A bill to be entitled
An act relating to transparency in health care;
amending s. 395.301, F.S.; requiring a facility
licensed under chapter 395, F.S., to provide timely
and accurate financial information and quality of
service measures to certain individuals; requiring a
licensed facility to post certain payment information
regarding defined bundles of services and procedures
and other specified consumer information and
notifications on its website; requiring a facility to
provide a good faith estimate of charges to a patient
or prospective patient within a certain timeframe;
requiring a facility to provide information regarding
its financial assistance policy to a patient or a
prospective patient; providing a penalty for failing
to provide such estimate of charges to a patient;
deleting a requirement that a licensed facility not
operated by the state provide notice to a patient of
his or her right to an itemized bill within a certain
timeframe; revising the information that must be
included on a patient's statement or bill; amending s.
395.107, F.S.; defining the term "facility" to mean an
urgent care center or a diagnostic-imaging center
operated by a licensed hospital but not located on the
hospital premises; requiring a facility to publish and
post a schedule of certain charges for medical
services offered to patients; providing a minimum size for the posting; requiring a schedule of charges to include certain information regarding medical services offered; providing that the schedule may group the facility's services by price levels and list the services in each price level; providing a fine for failure to publish and post a schedule of medical services; amending s. 408.05, F.S.; renaming the Florida Center for Health Information and Policy Analysis; revising requirements for the collection and use of health-related data by the Agency for Health Care Administration; requiring the agency to contract with a vendor to provide an Internet-based platform with certain attributes and a state-specific data set available to the public; providing vendor qualifications; requiring the agency to design a patient safety culture survey for hospitals and ambulatory surgical centers licensed under chapter 395, F.S.; requiring the survey to measure certain aspects of a facility's patient safety practices; exempting certain licensed facilities from survey requirements; prohibiting the agency from establishing a certain database without express legislative authority; revising the duties of the members of the State Consumer Health Information and Policy Advisory Council; revising provisions relating to the use of

CODING: Words **stricken** are deletions; words *underlined* are additions.
certain fees; revising the agency's rulemaking
authority; deleting an obsolete provision; amending s.
408.061, F.S.; revising requirements for the
submission of health care data to the agency; amending
s. 408.810, F.S.; requiring certain licensed hospitals
and ambulatory surgical centers to submit a facility
patient safety culture survey to the agency; amending
s. 456.0575, F.S.; requiring a health care
practitioner to provide a good faith estimate of
anticipated charges to a patient upon request within a
certain timeframe; providing for disciplinary action
and a fine for failure to comply; creating s.
627.6385, F.S.; requiring a health insurer to make
available on its website certain information and a
method for policyholders to estimate certain health
care services costs and charges; providing that an
estimate does not preclude an actual cost from
exceeding the estimate; requiring a health insurer to
provide notice in insurance policies that certain
information is available on its website; requiring a
health insurer that participates in the state group
health insurance plan or Medicaid managed care to
contribute all Florida claims data held by it or its
affiliates to the contracted vendor selected by the
agency; establishing a deadline for submission of
Medicaid managed care claims data by health insurers;
requiring that an insurer and its affiliates not submit claims data reflecting certain coverage to the contracted vendor; amending s. 641.54, F.S.; requiring a health maintenance organization to make certain information available to its subscribers on its website; requiring a health insurer to provide a hyperlink to certain health information on its website; requiring a health maintenance organization that participates in the state group health insurance plan or Medicaid managed care to contribute all Florida claims data held by it or its affiliates to the contracted vendor selected by the agency; establishing a deadline for submission of Medicaid managed care claims data by health maintenance organizations; requiring that a health maintenance organization and its affiliates not submit claims data reflecting certain coverage to the contracted vendor; amending s. 409.967, F.S.; requiring managed care plans to contribute all Florida claims data to the contracted vendor selected by the agency; amending s. 110.123, F.S.; requiring the Department of Management Services to contribute certain data to the vendor for the price transparency database established by the agency; requiring a contracted vendor for the state group health insurance plan to contribute Florida claims data to the contracted vendor selected by the agency;
agency; amending ss. 20.42, 381.026, 395.602, 395.6025, 400.991, 408.07, 408.18, 408.8065, 408.820, 465.0244, and 627.6499, F.S.; conforming cross-references and provisions to changes made by the act; providing intent of the act; declaring all persons or entities required to submit, receive, or publish data under the act to be acting pursuant to state requirements contained therein; exempting such persons or entities from state antitrust laws; providing an appropriation and authorizing a position; providing an effective date.

