to users of the data regarding the status and quality of any~~
560 ~~data reported by or available from the center.~~

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

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

568 ~~(i)-(k) Make Develop, in conjunction with the State~~
569 ~~Consumer Health Information and Policy Advisory Council, and~~
570 ~~implement a long-range plan for making available health care~~
571 ~~quality measures and financial data that will allow consumers to~~
572 ~~compare outcomes and other performance measures for health care~~



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573 | ~~services. The health care quality measures and financial data~~
574 | ~~the agency must make available include, but are not limited to,~~
575 | ~~pharmaceuticals, physicians, health care facilities, and health~~
576 | ~~plans and managed care entities. The agency shall update the~~
577 | ~~plan and report on the status of its implementation annually.~~
578 | ~~The agency shall also make the plan and status report available~~
579 | ~~to the public on its Internet website. As part of the plan, the~~
580 | ~~agency shall identify the process and timeframes for~~
581 | ~~implementation, barriers to implementation, and recommendations~~
582 | ~~of changes in the law that may be enacted by the Legislature to~~
583 | ~~eliminate the barriers. As preliminary elements of the plan, the~~
584 | ~~agency shall:~~

585 | ~~1. Make available patient safety indicators, inpatient~~
586 | ~~quality indicators, and performance outcome and patient charge~~
587 | ~~data collected from health care facilities pursuant to s.~~
588 | ~~408.061(1)(a) and (2). The terms "patient safety indicators" and~~
589 | ~~"inpatient quality indicators" have the same meaning as that~~
590 | ~~ascribed by the Centers for Medicare and Medicaid Services, an~~
591 | ~~accrediting organization whose standards incorporate comparable~~
592 | ~~regulations required by this state, or a national entity that~~
593 | ~~establishes standards to measure the performance of health care~~
594 | ~~providers, or by other states. The agency shall determine which~~
595 | ~~conditions, procedures, health care quality measures, and~~
596 | ~~patient charge data to disclose based upon input from the~~
597 | ~~council. When determining which conditions and procedures are to~~
598 | ~~be disclosed, the council and the agency shall consider~~



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599 ~~variation in costs, variation in outcomes, and magnitude of~~
600 ~~variations and other relevant information. When determining~~
601 ~~which health care quality measures to disclose, the agency:~~

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

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

615

616 ~~When determining which patient charge data to disclose, the~~
617 ~~agency shall include such measures as the average of~~
618 ~~undiscounted charges on frequently performed procedures and~~
619 ~~preventive diagnostic procedures, the range of procedure charges~~
620 ~~from highest to lowest, average net revenue per adjusted patient~~
621 ~~day, average cost per adjusted patient day, and average cost per~~
622 ~~admission, among others.~~

623 ~~2. Make available performance measures, benefit design,~~
624 ~~and premium cost data from health plans licensed pursuant to~~



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

639 ~~3. Determine the method and format for public disclosure~~
640 ~~of data reported pursuant to this paragraph. The agency shall~~
641 ~~make its determination based upon input from the State Consumer~~
642 ~~Health Information and Policy Advisory Council. At a minimum,~~
643 ~~the data shall be made available on the agency's Internet~~
644 ~~website in a manner that allows consumers to conduct an~~
645 ~~interactive search that allows them to view and compare the~~
646 ~~information for specific providers. The website must include~~
647 ~~such additional information as is determined necessary to ensure~~
648 ~~that the website enhances informed decisionmaking among~~
649 ~~consumers and health care purchasers, which shall include, at a~~
650 ~~minimum, appropriate guidance on how to use the data and an~~



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651 ~~explanation of why the data may vary from provider to provider.~~

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

656 ~~(4) TECHNICAL ASSISTANCE.—~~

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

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

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

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



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

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

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

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

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

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

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

702 (c) ~~The agency shall initiate, oversee, manage, and~~



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703 ~~evaluate the integration of health care data from each state~~
704 ~~agency that collects, stores, and reports on health care issues~~
705 ~~and make that data available to any health care practitioner~~
706 ~~through a state health information network.~~

