Tab 1	**SB 362** by **Bradley**; (Identical to H 00161) Medical Treatment Under the Workers' Compensation Law

Tab 2	**SB 542** by **Ingoglia**; (Identical to H 00543) Boards of Directors of Banks

Tab 3	**SB 568** by **Hooper**; (Identical to H 00639) Coverage for Out-of-network Ground Ambulance Emergency Services

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The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Boyd, Chair
Senator DiCeglie, Vice Chair

MEETING DATE: Tuesday, January 9, 2024
TIME: 4:30—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Boyd, Chair; Senator DiCeglie, Vice Chair; Senators Broxson, Burton, Hutson, Ingoglia, Mayfield, Powell, Thompson, Torres, and Trumbull

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 362** Bradley (Identical H 161)	Medical Treatment Under the Workers' Compensation Law; Increasing limits on witness fees charged by certain witnesses; increasing maximum reimbursement allowances for physicians and surgical procedures, etc. BI 01/09/2024 Favorable HP FP	Favorable Yeas 9 Nays 0
2	**SB 542** Ingoglia (Identical H 543)	Boards of Directors of Banks; Disqualifying certain persons from serving on the board of directors of a bank under certain circumstances, etc. BI 01/09/2024 Favorable CM RC	Favorable Yeas 8 Nays 1
3	**SB 568** Hooper (Identical H 639)	Coverage for Out-of-network Ground Ambulance Emergency Services; Requiring health insurers and health maintenance organizations, respectively, to reimburse out-of-network ambulance service providers at specified rates for providing emergency services; prohibiting cost-sharing responsibilities paid for an out-of-network ambulance service provider from exceeding those of an in-network ambulance service provider for covered services; requiring health insurers and health maintenance organizations, respectively, to remit payment for covered services if such transportation was requested by a first responder or a health care professional, etc. BI 01/09/2024 Fav/CS HP RC	Fav/CS Yeas 9 Nays 0

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 362
INTRODUCER:	Senator Bradley
SUBJECT:	Medical Treatment Under the Workers' Compensation Law
DATE:	January 8, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Favorable**
2.			HP	
3.			FP	

I. Summary:

SB 362 increases the maximum medical reimbursements for physicians and surgical procedures and the maximum fees for expert witnesses under ch. 440, F.S., "Workers Compensation Law" (law). The law requires employers to provide injured employees all medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require.

The bill increases the maximum reimbursement allowances (MRA) for physicians and surgical procedures to 200 percent of Medicare. Currently, the maximum reimbursement allowance for a physician licensed under ch. 458, F.S., or ch. 459, F.S., is 110 percent of Medicare and the maximum reimbursement allowance for surgical procedures is 140 percent of Medicare.

In regards to expert medical witnesses, the law currently limits the amount health care providers can be paid for expert testimony during depositions on a workers' compensation claim to $200 per hour, unless they only provided an expert medical opinion following a medical record review or provided direct personal services unrelated to the case in dispute, then they are limited to a maximum of $200, per day. The bill increases the maximum hourly amount allowed expert witnesses to $300, per hour. For those expert witnesses subject to the daily rate, the maximum amount allowed is increased to $300, per day.

Implementation of the bill is estimated to result in a 7.3 percent increase (or $286 million) in overall workers' compensation system costs. The estimated impact on state and local governments is indeterminate.

II. Present Situation:

Florida Workers' Compensation System

Florida's Workers' Compensation Law[1] requires employers to provide injured employees all medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require.[2] The Division of Workers' Compensation within the Department of Financial Services (DFS), provides regulatory oversight of the workers' compensation system in Florida, including the health care delivery system.

Reimbursement for Health Care Providers

Health care providers must receive authorization from the insurer before providing treatment, and submit treatment reports to the insurer.[3] Insurers must reimburse an individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program at either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.[4] DFS mediates utilization and reimbursement disputes.[5]

A three-member panel (panel) consisting of the Chief Financial Officer (CFO) or his or her designee and two Governor's appointees sets the MRAs.[6] The DFS incorporates the statewide schedules of the MRAs by rule in reimbursement manuals. In establishing the MRA manuals, the panel considers the usual and customary levels of reimbursement for treatment, services, and care; the cost impact to employers for providing reimbursement that ensures that injured workers have access to necessary medical care; and the financial impact of the MRAs on healthcare providers and facilities.[7] Florida law requires the panel to develop MRA manuals that are reasonable, promote the workers' compensation system's health care cost containment and efficiency, and are sufficient to ensure that medically necessary treatment is available for injured workers.[8]

The panel develops four different reimbursement manuals to determine statewide schedules of maximum reimbursement allowances. The health care provider manual limits the maximum reimbursement for licensed physicians to 110 percent of Medicare reimbursement,[9] while reimbursement for surgical procedures is limited to 140 percent of Medicare.[10] The hospital manual sets maximum reimbursement for outpatient scheduled surgeries at 60 percent of charges,[11] while other outpatient services are limited to 75 percent of usual and customary charges.[12] Reimbursement of inpatient hospital care is limited based on a schedule of per diem

[1] Ch. 440, F.S.
[2] Section 440.13(2)(a), F.S.
[3] Section 440.13, F.S.
[4] Section 440.13(12)(a), F.S.
[5] Section 440.13, F.S.
[6] *Id.*
[7] Section 440.13(12)(i), F.S.
[8] *Id.*
[9] Section 440.13(12)(f), F.S.
[10] Section 440.13(12)(g), F.S.
[11] Section 440.13(12)(d), F.S.
[12] Section 440.13(12)(a), F.S.

rates approved by the panel.[13] The ambulatory surgical centers manual limits reimbursement to 60 percent of usual and customary as such services are generally scheduled outpatient surgeries. The prescription drug reimbursement manual limits reimbursement to the average wholesale price plus a $4.18 dispensing fee.[14] Repackaged or relabeled prescription medication dispensed by a dispensing practitioner has a maximum reimbursement of 112.5 percent of the average wholesale price plus an $8.00 dispensing fee.[15] Fees may not exceed the schedules adopted under Ch. 440, F.S., and DFS rule.[16] DFS incorporates the MRAs approved by the Three-Member Panel in reimbursement manuals[17] through the rulemaking process provided by the Administrative Procedures Act.[18]

Expert Witness Fees for Health Care Providers

Chapter 440.13, F.S., limits the amount a health care provider can be paid for expert testimony during depositions on a workers' compensation claim. As an expert medical witness, a workers' compensation health care provider is limited to a maximum $200 per hour. An expert witness who only provided an expert medical opinion following a medical record review or provided direct personal services unrelated to the case in dispute is limited to a maximum witness fee of $200 per day.[19]

III. Effect of Proposed Changes:

Section 1 amends s. 440.13, F.S. Subsection (10) is amended to increase the maximum amount a health care provider can be paid for expert testimony during a deposition on a workers' compensation claim from $200 to $300 per hour. A health care provider that only provides an expert medical opinion following a medical record review or provides direct personal services unrelated to the case in dispute, is limited to a maximum witness fee of $300 rather than $200 per day.

Subsection (12) is amended to increase the maximum reimbursement for a physician licensed under ch. 458, F.S., or ch. 459, F.S., from 110 percent to 200 percent of Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater. The maximum reimbursement for surgical procedures is increased from 140 percent to 200 percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

Section 2 provides that act takes effect July 1, 2024.