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

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

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

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

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

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

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

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

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

(b)1. Upon request, and before providing any nonemergency
medical services, each licensed facility shall provide in
writing or by electronic means a good faith estimate of
reasonably anticipated charges by the facility for the treatment
of the patient's or prospective patient's specific condition.
The facility must provide the estimate to the patient or
prospective patient within 7 business days after receipt of the
request and shall adjust the estimate for any potential
insurance coverage. The estimate may be based on the descriptive
service bundles developed by the agency under s. 408.05(3)(c) unless the patient or prospective patient requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient.

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

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

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

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

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

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

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

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

(d)1. Upon request, and after the patient's discharge or release from a facility, the facility must provide a licensed facility not operated by the state shall notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. Within 7 days following the patient's discharge or release from a licensed facility not operated by the state, the licensed facility providing the service shall, upon request, submit to the patient, or to the patient's survivor or legal guardian, as may be appropriate, an itemized statement or bill detailing in plain language comprehensible to an ordinary layperson the specific nature of charges or expenses incurred by the patient. which in The initial statement or bill billing shall be provided within 7 days after the patient's discharge or release. The initial statement or bill must contain a statement of specific services
received and expenses incurred by date and provider for such
items of service, enumerating in detail as prescribed by the
agency the constituent components of the services received
within each department of the licensed facility and including
unit price data on rates charged by the licensed facility, as
prescribed by the agency. The statement or bill must also
clearly identify any facility fee and explain the purpose of the
fee. The statement or bill must identify each item as paid,
pending payment by a third party, or pending payment by the
patient and must include the amount due, if applicable. If an
amount is due from the patient, a due date must be included. The
initial statement or bill must direct the patient or the
patient's survivor or legal guardian, as appropriate, to contact
the patient's insurer or health maintenance organization
regarding the patient's cost-sharing responsibilities.

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

(e)(2)(a) Each such statement or bill provided submitted
pursuant to this subsection section:

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

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

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

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

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

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

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

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

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

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

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

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

(4) (10) A licensed facility shall make available to a 
patient all records necessary for verification of the accuracy 
of the patient's statement or bill within 10 30 business days 
after the request for such records. The records verification 
information must be made available in the facility's offices and 
through electronic means that comply with the Health Insurance 
Portability and Accountability Act of 1996 (HIPAA). Such records 
must shall be available to the patient before prior to and after 
payment of the statement or bill or claim. The facility may not 
charge the patient for making such verification records 
available; however, the facility may charge its usual fee for 
providing copies of records as specified in s. 395.3025.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) HEALTH-RELATED DATA.—The comprehensive health information system operated by the Florida Center for Health Information and Transparency Policy Analysis shall identify the best available data sets, compile new data when specifically authorized, sources and promote the use coordinate the compilation of extant health-related data and statistics. The center must maintain any data sets in existence before July 1, 2016, unless such data sets duplicate information that is readily available from other credible sources, and may and purposefully collect or compile data on:
(a) The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality.

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

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

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

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

(f) Health service inventories, including and acute care, long-term care, and other institutional care facilities, supplies and specific services provided by hospitals, nursing homes, home health agencies, and other licensed health care facilities.

(g) Service utilization for licensed health care facilities by type of provider.

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

(h) Family formation, growth, and dissolution.