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

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

719 ~~(j)(b) Conduct and The center shall publish, make~~
720 ~~available, and disseminate, promptly and as widely as~~
721 ~~practicable, the results of special health surveys, health care~~
722 ~~research, and health care evaluations conducted or supported~~
723 ~~under this section. Each year the center shall select and~~
724 ~~analyze one or more research topics that can be investigated~~
725 ~~using the data available pursuant to paragraph (c). The selected~~
726 ~~topics must focus on producing actionable information for~~
727 ~~improving quality of care and reducing costs. The first topic~~
728 ~~selected by the center must address preventable~~



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729 ~~hospitalizations. Any publication by the center must include a~~
730 ~~statement of the limitations on the quality, accuracy, and~~
731 ~~completeness of the data.~~

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

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

737 ~~(e) The center shall be responsible, to the extent~~
738 ~~resources are available, for conducting a variety of special~~
739 ~~studies and surveys to expand the health care information and~~
740 ~~statistics available for health policy analyses, particularly~~
741 ~~for the review of public policy issues. The center shall develop~~
742 ~~a process by which users of the center's data are periodically~~
743 ~~surveyed regarding critical data needs and the results of the~~
744 ~~survey considered in determining which special surveys or~~
745 ~~studies will be conducted. The center shall select problems in~~
746 ~~health care for research, policy analyses, or special data~~
747 ~~collections on the basis of their local, regional, or state~~
748 ~~importance; the unique potential for definitive research on the~~
749 ~~problem; and opportunities for application of the study~~
750 ~~findings.~~

751 (4) ~~(6)~~ PROVIDER DATA REPORTING.—This section does not
752 confer on the agency the power to demand or require that a
753 health care provider or professional furnish information,
754 records of interviews, written reports, statements, notes,



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755 memoranda, or data other than as expressly required by law. The
756 agency may not establish an all-payor claims database or a
757 comparable database without express legislative authority.

758 (5)~~(7)~~ BUDGET; FEES.—

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

762 ~~(b)~~ The Florida Center for Health Information and
763 Transparency Policy Analysis may apply for and receive and
764 accept grants, gifts, and other payments, including property and
765 services, from any governmental or other public or private
766 entity or person and make arrangements as to the use of same,
767 including the undertaking of special studies and other projects
768 relating to health-care-related topics. Funds obtained pursuant
769 to this paragraph may not be used to offset annual
770 appropriations from the General Revenue Fund.

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

776 (6)~~(8)~~ STATE CONSUMER HEALTH INFORMATION AND POLICY
777 ADVISORY COUNCIL.—

778 (a) There is established in the agency the State Consumer
779 Health Information and Policy Advisory Council to assist the
780 center ~~in reviewing the comprehensive health information system,~~



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781 ~~including the identification, collection, standardization,~~
782 ~~sharing, and coordination of health-related data, fraud and~~
783 ~~abuse data, and professional and facility licensing data among~~
784 ~~federal, state, local, and private entities and to recommend~~
785 ~~improvements for purposes of public health, policy analysis, and~~
786 ~~transparency of consumer health care information.~~ The council
787 consists ~~shall consist~~ of the following members:

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

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

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

794 4. Ten persons, to be appointed by the Secretary of Health
795 Care Administration, representing other state and local
796 agencies, state universities, business and health coalitions,
797 local health councils, professional health-care-related
798 associations, consumers, and purchasers.

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

806 (c) The council may meet at the call of its chair, at the



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807 request of the agency, or at the request of a majority of its
808 membership, but the council must meet at least quarterly.

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

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

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

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

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

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

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

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

829 (7) ~~(9)~~ APPLICATION TO OTHER AGENCIES. ~~Nothing in~~ This
830 section does not ~~shall~~ limit, restrict, affect, or control the
831 collection, analysis, release, or publication of data by any
832 state agency pursuant to its statutory authority, duties, or



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833 responsibilities.

834 Section 4. Subsection (1) of section 408.061, Florida
835 Statutes, is amended to read:

836 408.061 Data collection; uniform systems of financial
837 reporting; information relating to physician charges;
838 confidential information; immunity.—

839 (1) The agency shall require the submission by health care
840 facilities, health care providers, and health insurers of data
841 necessary to carry out the agency's duties and to facilitate
842 transparency in health care pricing data and quality measures.

843 Specifications for data to be collected under this section shall
844 be developed by the agency and applicable contract vendors, with
845 the assistance of technical advisory panels including
846 representatives of affected entities, consumers, purchasers, and
847 such other interested parties as may be determined by the
848 agency.