[13] *Id.*
[14] Section 440.13(12)(h), F.S.
[15] *Id.*
[16] Section 440.13(13)(b), F.S. DFS also has rulemaking authority under s. 440.591, F.S.
[17] Sections 440.13(12) and 440.13(13), F.S., and Ch. 69L-7, F.A.C.
[18] Ch. 120, F.S.
[19] S. 440.13(10), F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill increases the maximum payments to medical providers who appear as expert medical witnesses in litigated workers' compensation claims.

The bill increases payments to physicians and for surgical procedures (including all scheduled, non-emergency clinical laboratory and radiology services; and outpatient physical, occupational, and speech therapy services). Implementation of the bill would result in an estimated 7.3 percent increase (or $286 million) in overall workers' compensation system costs, as described below.

The National Council on Compensation Insurance, Inc., Analysis of SB 1344[20]

The National Council on Compensation Insurance, Inc., (NCCI) provided the following analysis of the impact of changing maximum reimbursement allowances (MRAs) in the

[20] NCCI, Analysis of Florida Medical Fee Schedule Changes (2023 Session, HB 1299/SB 1344) (Mar. 28, 2023). On file with Banking and Insurance Committee. For the 2024 Session, SB 362 was filed, which is identical to SB 1344. An updated analysis by NCCI to incorporate the 2024 changes in the Medicare fee schedules is expected to be available in late January or early February.

2016 edition of the Health Care Provider Reimbursement Manual (HCPRM). The Division of Workers' Compensation of DFS asked NCCI, the licensed rating and statistical organization for the Florida workers' compensation system, to analyze an additional four scenarios.

The current state multiplier for surgical is 140 percent and the current state multiplier for all others is 110 percent. The state-specific multipliers for HB 1299/SB1344 (scenario 3 increases both multipliers to 200 percent), as well as four additional scenarios are summarized below:

Type of Service	Proposed Multiplier by Scenario				
	1	2	3	4	5
Surgical	150 percent	175 percent	200 percent	225 percent	250 percent
All Other	150 percent	175 percent	200 percent	225 percent	250 percent

NCCI estimates that the changes to the MRAs, proposed to be effective July 1, 2023, would result in the following estimated impacts on overall Florida workers compensation system costs under each of the proposed scenarios, where Scenario 3 is the estimated impact of HB 1299/SB 1344:

Scenario	Estimated Percentage Impact	Estimated Impact on Overall Costs[21]
1	+3.1	+$122 million
2	+5.2	+$204 million
3	+7.3	+$286 million
4	+9.4	+$369 million
5	+11.5	+$451 million

In addition to physician services, the proposed changes would also impact MRAs for the following hospital outpatient services contained in the Florida Workers' Compensation Reimbursement Manual for Hospitals:

- All scheduled, non-emergency clinical laboratory and radiology services; and
- Outpatient physical, occupational, and speech therapy services.

The changes to the HCPRM also impact certain hospital outpatient services. In Florida, payments for hospital outpatient services represent 18.4 percent of medical costs, and hospital outpatient services subject to the HCPRM MRAs represent 3.3 percent of total hospital outpatient costs.

[21] Overall system costs are based on 2021 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. For each scenario, the estimated dollar impact is displayed for illustrative purposes only and calculated as the respective percentage impact multiplied by $3,921 million. These figures do not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

Expert Medical Witness Fees

Currently, the reimbursement for an expert medical witness cannot exceed $200/hour. HB 1299/SB 1344 seek to increase the maximum reimbursement amount to $300/hour, an increase of 50 percent (= $300 / $200 – 1). Comprehensive data on expert medical witness payments by employers/insurers is not readily available to NCCI. While the magnitude of the increase in workers compensation system costs resulting from the proposed change in the hourly rate for expert medical witness depositions is uncertain, NCCI anticipates that any such potential increase would be minimal. Minimal is defined in this context to be an impact on overall system costs of less than plus 0.2 percent.

C. Government Sector Impact:

See analysis above, in Private Sector Impact. Indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 440.13 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Bradley

6-00214-24 2024362__

A bill to be entitled

An act relating to medical treatment under the Workers' Compensation Law; amending s. 440.13, F.S.; increasing limits on witness fees charged by certain witnesses; increasing maximum reimbursement allowances for physicians and surgical procedures; providing an effective date.

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

Section 1. Subsection (10) and paragraphs (f) and (g) of subsection (12) of section 440.13, Florida Statutes, are amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(10) WITNESS FEES.—Any health care provider who gives a deposition shall be allowed a witness fee. The amount charged by the witness may not exceed $300 ~~$200~~ per hour. An expert witness who has never provided direct professional services to a party but has merely reviewed medical records and provided an expert opinion or has provided only direct professional services that were unrelated to the workers' compensation case may not be allowed a witness fee in excess of $300 ~~$200~~ per day.

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(f) Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be 200 ~~110~~ percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the

6-00214-24 2024362__

three-member panel as of January 1, 2003, whichever is greater.

(g) Maximum reimbursement for surgical procedures shall be 200 ~~140~~ percent of the reimbursement allowed by Medicare or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel. For prescription medication purchased under the requirements of this subsection, a dispensing practitioner shall not possess such medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days of the dispensing practitioner taking possession of that medication.

Section 2. This act shall take effect July 1, 2024.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

1/9/24
Meeting Date

B+1
Committee

362
Bill Number or Topic

Amendment Barcode (if applicable)

Name Mary Thomas

Phone 850 224 6496

Address 1430 Piedmont Dr E
Street

Email MThomas@flmedical.org

TLH FL 32308
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

Florida Medical Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Jan 9, 2024
Meeting Date

Banking & Insurance
Committee

~~SB~~ 362
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dr. Jason Oberste

Phone 850 228 3368

Address 4504 Rockbridge Hlw
Street

Email jason.oberste@fthoc.org

Tallahassee FL 32309
City State Zip

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

January 9, 2024
Meeting Date

Banking & Insurance
Committee

SB 362
Bill Number or Topic

Amendment Barcode (if applicable)

Name Chris Lyon

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Address 106 East College Ave., Suite 1500
Street

Email clyon@llw-law.com

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Osteopathic Medical Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 362
FINAL ACTION: Favorable
MEETING DATE: Tuesday, January 9, 2024
TIME: 4:30—6:00 p.m.
PLACE: 412 Knott Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
X		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
9	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 542
INTRODUCER:	Senator Ingoglia
SUBJECT:	Boards of Directors of Banks
DATE:	January 8, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Knudson	BI	**Favorable**
2.			CM	
3.			RC	

I. Summary:

Senate Bill 542 provides that a person who previously served on a board of directors of a bank conducting business in Florida that became insolvent is disqualified from serving as a board of director of another bank for 5 years after the date such bank became insolvent.

The bill is effective July 1, 2024.

II. Present Situation:

A bank fails when it must be closed, which generally happens when a bank becomes insolvent because it is unable to meet its monetary obligations.[1] The Federal Deposit Insurance Corporation (FDIC) reports that there have been 566 bank failures from 2001 through 2023,[2] five of which were in 2023.[3]

Dual Oversight of Depository Institutions

An institution must have a federal or state charter to accept deposits. Banks are chartered and regulated as national banks by the Office of the Comptroller of the Currency within the U.S. Department of the Treasury or as state banks by a state regulator.[4]

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[1] The FDIC, *When a Bank Fails – Facts for Depositors, Creditors, and Borrowers*, July 28, 2014, available at: FDIC: When a Bank Fails - Facts for Depositors, Creditors, and Borrowers (last visited Jan. 3, 2024) (hereinafter cited as "FDIC: When a Bank Fails – Facts for Depositors, Creditors, and Borrowers).