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

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

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

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

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

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

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

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

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

(d) Design a patient safety culture survey or surveys to be completed annually by each hospital and ambulatory surgical center licensed under chapter 395. The survey or surveys shall be anonymous to encourage staff employed by or working in the facility to complete the survey. The survey or surveys shall be
designed to measure aspects of patient safety culture, including
frequency of adverse events, quality of handoffs and
transitions, comfort in reporting a potential problem or error,
the level of teamwork within hospital units and the facility as
a whole, staff compliance with patient safety regulations and
guidelines, staff perception of facility support for patient
safety, and staff opinions on whether they would undergo a
health care service or procedure at the facility. The agency
shall review and analyze nationally recognized patient safety
culture survey products, including, but not limited to, the
patient safety surveys developed by the federal Agency for
Healthcare Research and Quality, to develop the patient safety
culture survey. This paragraph does not apply to licensed
facilities operating exclusively as state facilities.

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

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

(f)(e) Establish by rule:

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

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

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

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

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

(g) Consult with contracted vendors, the State Consumer Health Information and Policy Advisory Council, and other public and private users regarding the types of data that should be collected and the use of such data.
(h) Monitor data collection procedures and test data quality to facilitate the dissemination of data that is accurate, valid, reliable, and complete.

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

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

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

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

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

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

1. Make available patient-safety indicators, inpatient quality indicators, and performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The terms "patient-safety indicators" and "inpatient quality indicators" have the same meaning as that ascribed by the Centers for Medicare and Medicaid Services, an accrediting organization whose standards incorporate comparable
regulations required by this state, or a national entity that establishes standards to measure the performance of health care providers, or by other states. The agency shall determine which conditions, procedures, health care quality measures, and patient charge data to disclose based upon input from the council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which health care quality measures to disclose, the agency:

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

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

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

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

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

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

   (4) TECHNICAL ASSISTANCE.—

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

   1. Establish procedures identifying the circumstances
under which, the places at which, the persons from whom, and the
methods by which a person may secure data from the center,
including procedures governing requests, the ordering of
requests, timeframes for handling requests, and other procedures
necessary to facilitate the use of the center's data. To the
extent possible, the center should provide current data timely
in response to requests from public or private agencies.
2. Provide assistance to data sources and users in the areas of database design, survey design, sampling procedures, statistical interpretation, and data access to promote improved health-care-related data sets.

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

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

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

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

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

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

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

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

(c) The agency shall initiate, oversee, manage, and
evaluate the integration of health care data from each state
agency that collects, stores, and reports on health care issues
and make that data available to any health care practitioner
through a state health information network.

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

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

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

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

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

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

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

(5) (7) BUDGET; FEES.—

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

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

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

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

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

1. An employee of the Executive Office of the Governor, to be appointed by the Governor.
2. An employee of the Office of Insurance Regulation, to be appointed by the director of the office.
3. An employee of the Department of Education, to be appointed by the Commissioner of Education.
4. Ten persons, to be appointed by the Secretary of Health Care Administration, representing other state and local agencies, state universities, business and health coalitions, local health councils, professional health-care-related associations, consumers, and purchasers.

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

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

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

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

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

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

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

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

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

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

(7)(9) APPLICATION TO OTHER AGENCIES—Nothing in this section shall limit, restrict, affect, or control the
collection, analysis, release, or publication of data by any state agency pursuant to its statutory authority, duties, or responsibilities.

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

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

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

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to: case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as
specified by rule, with patient and provider-specific
identifiers included, actual charge data by diagnostic groups or
other bundled groupings as specified by rule, facility patient
safety culture surveys, financial data, accounting data,
operating expenses, expenses incurred for rendering services to
patients who cannot or do not pay, interest charges,
depreciation expenses based on the expected useful life of the
property and equipment involved, and demographic data. The
agency shall adopt nationally recognized risk adjustment
methodologies or software consistent with the standards of the
Agency for Healthcare Research and Quality and as selected by
the agency for all data submitted as required by this section.
Data may be obtained from documents such as, but not limited to:
leases, contracts, debt instruments, itemized patient statements
or bills, medical record abstracts, and related diagnostic
information. Reported data elements shall be reported
electronically in accordance with rule 59E-7.012, Florida
Administrative Code. Data submitted shall be certified by the
chief executive officer or an appropriate and duly authorized
representative or employee of the licensed facility that the
information submitted is true and accurate.