849 (a) Data submitted by health care facilities, including
850 the facilities as defined in chapter 395, shall include, but are
851 not limited to: case-mix data, patient admission and discharge
852 data, hospital emergency department data which shall include the
853 number of patients treated in the emergency department of a
854 licensed hospital reported by patient acuity level, data on
855 hospital-acquired infections as specified by rule, data on
856 complications as specified by rule, data on readmissions as
857 specified by rule, with patient and provider-specific
858 identifiers included, actual charge data by diagnostic groups or



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859 | other bundled groupings as specified by rule, financial data,
860 | accounting data, operating expenses, expenses incurred for
861 | rendering services to patients who cannot or do not pay,
862 | interest charges, depreciation expenses based on the expected
863 | useful life of the property and equipment involved, and
864 | demographic data. The agency shall adopt nationally recognized
865 | risk adjustment methodologies or software consistent with the
866 | standards of the Agency for Healthcare Research and Quality and
867 | as selected by the agency for all data submitted as required by
868 | this section. Data may be obtained from documents such as, but
869 | not limited to: leases, contracts, debt instruments, itemized
870 | patient statements or bills, medical record abstracts, and
871 | related diagnostic information. Reported data elements shall be
872 | reported electronically in accordance with rule 59E-7.012,
873 | Florida Administrative Code. Data submitted shall be certified
874 | by the chief executive officer or an appropriate and duly
875 | authorized representative or employee of the licensed facility
876 | that the information submitted is true and accurate.

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



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

887 (c) Data to be submitted by health insurers may include,
888 but are not limited to: claims, payments to health care
889 facilities and health care providers as specified by rule,
890 premium, administration, and financial information. Data
891 submitted shall be certified by the chief financial officer, an
892 appropriate and duly authorized representative, or an employee
893 of the insurer that the information submitted is true and
894 accurate. Information that is considered a trade secret under s.
895 812.081 shall be clearly designated.

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

907 (e) A requirement to submit data shall be adopted by rule
908 if the submission of data is being required of all members of
909 any type of health care facility, health care provider, or
910 health insurer. Rules are not required, however, for the



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911 submission of data for a special study mandated by the
912 Legislature or when information is being requested for a single
913 health care facility, health care provider, or health insurer.

914 Section 5. Section 456.0575, Florida Statutes, is amended
915 to read:

916 456.0575 Duty to notify patients.—

917 (1) Every licensed health care practitioner shall inform
918 each patient, or an individual identified pursuant to s.
919 765.401(1), in person about adverse incidents that result in
920 serious harm to the patient. Notification of outcomes of care
921 that result in harm to the patient under this section does ~~shall~~
922 not constitute an acknowledgment of admission of liability, nor
923 can such notifications be introduced as evidence.

924 (2) Upon request by a patient, before providing
925 nonemergency medical services in a facility licensed under
926 chapter 395, a health care practitioner shall provide, in
927 writing or by electronic means, a good faith estimate of
928 reasonably anticipated charges to treat the patient's condition
929 at the facility. The health care practitioner shall provide the
930 estimate to the patient within 7 business days after receiving
931 the request and is not required to adjust the estimate for any
932 potential insurance coverage. The health care practitioner shall
933 inform the patient that the patient may contact his or her
934 health insurer or health maintenance organization for additional
935 information concerning cost-sharing responsibilities. The health
936 care practitioner shall provide information to uninsured



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937 | patients and insured patients for whom the practitioner is not a
938 | network provider or preferred provider which discloses the
939 | practitioner's financial assistance policy, including the
940 | application process, payment plans, discounts, or other
941 | available assistance, and the practitioner's charity care policy
942 | and collection procedures. Such estimate does not preclude the
943 | actual charges from exceeding the estimate. Failure to provide
944 | the estimate in accordance with this subsection, without good
945 | cause, shall result in disciplinary action against the health
946 | care practitioner and a daily fine of \$500 until the estimate is
947 | provided to the patient. The total fine may not exceed \$5,000.

948 | Section 6. Section 627.6385, Florida Statutes, is created
949 | to read:

950 | 627.6385 Disclosures to policyholders; calculations of
951 | cost sharing.—

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

954 | (a) A method for policyholders to estimate their
955 | copayments, deductibles, and other cost-sharing responsibilities
956 | for health care services and procedures. Such method of making
957 | an estimate shall be based on service bundles established
958 | pursuant to s. 408.05(3)(c). Estimates do not preclude the
959 | actual copayment, coinsurance percentage, or deductible,
960 | whichever is applicable, from exceeding the estimate.