[2] The FDIC, *Bank Failures in Brief – Summary 2001 through 2023*, Nov. 3, 2023, available at: FDIC: Bank Failures in Brief (last visited Jan. 3, 2024).

[3] The five banks are: (a) Citizens Bank on November 3, 2023, (b) Heartland Tri-State Bank on July 28, 2023, (c) First Republic Bank on May 1, 2023, (d) Signature Bank on March 12, 2023, and (e) Silicon Valley Bank on March 10, 2023. The FDIC, *Failed Bank List*, Oct. 1, 2000, available at: FDIC: Failed Bank List (last visited Jan. 3, 2024).

[4] Congressional Research Service, *Introduction to Financial Services: Banking*, p. 1, Jan. 5, 2023, available at: https://crsreports.congress.gov/product/pdf/IF/IF10035 (last visited Jan. 4, 2024).

The Florida Financial Institutions Codes apply to all state-authorized or state-chartered financial banks, trust companies, credit unions and related entities.[5] The Office of Financial Regulation (OFR) licenses and regulates 200 financial entities, including 69 state-chartered banks as of January 2023.[6] There are also 26 nationally-chartered banks and 3 federally-chartered savings institutions operating in Florida as of September 2023.[7]

Due to federal preemptions, a state's regulatory powers in relation to federally chartered institutions is limited. However, the state may exercise powers within their exceptions to exclusive federal visitorial authority. Such exceptions are those recognized by federal law and courts of law or created by the U.S. Congress.[8] Banks chartered by OFR must become members of the Federal Reserve or obtain insurance from the Federal Deposit Insurance Corporation.[9] Thus, state-chartered banks are subject to a dual-regulatory system.[10]

OFR must examine the condition of each state-chartered financial institution at least every 18 months, and may conduct more frequent examinations as needed, based on risks associated with a licensee, such as prior examination results or significant operational changes.[11] When a state-chartered financial institution also has a federal regulator, OFR may accept an examination performed by the federal regulator[12] or the regulators may conduct a joint examination.[13]

Laws Relating to Directors

Once a financial institution obtains a charter, one of the regulator's primary tasks is to ensure solvency, which is achieved by conducting financial exams of its licensed entities. Financial institutions also need approval from their regulator to make changes in their upper management, merge with another company, pay dividends to shareholders, engage in material transactions with subsidiaries and affiliates, or make significant changes to their business operations.[14]

[5] Section 655.005(1)(k), F.S., states that the Financial Institutions Codes includes: Ch. 655, financial institutions generally; Ch. 657, credit unions; Ch. 658, banks and trust companies; Ch. 660, trust business; Ch. 662, family trust companies; Ch. 663, international banking; Ch. 665, relating to associations; and Ch. 667, savings banks.
[6] The OFR, *Fast Facts* (2023 ed.), available at: FastFacts.pdf (flofr.gov) (last visited Jan. 4, 2024).
[7] The FDIC, *FDIC State Tables*, Aug. 31, 2022, available at: FDIC: State Tables (last visited Jan. 4, 2024).
[8] 12 C.F.R. § 7.4000 (2011).
[9] Sections 658.22 and 658.38, F.S.
[10] The OCC, *Who Regulates My Bank?*, available at: Who Regulates My Bank? (helpwithmybank.gov) (last visited Jan. 4, 2024).
[11] Section 655.045(1), F.S.
[12] FDIC may conduct examinations or take authorized investigatory steps to determine compliance with applicable law and regulations. 12 U.S.C. § 1820.
[13] Section 655.045(1)(a), F.S.
[14] For a detailed discussion of the regulatory framework, see, Congressional Research Service, *Who Regulates Whom? An Overview of the U.S. Financial Regulatory Framework*, March 10, 2020, available at: https://crsreports.congress.gov/product/pdf/R/R44918/7 (last visited Jan. 4, 2024). Also see ss. 655.0385, 655.0386, 655.03855, and 655.412, F.S.

Disapproval of Directors

Federal law

An insurance depository institution[15] or a depository institution holding company[16] must notify the appropriate Federal banking agency[17] of the proposed addition of a board of director at least 30 days (or such other time as prescribed by the Federal banking agency) before such addition if:[18]

- The entity is noncompliant with minimum capital requirements or is otherwise in a troubled condition;[19] or
- The agency determines, within its specified authority, that prior notice is appropriate.

The appropriate Federal banking agency must issue a notice of disapproval if the competence, experience, character, or integrity of the individual indicates that it would not be in the best interests of the depositors of the depository institution or the public to permit the individual to be a director or be employed as a senior executive officer of the institution.[20] If the appropriate Federal banking agency issues a notice of disapproval before the end of a specified notice period, the entity may not add the individual to the board of directors.[21]

Florida law

Similar to Federal law, Florida law also authorizes the OFR to disapprove the proposed appointment of any individual to the board of directors if the state financial institution meets specified criteria, including, but not limited to, when the institution is non-compliant with minimum capital requirements or is otherwise operating in an unsafe and unsound condition.[22]

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[15] "Insured depository institution" is defined as any bank or savings association the deposits of which are insured by the FDIC pursuant to ch. 16. 12 U.S.C. § 1831(c)(2). Under Florida law, a state bank must obtain and thereafter maintain insurance of its deposits by the FDIC. Section 658.38, F.S.

[16] "Depository institution holding company" is defined as a bank holding company or a savings and loan holding company. 12 U.S.C. § 1831(w). "Bank holding company" means any company which has control over any bank or over any company that is or becomes a bank holding company by virtue of ch. 17. 12 U.S.C. § 1841. "Savings and loan holding company" is defined as any company that directly or indirectly controls a savings association or that controls any other company that is a savings and loan holding company except as specified in 12 U.S.C. § 1467a(a)(1)(D)(ii). 12 U.S.C. § 1467a(a)(1)(D)(i).

[17] "Appropriate Federal banking agency" is defined as: (1) the Office of the Comptroller of the Currency in the case of: (A) any national banking association; (B) any Federal branch or agency of a foreign bank; and (C) any Federal savings association; (2) the Federal Deposit Insurance Corporation, in the case of: (A) any State nonmember insured bank; (B) any foreign bank having an insured branch; and (C) any State savings association; (3) the Board of Governors of the Federal Reserve System, in the case of: (A) any State bank; (B) certain branch or agencies of a foreign bank; (C) any foreign bank which does not operate an insured branch; (D) any agency or commercial lending company other than a Federal agency; (E) supervisory or regulatory proceedings arising from the authority given to the Board of Governors under certain provisions; (F) any bank holding company and any non-depository subsidiaries of a bank holding company; and (G) any savings and loan holding company and any non-depository subsidiaries of a savings and loan holding company. 12 U.S.C. § 1813(q).

[18] 12 U.S.C. § 1831i(a).

[19] "Troubled condition" must be defined by each appropriate Federal banking agency. 12 U.S.C. § 1831i(f).

[20] 12 U.S.C. § 1831i(e).

[21] 12 U.S.C. § 1831i(b).

[22] "Unsafe and unsound practice" is defined as: 1. any practice or conduct found by the office to be contrary to generally accepted standards applicable to a financial institution, or a violation of any prior agreement in writing or order of a state or federal regulatory agency, which practice, conduct, or violation creates the likelihood of loss, insolvency, or dissipation of assets or otherwise prejudices the interest of the financial institution or its depositors or members. Section 655.005(y), F.S.