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

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

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

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

Section 5. Subsections (8), (9), and (10) of section 408.810, Florida Statutes, are renumbered as subsections (9), (10), and (11), respectively, and a new subsection (8) is added to that section to read:

408.810 Minimum licensure requirements.—In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

(8) Each licensee subject to s. 408.05(3)(d) shall submit the patient safety culture survey or surveys to the agency in accordance with applicable rules.

Section 6. Section 456.0575, Florida Statutes, is amended to read:

456.0575 Duty to notify patients.—

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

(2) Every licensed health care practitioner shall provide
upon request by a patient, before providing any nonemergency
medical services in a facility licensed under chapter 395, in
writing or by electronic means a good faith estimate of
reasonably anticipated charges to treat the patient's condition
at the facility. The health care practitioner must provide the
estimate to the patient within 7 business days after receiving
the request and shall adjust the estimate for any potential
insurance coverage. The health care practitioner must provide
information to uninsured patients and insured patients for whom
the practitioner is not a network provider or preferred provider
which discloses the practitioner's financial assistance policy,
including the application process, payment plans, discounts, or
other available assistance, and the practitioner's charity care
policy and collection procedures. Such estimate does not
preclude the actual charges from exceeding the estimate. Failure
to provide the estimate in accordance with this subsection shall
result in disciplinary action against the health care
practitioner and a daily fine of $500 until the estimate is
provided to the patient. The total fine may not exceed $5,000.

Section 7. Section 627.6385, Florida Statutes, is created
to read:

627.6385 Disclosures to policyholders; calculations of
cost sharing.—
(1) Each health insurer shall make available on its website:

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

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

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

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

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

(c) A hyperlink to the health information, including, but not limited to, service bundles and quality of care information, which is disseminated by the Agency for Health Care Administration pursuant to s. 408.05(3).
(2) Each health insurer shall include in every policy delivered or issued for delivery to any person in the state or in materials provided as required by s. 627.64725 notice that the information required by this section is available electronically and the address of the website where the information can be accessed.

(3) Each health insurer that participates in the state group health insurance plan created under s. 110.123 or Medicaid managed care pursuant to part IV of chapter 409 shall contribute all claims data from Florida policyholders held by the insurer and its affiliates to the contracted vendor selected by the Agency for Health Care Administration under s. 408.05(3)(c).

Health insurers shall submit Medicaid managed care claims data to the vendor beginning July 1, 2017, and may submit data before that date. However, each insurer and its affiliates may not contribute claims data to the contracted vendor which reflect coverage for the following benefits:

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

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

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

(d) Workers' compensation or similar insurance.

(e) Automobile medical payment insurance.

(f) Credit-only insurance.
(g) Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

(h) Limited scope dental or vision benefits.

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

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

(k) Hospital indemnity or other fixed indemnity insurance.

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

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

641.54 Information disclosure.—

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

(7) Each health maintenance organization that participates in the state group health insurance plan created under s. 110.123 or Medicaid managed care pursuant to part IV of chapter 409 shall contribute all claims data from Florida subscribers held by the organization and its affiliates to the contracted vendor selected by the Agency for Health Care Administration under s. 408.05(3)(c). Health maintenance organizations shall submit Medicaid managed care claims data to the vendor beginning July 1, 2017, and may submit data before that date. However, each health maintenance organization and its affiliates may not contribute claims data to the contracted vendor which reflect coverage for the following benefits:

(a) Coverage only for accident or disability income insurance, or any combination thereof.
(b) Coverage issued as a supplement to liability insurance.
(c) Liability insurance, including general liability insurance and automobile liability insurance.
(d) Workers' compensation or similar insurance.
(e) Automobile medical payment insurance.
(f) Credit-only insurance.
(g) Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

(h) Limited scope dental or vision benefits.