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



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

965 3. A policyholder must be able to create estimates by any
966 combination of the service bundles established pursuant to s.
967 408.05(3)(c), a specified provider, or a comparison of
968 providers.

969 (b) A method for policyholders to estimate their
970 copayments, deductibles, and other cost-sharing responsibilities
971 based on a personalized estimate of charges received from a
972 facility pursuant to s. 395.301 or a practitioner pursuant to s.
973 456.0575.

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

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

984 (3) Each health insurer that participates in the state
985 group health insurance plan created under s. 110.123 or Medicaid
986 managed care pursuant to part IV of chapter 409 shall contribute
987 all claims data from Florida policyholders held by the insurer
988 and its affiliates to the contracted vendor selected by the



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989 Agency for Health Care Administration under s. 408.05(3)(c).
990 Health insurers shall submit Medicaid managed care claims data
991 to the vendor beginning July 1, 2017, and may submit data before
992 that date. However, each insurer and its affiliates may not
993 contribute claims data to the contracted vendor which reflect
994 the following types of coverage:

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

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

999 (c) Liability insurance, including general liability
1000 insurance and automobile liability insurance.

1001 (d) Workers' compensation or similar insurance.

1002 (e) Automobile medical payment insurance.

1003 (f) Credit-only insurance.

1004 (g) Coverage for onsite medical clinics, including prepaid
1005 health clinics under part II of chapter 641.

1006 (h) Limited scope dental or vision benefits.

1007 (i) Benefits for long-term care, nursing home care, home
1008 health care, community-based care, or any combination thereof.

1009 (j) Coverage only for a specified disease or illness.

1010 (k) Hospital indemnity or other fixed indemnity insurance.

1011 (l) Medicare supplemental health insurance as defined
1012 under s. 1882(g)(1) of the Social Security Act, coverage
1013 supplemental to the coverage provided under chapter 55 of Title
1014 10, U.S.C., and similar supplemental coverage provided to



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1015 supplement coverage under a group health plan.

1016 Section 7. Subsection (6) of section 641.54, Florida
 1017 Statutes, is amended, present subsection (7) of that section is
 1018 redesignated as subsection (8) and amended, and a new subsection
 1019 (7) is added to that section, to read:

1020 641.54 Information disclosure.—

1021 (6) Each health maintenance organization shall make
 1022 available to its subscribers on its website or by request the
 1023 estimated copayment ~~copay~~, coinsurance percentage, or
 1024 deductible, whichever is applicable, for any covered services as
 1025 described by the searchable bundles established on a consumer-
 1026 friendly, Internet-based platform pursuant to s. 408.05(3)(c) or
 1027 as described by a personalized estimate received from a facility
 1028 pursuant to s. 395.301 or a practitioner pursuant to s.
 1029 456.0575, the status of the subscriber's maximum annual out-of-
 1030 pocket payments for a covered individual or family, and the
 1031 status of the subscriber's maximum lifetime benefit. Such
 1032 estimate does ~~shall~~ not preclude the actual copayment ~~copay~~,
 1033 coinsurance percentage, or deductible, whichever is applicable,
 1034 from exceeding the estimate.

1035 (7) Each health maintenance organization that participates
 1036 in the state group health insurance plan created under s.
 1037 110.123 or Medicaid managed care pursuant to part IV of chapter
 1038 409 shall contribute all claims data from Florida subscribers
 1039 held by the organization and its affiliates to the contracted
 1040 vendor selected by the Agency for Health Care Administration



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1041 under s. 408.05(3)(c). Health maintenance organizations shall
1042 submit Medicaid managed care claims data to the vendor beginning
1043 July 1, 2017, and may submit data before that date. However,
1044 each health maintenance organization and its affiliates may not
1045 contribute claims data to the contracted vendor which reflect
1046 the following types of coverage:

1047 (a) Coverage only for accident, or disability income
1048 insurance, or any combination thereof.

1049 (b) Coverage issued as a supplement to liability
1050 insurance.

1051 (c) Liability insurance, including general liability
1052 insurance and automobile liability insurance.

1053 (d) Workers' compensation or similar insurance.