Removal and Prohibition Orders of Directors

Federal law

Pursuant to 12 U.S.C. 1818(e), an appropriate Federal banking agency may serve upon a director (other than a bank holding company or savings and loan holding company)[23] a written notice of the agency's intention to remove such director from office or to prohibit any further participation in the conduct of the affairs of any insured depository institution if certain criteria are met.[24] Specifically, the appropriate Federal banking agency may take such action if it has determined that a director has:[25]

- Violated any law or regulation, any final cease-and-desist order, or certain conditions imposed in writing by, or any written agreement entered into with, certain Federal banking agencies;
- Engaged in any unsafe or unsound practice, or any act, omission, or practice which constitutions a breach of the director's fiduciary duty;
- By reason of the violation, practice, or breach:
    - Such insured depository institution or business institution has suffered or will probably suffer financial loss or other damage;
    - The interests of the insured depository institution's depositors have been or could be prejudiced; or
    - The director has received financial gain or other benefit by reason of such violation, practice, or breach; and
- Such violation, practice, or breach involves personal dishonesty by the director, or demonstrates willful or continuing disregard by the director for the safety or soundness of such insured depository institution or business.

The appropriate Federal banking agency may suspend the director from office or prohibit the director from further participation in the affairs of the depository institution if the agency finds that: (a) the director violated these provisions, and (b) that such action is necessary for the protection of the institution or the interests of the institution's depositors.[26]

Any director who is suspended from office or prohibited from participating in the affairs of the institution pursuant to this provision or pursuant to certain criminal offenses[27] may not, while such order is in effect, continue or commence to hold any office in, or participate in any manner in the conduct of the affairs of, any insured depository institution and other specified entities.[28]

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[23] Federal law applies to "any institution-affiliated party" which is a broader category of persons than only directors and is defined as: (1) any director, officer, employee, or controlling stockholder (other than a bank holding company or savings and loan holding company) of, or agent for, an insured depository institution; (2) any other person who has filed or is required to file a change-in-control notice with the appropriate Federal banking agency under s. 1817(j) of this title; (3) any shareholder (other than a bank holding company or savings and loan holding company), consultant, joint venture partner, and any other person as determined by the appropriate Federal banking agency (by regulation or case-by-case) who participates in the conduct of the affairs of an insured depository institution; and (4) certain independent contractors. 12 U.S.C. § 1813(u).

[24] 12 U.S.C. § 1818(e). The appropriate Federal banking agency may also remove a director for specific violations of federal law, such as intentionally violating provisions relating to records and reports on mandatory instruments transactions. 12 U.S.C. § 1818(e)(2).

[25] 12 U.S.C. § 1818(e)(1).

[26] 12 U.S.C. § 1818(e)(3)(i). The agency is also required to serve the director with written notice of the suspension order as condition of its issuance. 12 U.S.C. § 1818(e)(3)(ii).

[27] 12 U.S.C. § 1818(g).

[28] 12 U.S.C. § 1818(e)(7)(A).

A specified federal agency may consent to limit or cease enforcement of any order against a director.[29]

Pursuant to these provisions, the FDIC pursued enforcement actions against directors of First NBC Bank which was bank in New Orleans that failed in April 2017.[30] In April 2023, the FDIC issued orders of prohibition from further participation in specified activities, including serving or acting as a director unless or until the order is modified, terminated, suspended, or set aside by the FDIC and specified agencies.[31]

Florida law

Similar to Federal laws, Section 655.037, F.S., authorizes the OFR to issue and serve a complaint to remove a director[32] of a financial institution if the OFR has reason to believe that such party is engaging or has engaged in any specified conduct, including, but not limited to, an unsafe or unsound practice,[33] a prohibited act or practice, or a willful violation of any law relating to financial institutions.[34] The complaint must contain a statement of facts and notice of opportunity to be heard.[35] The OFR may enter an order removing the director or restricting or prohibiting participation by the director in the affairs of that particular or any other state financial institution, subsidiary, or service if: (a) the director does not request a hearing within the prescribed time, or (b) a hearing is held and the OFR makes findings that:[36]

- Any of the charges in the complaint are true;
- One of the following is met:
    - The state financial institution has suffered or will likely suffer loss or other damage;
    - The interests of the depositors, members, or shareholders could be seriously prejudiced; or
    - The director has received financial gain by reason of such violation, practice, or breach; and

[29] 12 U.S.C. § 1818(e)(7)(B).
[30] RegReport, *Directors from Failed NOLA Bank Prohibited from Further Service or Fined – or Both*, May 26, 2023, available at: Directors from failed NOLA bank prohibited from further service or fined – or both – Regulatory Report (regreport.info) (last visited Jan. 4, 2024).
[31] The FDIC, *ED&O Search Form*, available at: FDIC: Enforcement Decisions and Orders - Search Form (last visited Jan. 4, 2024).
[32] Florida law applies to any "financial institution-affiliated party" which is a broader category of persons than only directors and is defined as: 1. a director, officer, employee, or controlling stockholder, other than a financial institution holding company, of, or agent for, a financial institution, subsidiary, or service corporation; 2. Any other person who has filed or is required to file a change-of-control notice with the appropriate state or federal regulatory agency; 3. A stockholder, other than a financial institution holding company, a joint venture partner, or any other person as determined by the office who participates in the affairs of a financial institution, subsidiary, or service corporation; or 4. certain independent contractors. Section 655.005(j), F.S.
[33] "Unsafe or unsound practice" is defined as: 1. any practice or conduct found by the office to be contrary to generally accepted standards applicable to a financial institution, or a violation of any prior agreement in writing or order of a state or federal regulatory agency, which practice, conduct, or violation creates the likelihood of loss, insolvency, or dissipation of assets or otherwise prejudices the interest of the financial institution or its depositors or members. Section 655.005(y), F.S.
[34] Section 655.037(1), F.S.
[35] Section 655.037(2), F.S. The OFR's jurisdiction and authority to issue any notice and proceed with a complaint is not affected by resignation, termination of employment or participation, or separation from a state financial institution by the director if such notice is served before the end of the 6-year period beginning on the date such person ceases to be such a director with respect to the state financial institution. Section 655.037(8), F.S.
[36] Section 655.037(3), F.S.

- Such violation, practice, or breach of fiduciary duty is one involving personal dishonesty by the director, or a continued disregard for the safety or soundness of the state financial institution.

Under Florida law, any director removed from office pursuant to s. 655.037, F.S., is not eligible for reelection to such position or to any official position in any financial institution in Florida except with the written consent of the OFR.[37]

III. Effect of Proposed Changes:

Section 1 of the bill creates s. 655.038, F.S., which disqualifies a person who has previously served on a board of directors of a bank conducting business in Florida that became insolvent from serving as a board of director of another bank for 5 years after the date such bank became insolvent. The bill ensures such directors are disqualified as a matter of law. Currently, OFR may exercise discretion to prohibit or remove a director from serving in a state-chartered bank, but the agency must prove that the director has engaged in unsafe or unsound practices, violated specified laws or OFR rules, or committed a breach of trust or breach of fiduciary duty.

Section 2 of the bill provides for an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[37] Section 655.037(7), F.S.

B. Private Sector Impact:

State-chartered banks and their customers may benefit from not having directors that held the same position in a bank doing business in Florida that went insolvent within the previous 5 years.