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

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

(k) Hospital indemnity or other fixed indemnity insurance.

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

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

Section 9. Paragraph (n) is added to subsection (2) of section 409.967, Florida Statutes, to read:

409.967 Managed care plan accountability.—

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

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

Section 10. Paragraph (d) of subsection (3) of section 110.123, Florida Statutes, is amended to read:

110.123 State group insurance program.—

(3) STATE GROUP INSURANCE PROGRAM.—

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

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

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

4. Section 120.57(3) applies to the department's contracting process, except:

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

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

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

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

Section 11. Subsection (3) of section 20.42, Florida Statutes, is amended to read:

20.42 Agency for Health Care Administration.—

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

Section 12. Paragraph (c) of subsection (4) of section 381.026, Florida Statutes, is amended to read:

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

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

(c) Financial information and disclosure.—

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

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

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

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

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

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

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

Section 13. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

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

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

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

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

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

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

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

Section 14. Section 395.6025, Florida Statutes, is amended
to read:

395.6025 Rural hospital replacement facilities.—
Notwithstanding the provisions of s. 408.036, a hospital defined
as a statutory rural hospital in accordance with s. 395.602, or
a not-for-profit operator of rural hospitals, is not required to
obtain a certificate of need for the construction of a new
hospital located in a county with a population of at least
15,000 but no more than 18,000 and a density of fewer less than
30 persons per square mile, or a replacement facility, provided
that the replacement, or new, facility is located within 10
miles of the site of the currently licensed rural hospital and
within the current primary service area. As used in this
section, the term "service area" means the fewest number of zip
codes that account for 75 percent of the hospital's discharges
for the most recent 5-year period, based on information
available from the hospital inpatient discharge database in the
Florida Center for Health Information and Transparency Policy
Section 15. Paragraph (c) of subsection (4) of section 400.991, Florida Statutes, is amended to read:

400.991 License requirements; background screenings; prohibitions.—

(4) In addition to the requirements of part II of chapter 408, the applicant must file with the application satisfactory proof that the clinic is in compliance with this part and applicable rules, including:

(c) Proof of financial ability to operate as required under s. 408.810(9). As an alternative to submitting proof of financial ability to operate as required under s. 408.810(9), the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic, payable to the agency. The agency may adopt rules to specify related requirements for such surety bond.

Section 16. Paragraph (d) of subsection (43) of section 408.07, Florida Statutes, is amended to read:

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

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

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

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

Section 17. Paragraph (a) of subsection (4) of section 408.18, Florida Statutes, is amended to read:

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

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

Section 18. Paragraph (a) of subsection (1) of section 408.8065, Florida Statutes, is amended to read:

408.8065 Additional licensure requirements for home health agencies, home medical equipment providers, and health care clinics.—

(1) An applicant for initial licensure, or initial licensure due to a change of ownership, as a home health agency, home medical equipment provider, or health care clinic shall:

(a) Demonstrate financial ability to operate, as required under s. 408.810(9) and this section. If the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses, and the applicant provides independent evidence that the funds necessary for startup costs, working capital, and contingency financing exist and will be available as needed, the applicant has demonstrated the financial ability to operate.

All documents required under this subsection must be prepared in accordance with generally accepted accounting principles and may
be in a compilation form. The financial statements must be signed by a certified public accountant.

Section 19. Section 408.820, Florida Statutes, is amended to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

(1) Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102, are exempt from s. 408.810(5)-(11) 408.810(5)-(10).

(2) Birth centers, as provided under chapter 383, are exempt from s. 408.810(7)-(11) 408.810(7)-(10).