1054 (e) Automobile medical payment insurance.

1055 (f) Credit-only insurance.

1056 (g) Coverage for onsite medical clinics, including prepaid
1057 health clinics under part II of chapter 641.

1058 (h) Limited scope dental or vision benefits.

1059 (i) Benefits for long-term care, nursing home care, home
1060 health care, community-based care, or any combination thereof.

1061 (j) Coverage only for a specified disease or illness.

1062 (k) Hospital indemnity or other fixed indemnity insurance.

1063 (l) Medicare supplemental health insurance as defined
1064 under s. 1882(g)(1) of the Social Security Act, coverage
1065 supplemental to the coverage provided under chapter 55 of Title
1066 10, U.S.C., and similar supplemental coverage provided to



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1067 supplement coverage under a group health plan.

1068 (8)(7) Each health maintenance organization shall make
 1069 available on its ~~Internet~~ website a hyperlink link to the health
 1070 information ~~performance outcome and financial data~~ that is
 1071 disseminated ~~published~~ by the Agency for Health Care
 1072 Administration pursuant to s. 408.05(3) ~~s. 408.05(3)(k)~~ and
 1073 shall include in every policy delivered or issued for delivery
 1074 to any person in the state or in any materials provided as
 1075 required by s. 627.64725 notice that such information is
 1076 available electronically and the address of its ~~Internet~~
 1077 website.

1078 Section 8. Paragraph (n) is added to subsection (2) of
 1079 section 409.967, Florida Statutes, to read:

1080 409.967 Managed care plan accountability.—

1081 (2) The agency shall establish such contract requirements
 1082 as are necessary for the operation of the statewide managed care
 1083 program. In addition to any other provisions the agency may deem
 1084 necessary, the contract must require:

1085 (n) Transparency.—Managed care plans shall comply with ss.
 1086 627.6385(3) and 641.54(7).

1087 Section 9. Paragraph (d) of subsection (3) of section
 1088 110.123, Florida Statutes, is amended to read:

1089 110.123 State group insurance program.—

1090 (3) STATE GROUP INSURANCE PROGRAM.—

1091 (d)1. Notwithstanding ~~the provisions of~~ chapter 287 and
 1092 the authority of the department, for the purpose of protecting



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1093 | the health of, and providing medical services to, state
 1094 | employees participating in the state group insurance program,
 1095 | the department may contract to retain the services of
 1096 | professional administrators for the state group insurance
 1097 | program. The agency shall follow good purchasing practices of
 1098 | state procurement to the extent practicable under the
 1099 | circumstances.

1100 | 2. Each vendor in a major procurement, and any other
 1101 | vendor if the department deems it necessary to protect the
 1102 | state's financial interests, shall, at the time of executing any
 1103 | contract with the department, post an appropriate bond with the
 1104 | department in an amount determined by the department to be
 1105 | adequate to protect the state's interests but not higher than
 1106 | the full amount estimated to be paid annually to the vendor
 1107 | under the contract.

1108 | 3. Each major contract entered into by the department
 1109 | pursuant to this section shall contain a provision for payment
 1110 | of liquidated damages to the department for material
 1111 | noncompliance by a vendor with a contract provision. The
 1112 | department may require a liquidated damages provision in any
 1113 | contract if the department deems it necessary to protect the
 1114 | state's financial interests.

1115 | 4. Section ~~The provisions of s. 120.57(3)~~ applies apply to
 1116 | the department's contracting process, except:

1117 | a. A formal written protest of any decision, intended
 1118 | decision, or other action subject to protest shall be filed



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1119 | within 72 hours after receipt of notice of the decision,
 1120 | intended decision, or other action.

1121 | b. As an alternative to any provision of s. 120.57(3), the
 1122 | department may proceed with the bid selection or contract award
 1123 | process if the director of the department sets forth, in
 1124 | writing, particular facts and circumstances that ~~which~~
 1125 | demonstrate the necessity of continuing the procurement process
 1126 | or the contract award process in order to avoid a substantial
 1127 | disruption to the provision of any scheduled insurance services.

1128 | 5. The department shall make arrangements as necessary to
 1129 | contribute claims data of the state group health insurance plan
 1130 | to the contracted vendor selected by the Agency for Health Care
 1131 | Administration pursuant to s. 408.05(3)(c).