A state-chartered bank may incur replacement costs to the extent that any current directors are disqualified under the provisions of the bill. Directors who, but for the provisions of SB 542, would serve as a director of a state-chartered bank may have lost compensation.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 658.33 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Ingoglia

11-00212B-24 2024542__

A bill to be entitled

An act relating to boards of directors of banks; amending s. 658.33, F.S.; disqualifying certain persons from serving on the board of directors of a bank under certain circumstances; providing an effective date.

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

Section 1. Present subsections (2) through (5) of section 658.33, Florida Statutes, are redesignated as subsections (3) through (6), respectively, and a new subsection (2) is added to that section, to read:

658.33 Directors, number, qualifications; officers.—

(2) If a person has previously served on a board of directors of a bank doing business in this state which became insolvent, such person is disqualified from serving on the board of directors of another bank for 5 years after the date such bank became insolvent.

Section 2. This act shall take effect July 1, 2024.

THE FLORIDA SENATE

Tallahassee, Florida. 32399-1100

COMMITTEES:
Finance and Tax, *Chair*
Appropriations
Banking and Insurance
Criminal Justice
Ethics and Elections

SELECT COMMITTEE:
Select Committee on Resiliency

JOINT COMMITTEE:
Joint Administrative Procedures Committee, *Alternating Chair*

Senator Blaise Ingoglia
11th District

December 7, 2023

The Honorable Jim Boyd, Chair
Banking and Insurance Committee
415 Senate Office Building
402 South Monroe Street
Tallahassee, FL 32399

Re: SB 542 Boards of Directors of Banks

Chair Boyd,

SB 542 has been referred to the Banking and Insurance Committee as its first committee of reference. I respectfully request that it be placed on the agenda at your earliest convenience.

If I may answer questions or be of assistance, please do not hesitate to contact me. Thank you for your leadership and consideration.

Regards,

Blaise Ingoglia
State Senator, District 11

Cc: James Knudson, Staff Director, Lisa Johnson, Deputy Staff Director, Amaura Canty, Committee Administrative Assistant

1/9/24
Meeting Date

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

542
Bill Number or Topic

Banking + Insurance
Committee

Amendment Barcode (if applicable)

Name Anthony DiMarco

Phone (850) 224-2265

Address 100 E Tennessee Rd
Street

Email adimarco@floridabankers.com

Tallahassee FL 32303
City State Zip

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
FL Bankers Assoc.

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 542
FINAL ACTION: Favorable
MEETING DATE: Tuesday, January 9, 2024
TIME: 4:30—6:00 p.m.
PLACE: 412 Knott Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
X		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
	X	Powell						
X		Thompson						
		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
8	1	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 568
INTRODUCER:	Senator Hooper
SUBJECT:	Coverage for Out-of-network Ground Ambulance Emergency Services
DATE:	January 10, 2024 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			HP	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 568 requires all health insurers and health maintenance organizations (HMOs) to reimburse nonparticipating or out-of-network ground ambulance service providers for emergency ambulance services at the lowest of the following rates:

- The rate set or approved by a local government entity in the jurisdiction in which the covered services originated;
- Three hundred and twenty five percent of the current rates for ambulance services established by Medicare for the same service provided in the same geographic area; or
- The provider's billed charges.

Payment made pursuant to this fee schedule is deemed to be payment in full for the emergency ground ambulance services provides except for any cost sharing required to be paid by the insured or subscriber. Accordingly, an insured or subscriber may not be balanced billed for the difference between the payment prescribed in the bill and the amount billed by the ground ambulance service provider.

Possible fiscal impacts from this bill are addressed in Section V of this analysis.

II. Present Situation:

Ground emergency medical transportation is a life-saving service that may affect anyone, including the uninsured, privately insured, and those covered by governmental health care programs. In 2020, 37 percent[1] of emergency ground ambulance rides were provided through local fire departments[2], 25 percent through other government agencies, 30 percent through private companies, and 8 percent through hospitals.[3]

Federal laws and current Florida laws do not provide balance billing protections for insured consumers that use a non-participating or out-of-network ground ambulance service. Balance billing occurs when a provider bills a patient for the difference between the amounts the provider charges and the amount that the patient's insurance company pays. This does not include cost-sharing requirements such as copayments that are typically paid by a patient. As a result, a consumer may incur an average balance billing or out of pocket cost of $450.[4] In some states, the average is more than $1,000.[5]

Federal and State Laws Relating to Emergency Medical Treatment

Emergency Medical Treatment and Active Labor Act (EMTALA)

In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay. The EMTALA imposes specific obligations on hospitals participating in the Medicare program, which offer emergency services. Any patient who comes to the emergency department must be provided with a medical screening examination to determine if the patient has an emergency medical condition. If an emergency medical condition exists, the hospital must provide treatment within its service capability to stabilize the patient. If a hospital is unable to stabilize a patient or, if the patient requests, the hospital must transfer the patient to another appropriate facility.[6] A hospital that violates EMTALA is subject to civil monetary penalty[7] or civil suit by a patient who suffers personal harm.[8]

Florida law imposes a similar duty.[9] The law requires the Agency for Health Care Administration (agency) to maintain an inventory of the service capability of all licensed

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[1] Ground ambulance rides and potential for surprise billing - Peterson-KFF Health System Tracker (June 24, 2021) (last visited Jan. 4, 2024).
[2] What are the differences between public and private ambulance services? (ems1.com) (Oct. 23, 2017) (last visited Jan. 3, 2024).
[3] Protecting Consumers from Surprise Ambulance Bills | Commonwealth Fund (Nov. 15, 2021) (last visited Jan. 6, 2024).
[4] https://www.medicalbillersandcoders.com/blog/role-of-states-in-exclusion-of-ground-ambulances-from-nsa/ (last visited Jan. 5, 2024).
[5] EMERGENCY: The high cost of ambulance surprise bills (pirg.org) (Oct. 26, 2023) (last visited Jan. 6, 2024).
[6] Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. §1395dd; *see also* CENTERS FOR MEDICARE & MEDICAID SERVICES, *Emergency Medical Treatment & Labor Act (EMTALA),* http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/ (last visited Jan. 4, 2024).
[7] 42 U.S.C. s. 1395dd(d)(1).
[8] 42 U.S.C. s. 1395dd(d)(2).
[9] *See* s. 395.1041, F.S. A hospital that violates Florida's access to care statute is subject to administrative penalties; denial, revocation, or suspension of its license; or civil action by another hospital or physician suffering financial loss. In addition, hospital administrative or medical staff are subject to civil suit by a patient who suffers personal harm and may be found

hospitals that provide emergency care in order to assist emergency medical services (EMS or ambulance) providers and the public in locating appropriate medical care. Hospitals must provide all listed services when requested, whether by a patient, an emergency medical services provider, or another hospital, regardless of the patient's ability to pay. If the hospital is at capacity or does not provide the requested emergency service, the hospital may transfer the patient to the nearest facility with appropriate available services. Each hospital must ensure the services listed can be provided at all times either directly or through another hospital. A hospital is prohibited from basing emergency treatment and care on a patient's insurance status, economic status, or ability to pay.