(3) Abortion clinics, as provided under chapter 390, are exempt from s. 408.810(7)-(11) 408.810(7)-(10).

(4) Crisis stabilization units, as provided under parts I and IV of chapter 394, are exempt from s. 408.810(8)-(11)

408.810(8)-(10).

(5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394, are exempt from s. 408.810(8)-(11) 408.810(8)-(10).

(6) Residential treatment facilities, as provided under part IV of chapter 394, are exempt from s. 408.810(8)-(11) 408.810(8)-(10).

(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394, are exempt from s. 408.810(8)-(11) 408.810(8)-(10).
(8) Hospitals, as provided under part I of chapter 395, are exempt from s. 408.810(7), (9), and (10) 408.810(7)–(9).

(9) Ambulatory surgical centers, as provided under part I of chapter 395, are exempt from s. 408.810(7), (9), (10), and (11) 408.810(7)–(10).

(10) Mobile surgical facilities, as provided under part I of chapter 395, are exempt from s. 408.810(7)–(11) 408.810(7)–(10).

(11) Health care risk managers, as provided under part I of chapter 395, are exempt from ss. 408.806(7), 408.810(4)–(11) 408.810(4)–(10), and 408.811.

(12) Nursing homes, as provided under part II of chapter 400, are exempt from ss. 408.810(7) and (8) and 408.813(2).

(13) Assisted living facilities, as provided under part I of chapter 429, are exempt from s. 408.810(8) and (11) 408.810(10).

(14) Home health agencies, as provided under part III of chapter 400, are exempt from s. 408.810(8) and (11) 408.810(10).

(15) Nurse registries, as provided under part III of chapter 400, are exempt from s. 408.810(6), (8), and (11) 408.810(6)–(10).

(16) Companion services or homemaker services providers, as provided under part III of chapter 400, are exempt from s. 408.810(6)–(11) 408.810(6)–(10).

(17) Adult day care centers, as provided under part III of chapter 429, are exempt from s. 408.810(8) and (11) 408.810(10).

(18) Adult family-care homes, as provided under part II of chapter 400, are exempt from s. 408.810(8) and (11) 408.810(10).
chapter 429, are exempt from s. 408.810(7)-(11).  
(19) Homes for special services, as provided under part V of chapter 400, are exempt from s. 408.810(7)-(11).

(20) Transitional living facilities, as provided under part XI of chapter 400, are exempt from s. 408.810(8) and (11).

(21) Prescribed pediatric extended care centers, as provided under part VI of chapter 400, are exempt from s. 408.810(8) and (11).

(22) Home medical equipment providers, as provided under part VII of chapter 400, are exempt from s. 408.810(8) and (11).

(23) Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400, are exempt from s. 408.810(7) and (8).

(24) Health care services pools, as provided under part IX of chapter 400, are exempt from s. 408.810(6)-(11).

(25) Health care clinics, as provided under part X of chapter 400, are exempt from s. 408.810(6), (7), (8), and (11).

(26) Clinical laboratories, as provided under part I of chapter 483, are exempt from s. 408.810(5)-(11).

(27) Multiphasic health testing centers, as provided under part II of chapter 483, are exempt from s. 408.810(5)-(11).
408.810(5)-(10).

(28) Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765, are exempt from s. 408.810(5)-(11) 408.810(5)-(10).

Section 20. Section 465.0244, Florida Statutes, is amended to read:

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

Section 21. Subsection (2) of section 627.6499, Florida Statutes, is amended to read:

627.6499 Reporting by insurers and third-party administrators.—

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

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

Section 23. For the 2016-2017 fiscal year, the sums of $952,919 in recurring funds and $3.1 million in nonrecurring funds from the Health Care Trust Fund are appropriated to the Agency for Health Care Administration, and one full-time equivalent position with associated salary rate of 41,106 is authorized, for the purpose of implementing this act.

Section 24. This act shall take effect July 1, 2016.