1132 | 6. Each contracted vendor for the state group health
 1133 | insurance plan shall contribute Florida claims data to the
 1134 | contracted vendor selected by the Agency for Health Care
 1135 | Administration pursuant to s. 408.05(3)(c).

1136 | Section 10. Subsection (3) of section 20.42, Florida
 1137 | Statutes, is amended to read:

1138 | 20.42 Agency for Health Care Administration.—

1139 | (3) The department shall be the chief health policy and
 1140 | planning entity for the state. The department is responsible for
 1141 | health facility licensure, inspection, and regulatory
 1142 | enforcement; investigation of consumer complaints related to
 1143 | health care facilities and managed care plans; the
 1144 | implementation of the certificate of need program; the operation



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1145 of the Florida Center for Health Information and Transparency
1146 ~~Policy Analysis~~; the administration of the Medicaid program; the
1147 administration of the contracts with the Florida Healthy Kids
1148 Corporation; the certification of health maintenance
1149 organizations and prepaid health clinics as set forth in part
1150 III of chapter 641; and any other duties prescribed by statute
1151 or agreement.

1152 Section 11. Paragraph (c) of subsection (4) of section
1153 381.026, Florida Statutes, is amended to read:

1154 381.026 Florida Patient's Bill of Rights and
1155 Responsibilities.—

1156 (4) RIGHTS OF PATIENTS.—Each health care facility or
1157 provider shall observe the following standards:

1158 (c) *Financial information and disclosure.*—

1159 1. A patient has the right to be given, upon request, by
1160 the responsible provider, his or her designee, or a
1161 representative of the health care facility full information and
1162 necessary counseling on the availability of known financial
1163 resources for the patient's health care.

1164 2. A health care provider or a health care facility shall,
1165 upon request, disclose to each patient who is eligible for
1166 Medicare, before treatment, whether the health care provider or
1167 the health care facility in which the patient is receiving
1168 medical services accepts assignment under Medicare reimbursement
1169 as payment in full for medical services and treatment rendered
1170 in the health care provider's office or health care facility.



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1171 3. A primary care provider may publish a schedule of
1172 charges for the medical services that the provider offers to
1173 patients. The schedule must include the prices charged to an
1174 uninsured person paying for such services by cash, check, credit
1175 card, or debit card. The schedule must be posted in a
1176 conspicuous place in the reception area of the provider's office
1177 and must include, but is not limited to, the 50 services most
1178 frequently provided by the primary care provider. The schedule
1179 may group services by three price levels, listing services in
1180 each price level. The posting must be at least 15 square feet in
1181 size. A primary care provider who publishes and maintains a
1182 schedule of charges for medical services is exempt from the
1183 license fee requirements for a single period of renewal of a
1184 professional license under chapter 456 for that licensure term
1185 and is exempt from the continuing education requirements of
1186 chapter 456 and the rules implementing those requirements for a
1187 single 2-year period.

1188 4. If a primary care provider publishes a schedule of
1189 charges pursuant to subparagraph 3., he or she must continually
1190 post it at all times for the duration of active licensure in
1191 this state when primary care services are provided to patients.
1192 If a primary care provider fails to post the schedule of charges
1193 in accordance with this subparagraph, the provider shall be
1194 required to pay any license fee and comply with any continuing
1195 education requirements for which an exemption was received.

1196 5. A health care provider or a health care facility shall,



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1197 upon request, furnish a person, before the provision of medical
 1198 services, a reasonable estimate of charges for such services.
 1199 The health care provider or the health care facility shall
 1200 provide an uninsured person, before the provision of a planned
 1201 nonemergency medical service, a reasonable estimate of charges
 1202 for such service and information regarding the provider's or
 1203 facility's discount or charity policies for which the uninsured
 1204 person may be eligible. Such estimates by a primary care
 1205 provider must be consistent with the schedule posted under
 1206 subparagraph 3. Estimates shall, to the extent possible, be
 1207 written in language comprehensible to an ordinary layperson.
 1208 Such reasonable estimate does not preclude the health care
 1209 provider or health care facility from exceeding the estimate or
 1210 making additional charges based on changes in the patient's
 1211 condition or treatment needs.