Federal Patient Protection and Affordable Care Act (PPACA)[10]

The PPACA imposes many insurance requirements, such as mandated benefits, rating and underwriting standards, review of rate increases, reporting of medical loss ratios and payment of rebates, coverage of adult dependents, internal and external appeals of adverse benefit determinations, and other requirements. The PPACA also requires that major medical coverage provide ten essential health benefits in the individual and small group markets, which includes emergency services.[11]

The Federal No Surprise Act[12]

The No Surprises Act[13] protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from non-participating providers at in-network facilities, and services from non-participating air ambulance service providers. It does not regulate the payment of nonparticipating ground ambulance services or prohibit balance billing by such providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

The No Surprises Act requires the establishment of an Advisory Committee on Air Ambulance Quality and Patient Safety Advisory Committee. The committee's final report is expected to be issued in early 2024,[14] and the recommendations must address, at a minimum:

- Options, best practices, and identified standards to prevent instances of balance billing;
- Steps that can be taken by state legislatures, state insurance regulators, state attorneys general, and other state officials as appropriate, consistent with current legal authorities regarding consumer protection; and

guilty of a second-degree misdemeanor for a knowing or intentional violation. Physicians who violate the statute are also subject to disciplinary action against their license or civil action by another hospital or physician suffering financial loss.

[10] P.L. 111-148. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.

[11] 42 U.S.C. 300gg-6.

[12] No Surprises: Understand your rights against surprise medical bills | CMS (last visited Jan. 6, 2024).

[13] Pub. L. No. 116-260, 134 Stat. 1182, Division BB, s. 109.

[14] Ground Ambulance and Patient Billing- Third Meeting Summary Final (cms.gov) (last visited Jan. 6, 2024).

- Legislative options for Congress to prevent balance billing.[15]

In late 2023, the committee presented the following key findings:[16]

- Congress should work with stakeholders once the data from the Ground Ambulance Data Collection System and Medicare Payment Advisory Commission reports are available to modernize the Medicare ground ambulance benefit.
- Congress should establish a standing advisory committee to evaluate expanding coverage and reimbursement of ground ambulance services beyond transports under the Social Security Act to include community paramedicine, advanced life support and first response, high-cost drugs and medical equipment, and oxygen and other ancillary supplies.
- Congress and the Secretary of Health and Human Services should evaluate and limit the Medicare beneficiary out-of-pocket obligations for ground ambulance emergency and nonemergency.
- Congress and the Secretary of Health and Human Services should consider evaluating the cost and reimbursement of services under the Social Security Act for those ground ambulance service providers and suppliers in rural, super-rural, and medically-underserved areas.[17]

State Regulation of Emergency Medical Transportation

Part III of ch. 401, F.S., governs the provision of emergency medical transportation services in Florida and establishes the licensure and operational requirements for emergency medical services, including air ambulances[18] and ground ambulances.[19]

State Regulation of Insurance

In Florida, the Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities.[20] To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.[21] The agency regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority[22] from the OIR, an HMO must receive a Health Care Provider Certificate from the agency. As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[23]

Balance Billing

[15] See s. 117 of the No Surprises Act.
[16] *Supra* at 14.
[17] Federal Ground Ambulance and Patient Billing Advisory Committee, Key Findings. On file with the Senate Committee on Banking and Insurance staff.
[18] Sections 401.23 and 401.251, F.S. An air ambulance service refers to a licensed publicly or privately owned service that operates air ambulances to transport persons requiring or likely to require medical attention during transport. An air ambulance is intended to be used for, the air transportation of sick or injured persons that require or are likely to require medical attention during transport.
[19] Section 401.25, F.S.
[20] Section 20.121(3)(a)1., F.S.
[21] Section 641.21(1), F.S.
[22] Sections 624.401 and 641.49, F.S.
[23] Section 641.495, F.S.

A provider, regardless of whether it is under contract with an HMO, may not collect or attempt to collect money from a subscriber.[24] The subscriber is not liable for payment of fees to the provider.[25] Balance billing is also prohibited in cases when emergency services are provided by a nonparticipating provider, and when nonemergency services are provided by a nonparticipating provider and the insured or subscriber does not have the ability and opportunity to choose a participating provider at the facility who is available to treat that patient.[26] However, this provision does not prohibit balance billing of services related to ground ambulance providers.

Insurance Coverage for Air Ambulance Services

In 2020, the Florida Legislature enacted legislation to address coverage for air ambulance services.[27] The law requires a health insurer[28] or HMO[29] to provide reasonable reimbursement to an air ambulance service for emergency and nonemergency transport services provided to a covered individual in accordance with the terms of the insurance policy or HMO contract. The bill defines "reasonable reimbursement" as payment that considers the direct cost of services provided, costs incurred by the operation of an air ambulance service by a county which operates entirely within a designated area of critical state concern[30] as determined by the Department of Economic Opportunity, and in-network reimbursement for comparable services.

In cases where an air ambulance provider and an insurer have not contractually agreed to reimbursement rates, the air ambulance provider would be required to accept "reasonable reimbursement" from the insurer. The term, "reasonable reimbursement" does not include the amount of billed charges for the costs of services rendered.[31] The bill specifies that payment in full of applicable copayments, coinsurance, and deductibles by an insured patient who receives air ambulance services shall constitute the full financial obligation of the patient for those services. Accordingly, an air ambulance service provider may not balance bill insureds or subscribers.

Prompt Payment of Health Insurance Claims

The Insurance Code prescribes rights and responsibilities of health care providers, health insurers, and health maintenance organization for the payment of claims. Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, in accordance with ss. 627.6131 and 641.3155, F.S., respectively.[32] The law prescribes a protocol for specified providers to use for the submission of their claims to an insurer or HMO, as well as a statutory process for insurers or HMOs use for the payment or denial of the claims.

[24] Sections 641.315(1) and 641.3154(1) and (4), F.S.
[25] *Id.*
[26] Section 627.64194, F.S.
[27] Ch. 2020-177, Laws of Fla.
[28] Section 627.42397, F.S. Ch. 2016-222, Laws of Fla.
[29] Section 641.514, F.S.
[30] The Areas of Critical State Concern Program was created by the Florida Environmental Land and Water Management Act of 1972. The program is intended to protect resources and public facilities of major statewide significance, within designated geographic areas, from uncontrolled development that would cause substantial deterioration of such resources.
[31] Section 627.42397(1)(c), F.S.
[32] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S., including preferred provider policies and an exclusive provider organizations, and specified contracts.

Division of State Group Insurance

Under the authority of s. 110.123, F.S., the Department of Management Services, through the Division of State Group Insurance, administers the state group health insurance program under a cafeteria plan consistent with s. 125, Internal Revenue Code. To administer the state group health insurance program, DMS contracts with third party administrators for self-insured health plans and insured (HMOs), as well as a pharmacy benefits manager for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.

Florida's Medicaid Coverage of Emergency Transportation Services[33]

The Agency for Health Care Administration (agency) administers Florida's Medicaid Program, which is a partnership of the federal and state governments, and provides coverage for health services for eligible persons. [34] Medicaid reimburses for medically necessary emergency ground or air ambulance transportation. This service is one of the minimum covered services for all Managed Medical Assistance, Long-Term Care, and Comprehensive Long-Term Care plans serving Medicaid enrollees. All Medicaid eligible recipients may receive emergency transportation services, when the recipient's condition meets emergency criteria. Under current law, balance billing is prohibited for services provided by Medicaid.[35]

The agency adopts transportation services fee schedules, which provide a breakout for ground ambulance emergency codes, non-emergency codes, and air ambulance codes.[36] Within the schedule for ground ambulances, services are offered for basic life support, advanced life support, negotiated transportation services, advanced life support, level 2, and specialty care transport.[37] Each of these services has a standard fee except for the negotiated transportation service.

