

[Fla. Stat. § 395.301.]

§ 395.301. Price transparency; itemized patient statement or bill; patient admission status notification: Hospitals and Other Licensed Facilities

(1) A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to patients and prospective 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. If applicable, notify patients and prospective patients that services may be provided in the health care facility by the facility as well as by other health care providers who may separately bill the patient and that such health care providers may or may not participate with the same health insurers or health maintenance organizations as the facility.
3. Inform patients and prospective patients that they may request from the facility and other health care providers a more personalized estimate of charges and other information, and inform patients that they should contact each health care practitioner who will provide services in the hospital to determine 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 network providers or preferred providers.

(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 the receipt of the request and is not required to adjust the estimate for any potential insurance coverage. The estimate may be based on the descriptive service bundles developed by the agency under s. 408.05(3)(c) unless the patient or prospective patient requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient. The facility shall inform the patient or prospective patient that he or she may contact his or her health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities.

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

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

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

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

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

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

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

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

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

2. Any subsequent statement or bill provided to a patient or to the patient's survivor or legal guardian, as appropriate, relating to the episode of care must include all of the information required by subparagraph 1., with any revisions clearly delineated.
3. Each statement or bill provided pursuant to this subsection:
 - a. Must include notice of hospital-based physicians and other health care providers who bill separately.
 - b. May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.
 - c. Must list drugs by brand or generic name and not refer to drug code numbers when referring to drugs of any sort.
 - d. Must specifically identify physical, occupational, or speech therapy treatment by date, type, and length of treatment when such treatment is a part of the statement or bill.
- (2) 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, and the billing department.
- (3) If a licensed facility places a patient on observation status rather than inpatient status, the licensed facility must immediately notify the patient of such status using the form adopted under 42 C.F.R. s. 489.20 for Medicare patients or a form adopted by agency rule for non-Medicare patients. Such notification must be documented in the patient's medical records and discharge papers. The patient's survivor or legal guardian must be notified of observation services through discharge papers, which may also include brochures, signage, or other forms of communication for this purpose.
- (4) 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 business days after the request for such records. The records 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, 42 U.S.C. s. 1320d, as amended. Such records must be available to the patient before and after payment of the statement or bill. 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) 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 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 of the agency to which the issue may be sent for review.
- (6) A hospital shall post on its website:
 - (a) The names and hyperlinks for direct access to the websites of all health insurers and health maintenance organizations for which the hospital contracts as a network provider or participating provider.
 - (b) A statement that:
 1. Services may be provided in the hospital by the facility as well as by other health care practitioners who may separately bill the patient;

2. Health care practitioners who provide services in the hospital may or may not participate with the same health insurers or health maintenance organizations as the hospital; and
 3. Prospective patients should contact the health care practitioner who will provide services in the hospital to determine which health insurers and health maintenance organizations the practitioner participates in as a network provider or preferred provider.
- (c) As applicable, 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 hospital, and instructions on how to contact the practitioners and groups to determine which health insurers and health maintenance organizations they participate in as network providers or preferred providers.