1212 6. Each licensed facility, except a facility operating
 1213 exclusively as a state facility, ~~not operated by the state~~ shall
 1214 make available to the public on its ~~Internet~~ website or by other
 1215 electronic means a description of and a hyperlink link to the
 1216 health information ~~performance outcome and financial data~~ that
 1217 is disseminated ~~published~~ by the agency pursuant to s. 408.05(3)
 1218 ~~s. 408.05(3)(k)~~. The facility shall place a notice in the
 1219 reception area that such information is available electronically
 1220 and the website address. The licensed facility may indicate that
 1221 the pricing information is based on a compilation of charges for
 1222 the average patient and that each patient's statement or bill



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1223 | may vary from the average depending upon the severity of illness
 1224 | and individual resources consumed. The licensed facility may
 1225 | also indicate that the price of service is negotiable for
 1226 | eligible patients based upon the patient's ability to pay.

1227 | 7. A patient has the right to receive a copy of an
 1228 | itemized statement or bill upon request. A patient has a right
 1229 | to be given an explanation of charges upon request.

1230 | Section 12. Paragraph (e) of subsection (2) of section
 1231 | 395.602, Florida Statutes, is amended to read:

1232 | 395.602 Rural hospitals.—

1233 | (2) DEFINITIONS.—As used in this part, the term:

1234 | (e) "Rural hospital" means an acute care hospital licensed
 1235 | under this chapter, having 100 or fewer licensed beds and an
 1236 | emergency room, which is:

1237 | 1. The sole provider within a county with a population
 1238 | density of up to 100 persons per square mile;

1239 | 2. An acute care hospital, in a county with a population
 1240 | density of up to 100 persons per square mile, which is at least
 1241 | 30 minutes of travel time, on normally traveled roads under
 1242 | normal traffic conditions, from any other acute care hospital
 1243 | within the same county;

1244 | 3. A hospital supported by a tax district or subdistrict
 1245 | whose boundaries encompass a population of up to 100 persons per
 1246 | square mile;

1247 | 4. A hospital with a service area that has a population of
 1248 | up to 100 persons per square mile. As used in this subparagraph,



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1249 the term "service area" means the fewest number of zip codes
1250 that account for 75 percent of the hospital's discharges for the
1251 most recent 5-year period, based on information available from
1252 the hospital inpatient discharge database in the Florida Center
1253 for Health Information and Transparency Policy Analysis at the
1254 agency; or

1255 5. A hospital designated as a critical access hospital, as
1256 defined in s. 408.07.

1257
1258 Population densities used in this paragraph must be based upon
1259 the most recently completed United States census. A hospital
1260 that received funds under s. 409.9116 for a quarter beginning no
1261 later than July 1, 2002, is deemed to have been and shall
1262 continue to be a rural hospital from that date through June 30,
1263 2021, if the hospital continues to have up to 100 licensed beds
1264 and an emergency room. An acute care hospital that has not
1265 previously been designated as a rural hospital and that meets
1266 the criteria of this paragraph shall be granted such designation
1267 upon application, including supporting documentation, to the
1268 agency. A hospital that was licensed as a rural hospital during
1269 the 2010-2011 or 2011-2012 fiscal year shall continue to be a
1270 rural hospital from the date of designation through June 30,
1271 2021, if the hospital continues to have up to 100 licensed beds
1272 and an emergency room.

1273 Section 13. Section 395.6025, Florida Statutes, is amended
1274 to read:



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1275 | 395.6025 Rural hospital replacement facilities.—
 1276 | Notwithstanding ~~the provisions of~~ s. 408.036, a hospital defined
 1277 | as a statutory rural hospital in accordance with s. 395.602, or
 1278 | a not-for-profit operator of rural hospitals, is not required to
 1279 | obtain a certificate of need for the construction of a new
 1280 | hospital located in a county with a population of at least
 1281 | 15,000 but no more than 18,000 and a density of fewer ~~less~~ than
 1282 | 30 persons per square mile, or a replacement facility, provided
 1283 | that the replacement, or new, facility is located within 10
 1284 | miles of the site of the currently licensed rural hospital and
 1285 | within the current primary service area. As used in this
 1286 | section, the term "service area" means the fewest number of zip
 1287 | codes that account for 75 percent of the hospital's discharges
 1288 | for the most recent 5-year period, based on information
 1289 | available from the hospital inpatient discharge database in the
 1290 | Florida Center for Health Information and Transparency Policy
 1291 | ~~Analysis~~ at the Agency for Health Care Administration.