Insurance Consumer Advocate Report on Emergency Medical Transportation (EMT) Costs in Florida[38]

In a 2018 report, the Insurance Consumer Advocate[39] found that emergency medical transportation services preserve life and improve health and safety, but they must also be accessible and affordable to those with private insurance. The Insurance Consumer Advocate created an EMT working group, and issued the following recommendations relating to ground

[33] Emergency Transportation Services (myflorida.com) (last visited Jan. 3, 2024).
[34] Section 409.963, F.S.
[35] Section 409.907(3)(j), F.S.; Medicaid managed care plans and their providers are required to comply with the Provider General Handbook, which expressly prohibits balance billing. In addition, the Statewide Medicaid Managed Care Contract (CORE contract) establishes minimum requirements for contracts between plans and providers. The CORE contract requires those contracts to prohibit balance billing, except for any applicable cost sharing.
[36] 2023 Transportation Services Fee Schedule.pdf (myflorida.com) (last visited Jan. 5, 2024).
[37] *Id.*
[38] Department of Financial Services, Insurance Consumer Advocate, Emergency Medical Transportation Costs in Florida. (June 2018). The report also contained recommendations relating to air ambulance transport. On file with Senate Banking and Insurance Committee staff.
[39] Section 20.121(2)(n), F.S. The Office of Insurance Consumer Advocate is created within the Department of Financial Services.

ambulance to protect Florida's insurance consumers from surprise emergency medical transportation costs:

- Reform ground EMT billing models. The current billing model used for ground EMT should be reformed by shifting to a value-based model for ground EMT. This would allow ground ambulance companies to charge for medical services and treatments without the requirement of transporting the patient to a medical facility. This would be a significant change from the fee-for-service model which requires that the patient be transported in order for the provider to be reimbursed for the emergency medical care. The fee-for-service model prevents EMT services from billing an insurance company for the critical care without having transported the patient. Transforming the billing model would allow ground EMT services to recoup emergency medical costs from insurance companies and mitigate the need to balance bill consumers.
- Increase access to in-network EMT providers. Consumers should have increased access to in-network EMT providers in order to decrease the likelihood of surprise medical bills. Providers and insurance companies must work together to improve value, efficiency, and use of health care services to reduce costs. Collaborative contracting efforts between EMT providers and insurance companies are integral in reducing the likelihood that consumers are left paying out-of-network prices for life-saving transportation to a medical facility. Regulators should also include and monitor emergency medical transportation in its network adequacy standards.

Medicare Ambulance Fee Schedules (AFS)[40]

The Medicare Part B is a national fee schedule for ambulance services. The fee schedule applies to all ambulance services provided by:

- Volunteer, municipal, private, and independent ambulance suppliers
- Institutional providers, including hospitals and skilled nursing facilities
- Critical access hospitals, except when they're the only ambulance service within 35 miles

Ambulance providers and suppliers must:

- Accept Medicare allowed charges as payment in full.[41] Medicare payment for ambulance services is based on the lesser of the actual charge or the applicable fee schedule amount. The fee schedule payment for ambulance services equals a base rate for the level of service plus payment for mileage and applicable adjustment factors. Except for services furnished by certain critical access hospitals or entities owned and operated by them, as described in s. 413.70(b) of this chapter, all ambulance services are paid under the fee schedule specified in this subpart (regardless of the vehicle furnishing the service).
- Bill beneficiaries for Part B coinsurance and deductible only.[42]

[40] Ambulance Fee Schedule & ZIP Code Files | CMS (last visited Jan. 6, 2024).
[41] eCFR :: 42 CFR 414.610 -- Basis of payment. (last visited Jan. 6, 2024).
[42] Medicare Part B (Medical Insurance) covers certain doctors' services, outpatient care, medical supplies, and preventive services; and covers ground ambulance transportation when traveling in any other vehicle could endanger the patient's health, and the patient needs medically necessary services from a hospital, critical access hospital, rural emergency hospital, or skilled nursing facility. Medicare may pay for emergency ambulance transportation in an airplane or helicopter if a patient needs immediate and rapid transport that ground transportation can't provide. In some cases, Medicare may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that the transportation is medically necessary. *See* Ambulance services coverage (medicare.gov) (last visited Jan. 5, 2024).

Medicare Ground Ambulance Data Collection System

Effective January 1, 2020-2024, the Centers for Medicare & Medicare Services (CMS) requires selected ground ambulance organizations to collect and report cost, revenue, utilization, and other information through the Medicare Ground Ambulance Data Collection System (GADCS).[43] The collected information will be analyzed by the Medicare Payment Advisory Commission (MedPAC) in order to submit a report to Congress on the adequacy of payments for ground ambulance services and geographic variations in the cost of furnishing such services, utilization, revenue, and other service characteristics.[44]

Limited Survey of State Legislation Relating to the Reimbursement of Ground Ambulance Services

Washington

The Insurance Commissioner of Washington State released a report[45] on ground ambulance billing in 2023. An analysis of the state's all payer claims database showed substantial disparity between billed charges and allowed amounts of public versus private ground ambulance providers. The report noted that this is likely because public providers base their billed charges on locally set rates and have access to public funding to support their services. The allowed amounts as a percentage of Medicare for basic life support transports (A0429), the most commonly billed code, ranged from 172 to 327 percent of Medicare. For the second most common code for advanced life support emergency transport level 1 (A0427), the range was 186 to 340 percent of Medicare. It was recommended that the fixed percentage of Medicare fall between the ranges of these codes and be set in statute. The report made the following recommendations:

- Prohibit balance billing of consumers for emergency and non-emergency transports by public and private providers.
- Reimburse ground ambulance services at a local jurisdiction's fixed rate or, if no local rate exists, at the lessor of a fixed percentage of Medicare or billed charges for emergency transports by public or private providers.
- Mandate coverage for emergency transportation by public or private providers to alternative sites, such as behavioral health emergency services providers and other crisis providers.

Colorado[46]

Health plans are required to reimburse nonparticipating ground ambulances at 325 percent of Medicare rates or at negotiated independent reimbursement rate.[47] Taxpayer-funded ambulance

[43] Medicare Ground Ambulance Data Collection System (GADCS) Frequently Asked Questions (FAQ) (cms.gov) (last visited Jan. 4, 2023).
[44] Medicare Ground Ambulance Data Collection System | CMS (last visited Jan. 4, 2024).
[45] Office of the Insurance Commissioner, Washington State, Ground ambulance balance billing study, Executive summary (Oct. 1, 2023) https://www.insurance.wa.gov/sites/default/files/documents/ground_ambulance_balance_billing_report_final.pdf (last visited Jan. 7, 2024).
[46] Colorado House Bill 22-1284. Enacted in 2019.
[47] Protecting Consumers from Surprise Ambulance Bills | Commonwealth Fund (Nov. 15, 2021) and Filling a Gap in the No Surprises Act: What are States Doing to Protect Consumers from Out-of-Network Ground Ambulance Bills? | CHIRblog (Nov. 15, 2021).

providers are exempted. Private ambulance providers may also be exempt if they have a contract with a city. In those cases, the terms of the contract take precedence over state law.

Louisiana

Effective August 1, 2023, SB 109[48] provides that the minimum allowable reimbursement under any health care plan issued by an insurer to a nonparticipating ground ambulance provider for providing emergency services must be one of the following:

1) At the rates set or approved, whether in contract or ordinance, by a local governmental entity in the jurisdiction in which the covered health care services originate, or as provided for in R.S. 33:4791.
2) In the absence of rates described in (1), the minimum allowable rate of reimbursement under any health benefit plan issued by any healthcare insurer must be 325 percent of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same service provided in the same geographic area; or the ambulance provider's billed charges, whichever is less. The law is similar to SB 568, regarding the claims payment process. Balance billing of the insured or subscriber by the provider is prohibited.

