A bill to be entitled

An act relating to health care consumer protection; amending s. 381.026; revising the Florida Patient's Bill of Rights and Responsibilities to require online posting by certain health care practitioners of financial and patient quality information; creating s. 381.0262; establishing protections against unconscionable prices for products and services provided during medically essential treatment; amending s. 408.05; clarifying and adding duties to the comprehensive health information system's primary role to assist consumers in making health care decisions.

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

Section 1. Section 381.026, Florida Statutes is amended to read:

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

(1) SHORT TITLE.—~~This section~~ Sections 381.026, 381.0261, and 381.0262 may be cited as the "Florida Patient's Bill of Rights and Responsibilities."

(2) DEFINITIONS.—As used in this section, ~~and~~ s. 381.0261, and s. 381.0262, the term:

(a) "Ambulatory patient group" (APG) means a classification system that groups similar clinical conditions (diagnoses) and the ambulatory procedures furnished during an episode of care. The

patient's principal diagnosis and secondary diagnoses that may include comorbidities or complications determine the APG assignment. APG assignment can be affected by procedures furnished during the episode including a patient's gender, age, or discharge status disposition.

(b) "Average amount accepted" means the sum of all payment amounts received in full on claims for emergency or medically necessary care from all commercial, nongovernmental insurers as the primary payer of these claims during a prior twelve month period divided by the total number of these individual claims. Full payment amounts shall include, at a minimum, the portion paid by the insurers plus any associated portions of the claims paid by insured individuals, including, but not limited to, co-insurance, copayments, and deductibles.

(c) "Chargemaster" means the list of a health care facility's charges for every single procedure performed in the facility and for every supply item used during those procedures.

(d) "Charity care" means financial assistance in the form of free or discounted emergency or medically necessary care provided by a health care facility based on a patient's inability to pay for all or a portion of the care.

(e) "Department" means the Department of Health.

(f) "Diagnosis-related groups" (DRG) means a classification system that groups similar clinical conditions (diagnoses) and the procedures furnished by a hospital during an inpatient admission. The

patient's principal diagnosis and secondary diagnoses that may include comorbidities or complications determine the DRG assignment. DRG assignment can be affected by procedures furnished during the stay, a patient's gender, age, or discharge status disposition.

(g) "Gross charges per inpatient admission" means the sum of all charges by a health care facility for all procedures and supply items rendered during the course of a single inpatient stay from the time of admission to discharge, before applying any credits, deductions, or other adjustments to this gross amount.

(h) "Gross charges per outpatient visit" means the sum of all charges by a health care facility for all procedures and supply items rendered during the course of a single outpatient visit, before applying any credits, deductions, or other adjustments to this gross amount.

(i) "Health care facility" means a facility licensed under chapter 395.

(j) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, or a podiatric physician licensed under chapter 461.

(k) "Medical emergency" means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

2. With respect to a pregnant woman:

a. That there is inadequate time to effect safe transfer to another hospital prior to delivery.

b. That a transfer may pose a threat to the health and safety of the patient or fetus.

c. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(l) "Medically necessary care" means any combination of medical services or medical supply items which are used to identify or treat an illness or injury, are appropriate to the patient's diagnosis and status of recovery, and are consistent with the location of service, the level of care provided, and applicable practice parameters. The services should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The services must not be of an experimental, investigative, or research nature.

(m) "Total billed per inpatient admission" means the total amount that remains after applying any credits, deductions, or other adjustments to the gross charges per inpatient admission.

(n) "Total billed per outpatient visit" means the total amount that remains after applying any credits, deductions, or other adjustments to the gross charges per outpatient visit.

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

(c) Financial information and disclosure.—

6. Each ~~licensed~~ health care facility not operated by the state shall make available to the public in readily accessible formats through a community relations section or similar prominent section on its Internet website all of the following:

a. A clear description of and a direct link to the performance outcome and financial data that is published by the agency pursuant to s. 408.05 (3)(k);

b. The health care facility's entire chargemaster;

c. No less than 90 days after each calendar quarter, the average amount in gross charges and the average amount accepted per inpatient admission by the health care facility according to each diagnosis related group for the most recent twelve month period. The diagnosis related group classification system shall be the all-patient refined diagnosis related grouping system or another singularly comprehensive classifications system specified by the Agency for Health Care Administration;

d. No less than 90 days after each calendar quarter, the average amount in gross charges and the average amount accepted per

outpatient visit by the health care facility according to each ambulatory patient group for the most recent twelve month period. The ambulatory patient group classification system shall be the enhanced ambulatory patient grouping system or another singularly comprehensive classification system specified by the Agency for Health Care Administration;

e. Information regarding the availability of charity care offered by the health care facility, including, at a minimum:

(I) Any eligibility criteria, including income and asset thresholds;

(II) Any applications or other documentation required as a prerequisite for qualifying to receive such charity care;

(III) The bases and methodologies for calculating discounts and total amounts billed;

(IV) Methods by which patients may apply to qualify or receive charity care; and

(V) Actions, including billing and collection practices, that will be taken by the health care facility in the event of non-payment;

f. Performance of the health care facility on a standardized set of no more than ten specific patient quality measures set by the Agency for Health Care Administration in conjunction with the State Consumer Health Information and Policy Advisory Council. Such measures may include, but are not limited to, rates of preventable facility admissions and readmissions, rates of preventable facility-acquired

complications, facility safety scores, and facility patient satisfaction scores; and

g. The three most recently filed annual Internal Revenue Service Forms 990 or the three most recently filed Securities and Exchange Commission Forms 10-K for the health care facility.

~~or by other electronic means a description of and a link to the performance outcome and financial data that is 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 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.~~

Section 2. Section 381.0262, Florida Statutes, is created to read:

381.0262. Patient's bill of rights; protection against unconscionable prices.—

(1) It is prima facie evidence that a price is unconscionable if:

(a) The total billed for an inpatient admission represents more than 115% of the average amount accepted for the health care facility for the same diagnosis related group;

(b) The total billed for an outpatient visit represents more than 115% of the average amount accepted for the health care facility for the same ambulatory patient group; and

(c) The total charged for an item not listed on the health care facility's chargemaster exceeds 100% of the usual and customary retail price for that same item.

(2) It is unlawful and a violation of s. 501.204 for a health care facility to bill at an unconscionable price any inpatient admission, outpatient visit, or item that is necessary as a direct result of a medical emergency or medically necessary care.

(3) A price level approved by an appropriate government agency shall not be a violation of this section.

(4) Any violation of this section may be enforced by the office of the state attorney or the Department of Legal Affairs. The state attorney or the Department of Legal Affairs may use the report specified under s. 408.05(5)(f) as a reference for establishing or interpreting thresholds or similar criteria for use to determine whether a price is unconscionable.

(5) In addition to any other limitation under s. 501.211, recovery of actual damages is limited to the amount of medical or

health care expenses incurred that are actually paid by or on behalf of the claimant.

Section 3. Subsections (3) and (5) of section 408.05, Florida Statutes is amended to read:

408.05 Florida Center for Health Information and Policy Analysis.—

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

(k) ~~Develop, i~~In conjunction with the State Consumer Health Information and Policy Advisory Council, ~~and implement a long-range plan for making~~ make available health care quality measures and financial data that will allow consumers to compare and shop 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, t~~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 by January 1, 2017 shall include, at a minimum:

a. Estimates for consumers' out-of-pocket expenses, with adjustments according to particular insurance coverage;

b. Risk-adjusted rates of adverse incidents such as those pertaining to facility readmissions and complications, with adjustments according to patient characteristics and patient health care needs;

c. Clear language presented in a manner understandable by the general public;

d. Ease of navigation and layout;

e. No fewer than 150 of the most commonly performed adult and

pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures;

f. All health care facilities licensed under chapter 395;

g. Paid amounts, rather than just charges; and

h. Confidence of estimates and current data.

~~, 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.~~

(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:

(f) Beginning January 1, 2017, the center shall publish and make available on a prominent section of the Agency for Health Care Administration's website an annual report detailing average amounts in gross charges and average accepted amounts per inpatient admission by each diagnosis related group and per outpatient visit by each ambulatory patient group for each and all applicable health care facilities across the state. The diagnosis related group classification system used for this report shall be the all-patient refined diagnosis related grouping system or another singularly

comprehensive classification system specified by the Agency for Health Care Administration. The report may provide additional detailed information, including, but not limited to:

1. Average amounts in gross charges and average accepted amounts per inpatient admission by each diagnosis related group, broken down by payer type;

2. The risk-adjusted rate of potentially preventable facility readmissions and complications by each diagnosis related group; and

3. Average amounts both in gross charges and average accepted amounts per outpatient visit by each ambulatory patient group for each and all applicable health care facilities, broken down by payer type. Any ambulatory patient group classification system used for this purpose shall be a singularly comprehensive system specified by the agency.

Section 4. This act shall take effect July 1, 2016.