1292 | Section 14. Subsection (43) of section 408.07, Florida
 1293 | Statutes, is amended to read:

1294 | 408.07 Definitions.—As used in this chapter, with the
 1295 | exception of ss. 408.031-408.045, the term:

1296 | (43) "Rural hospital" means an acute care hospital
 1297 | licensed under chapter 395, having 100 or fewer licensed beds
 1298 | and an emergency room, and which is:

1299 | (a) The sole provider within a county with a population
 1300 | density of no greater than 100 persons per square mile;



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1301 (b) An acute care hospital, in a county with a population
 1302 density of no greater than 100 persons per square mile, which is
 1303 at least 30 minutes of travel time, on normally traveled roads
 1304 under normal traffic conditions, from another acute care
 1305 hospital within the same county;

1306 (c) A hospital supported by a tax district or subdistrict
 1307 whose boundaries encompass a population of 100 persons or fewer
 1308 per square mile;

1309 (d) A hospital with a service area that has a population
 1310 of 100 persons or fewer per square mile. As used in this
 1311 paragraph, the term "service area" means the fewest number of
 1312 zip codes that account for 75 percent of the hospital's
 1313 discharges for the most recent 5-year period, based on
 1314 information available from the hospital inpatient discharge
 1315 database in the Florida Center for Health Information and
 1316 Transparency Policy Analysis at the Agency for Health Care
 1317 Administration; or

1318 (e) A critical access hospital.

1319
 1320 Population densities used in this subsection must be based upon
 1321 the most recently completed United States census. A hospital
 1322 that received funds under s. 409.9116 for a quarter beginning no
 1323 later than July 1, 2002, is deemed to have been and shall
 1324 continue to be a rural hospital from that date through June 30,
 1325 2015, if the hospital continues to have 100 or fewer licensed
 1326 beds and an emergency room. An acute care hospital that has not



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1327 | previously been designated as a rural hospital and that meets
 1328 | the criteria of this subsection shall be granted such
 1329 | designation upon application, including supporting
 1330 | documentation, to the Agency for Health Care Administration.

1331 | Section 15. Paragraph (a) of subsection (4) of section
 1332 | 408.18, Florida Statutes, is amended to read:

1333 | 408.18 Health Care Community Antitrust Guidance Act;
 1334 | antitrust no-action letter; market-information collection and
 1335 | education.—

1336 | (4) (a) Members of the health care community who seek
 1337 | antitrust guidance may request a review of their proposed
 1338 | business activity by the Attorney General's office. In
 1339 | conducting its review, the Attorney General's office may seek
 1340 | whatever documentation, data, or other material it deems
 1341 | necessary from the Agency for Health Care Administration, the
 1342 | Florida Center for Health Information and Transparency Policy
 1343 | ~~Analysis~~, and the Office of Insurance Regulation of the
 1344 | Financial Services Commission.

1345 | Section 16. Section 465.0244, Florida Statutes, is amended
 1346 | to read:

1347 | 465.0244 Information disclosure.—Every pharmacy shall make
 1348 | available on its ~~Internet~~ website a hyperlink link to the health
 1349 | information ~~performance outcome and financial data~~ that is
 1350 | disseminated ~~published~~ by the Agency for Health Care
 1351 | Administration pursuant to s. 408.05(3) ~~s. 408.05(3)(k)~~ and
 1352 | shall place in the area where customers receive filled



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1353 | prescriptions notice that such information is available
 1354 | electronically and the address of its Internet website.

1355 | Section 17. This act is intended to promote health care
 1356 | price and quality transparency to enable consumers to make
 1357 | informed choices regarding health care treatment and improve
 1358 | competition in the health care market. Persons or entities
 1359 | required to submit, receive, or publish data under this act are
 1360 | acting pursuant to state requirements contained therein and are
 1361 | exempt from state antitrust laws.

1362 | Section 18. For the 2016-2017 fiscal year, the sums of
 1363 | \$952,919 in recurring funds and \$3.1 million in nonrecurring
 1364 | funds from the Health Care Trust Fund are appropriated to the
 1365 | Agency for Health Care Administration, and one full-time
 1366 | equivalent position with associated salary rate of 41,106 is
 1367 | authorized, for the purpose of implementing this act.

1368 | Section 19. This act shall take effect July 1, 2016.
 1369 |