Texas

In response to a statutory mandate, the Texas Department of Insurance conducted a study[49] on ground ambulance billing practices and released a report that focused on the following issues:

- Balanced billing practices. In 2020, about 45 percent of the ground ambulance providers responded that they would balance bill patients who were covered by a commercial plan for the amount the insurer did not pay. About 25 percent of the providers responded that they would send unpaid bills to a collection agency.
- Price variations. The 2020 statewide average charge or billing for basic life support was about $1,004 and $1,232 for advanced life support.
- In-network with a health plan or out-of-network ratios. In 2020, at a statewide level, 23 percent of the providers/respondents had at least one in-network commercial health plan contract. More than half of the private providers contracted with at least one commercial plan, compared to only 14 percent of those that were not private.
- Health plan network inclusion trends. In 2020, seven percent of the providers noted that they had more network contracts with commercial plans than five years. However, 32 percent of the providers noted that they had no change in the number of contracts. In 2020, 86 percent of the billed amounts by ground ambulances were out-of-network.
- Factors contributing to health plan network status. About 59 percent of the providers noted that they were most likely to join a network if the plan offered favorable reimbursement rates. It was noted that 68 percent of the respondents were least likely to join a network due to unfavorable reimbursement rates.

Effective September 1, 2023, Texas law prohibits ground ambulance emergency medical services providers from engaging in balance billing. The law authorizes a political subdivision to

[48] 2023 Regular Session SB 109, Act No. 453. ViewDocument.aspx (la.gov) (last visited Jan. 5, 2024).
[49] Texas Department of Insurance, Ground Ambulance Billing Practices Report (Sep. 2022) https://www.tdi.texas.gov/health/ambsurvey.html (Sep. 2022) (last visited Jan. 6, 2024).

submit a rate set regulated by the political subdivision that a health benefit plan administrator must pay for covered transportation services provided by a nonparticipating, ground emergency medical services providers. If the political subdivision has not submitted a rate, the health benefit plan administrator must pay the lesser of the provider's billed charge or 325 percent of the current Medicare rate. The law applies to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2024. The section of the law establishing the rate which a health benefit plan administrator must pay for nonparticipating emergency medical services sunsets or expires on September 1, 2025.

According to the Teacher Retirement System (TRS), implementing the provisions of the bill would result in additional costs to the TRS-Care and TRS-ActiveCare health plans by requiring the benefit plans to cover out-of-network emergency medical services at either the rate set, controlled by the political subdivision, or the lesser of 1) the provider's billed charge or 2) 325.0 percent of the current Medicare rate.[50]

The fiscal impact to the TRS-Care program are estimated to be $5.1 million for the biennium and the TRS-ActiveCare program are estimated to be $3.0 million for the biennium. These costs are based on the difference between the total number of emergency medical services providers billed for out-of-network providers in plan year 2022 and 325.0 percent of the current Medicare rate. The difference between the total number of emergency medical services providers billed for out-of-network providers in plan year 2022 and the usual and customary rate is $3.3 million for the biennium for TRS-Care and $1.3 million for the biennium for TRS-ActiveCare. Additional costs would not increase the statutorily required state contributions to the TRS-Care and TRS-ActiveCare programs for the 2024-25 biennium; therefore, no significant fiscal impact to the General Revenue Fund is anticipated. However, the additional costs may result in the need for additional contributions from the state, employers, or members to the TRS-Care and TRS-ActiveCare programs, or for plan benefit changes.

III. Effect of Proposed Changes:

Sections 1, and 3 create sections 627.42398 and 641.31078, F.S., respectively, and require health insurance policies and HMO contracts providing major medical coverage to provide coverage for nonparticipating or out-of-network ground ambulance emergency services and prohibit balance billing by ground ambulance service providers. Insurers and HMOs are required to reimburse an out-of-network ground ambulance service provider for providing covered services at a rate that is the lowest of the following:

- The rate set or approved, whether in contract, in ordinance, or otherwise, by a local governmental entity in the jurisdiction in which the covered services originated.
- Three hundred and twenty five percent of the current published Medicare rate for ambulance services for the same service provided in the same geographic area; or
- The ambulance service provider’s billed charges; whichever is less.

[50] SB02476E.pdf (texas.gov) Legislative Budget Board, Fiscal Note, 88th Legislative Regular Session (May 8, 2023) (last visited Jan. 5, 2024).

The bill requires that cost-sharing responsibilities of the insured for covered out-of-network ambulance services may not exceed the in-network cost-sharing rate.

Section 2 amends s. 627.6699, F.S., to apply the reimbursement provisions of Section 1 to policies issued by small employer carriers pursuant to the Employee Health Care Access Act. **Section 4** provides the bill takes effect January 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

By prohibiting the use of balance billing, the bill will reduce the number of insureds or subscribers who receive unexpected bills resulting from ground ambulance transport.

It is expected that in most situations addressed by the bill, out-of-network and nonparticipating ambulance providers will receive more money for their services.

The amount of the statutory fee schedule for the reimbursement of nonparticipating or out-of-network ground ambulances may discourage such providers from becoming participating or network providers.

It is unclear how the implementation of the fee schedule will impact premiums charged by insurers and HMOs. Currently, insurers and HMOs negotiate the reimbursement rate with nonparticipating ground ambulance providers.

C. Government Sector Impact:

Indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The provider reimbursement provisions of the bill would not apply to self-funded employer plans or ERISA plans. The federal Employee Retirement Income Security Act of 1974, or ERISA exempts self-funded plans established by private employers (but not public employers) from most state insurance laws, including reserve requirements, mandated benefits, premium taxes, and many consumer protection regulations. An estimated 65 percent of covered workers are in a plan that is self-funded plan.[51]

VIII. Statutes Affected:

This bill creates sections 627.42398 and 641.31078 of the Florida Statutes.
The bill amends s. 627.6699 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on January 9, 2023:

The CS provides the following changes:

- Eliminates a proposed new provider claims submission and insurer claims payment process since such a process currently exists in the Insurance Code.
- Revises the bill's formula for calculating reimbursement for out-of-network ground ambulance service providers to require the selection of the lowest rate instead of the highest rate. Revises Medicare rate from 350 to 325 percent for purposes of calculating reimbursement for out-of-network ground ambulance service providers.
- Revises the effective date of the bill from July 1, 2024 to January 1, 2025.
- Clarifies the types of health insurance that are subject to the provisions of the bill.
- Provides technical, conforming changes.

B. Amendments:

None.

[51] Section 10: Plan Funding - 10240 | KFF, 2023 Employer Health Benefits Survey (Oct. 18, 2023) (last visited Jan. 7, 2024).

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/11/2024	.	
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The Committee on Banking and Insurance (Hooper) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 627.42398, Florida Statutes, is created to read:

627.42398 Coverage for nonparticipating ambulance services.—

(1) As used in this section, the term:

(a) "Ambulance service provider" means a ground ambulance

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service licensed pursuant to s. 401.25.

(b) "Nonparticipating ambulance service provider" means a provider that is not a preferred provider as defined in s. 627.6471(1) or a provider that is not an exclusive provider as defined in s. 627.6472(1).

(2) A health insurer that offers an individual or group health insurance policy providing major medical coverage that includes coverage for ground ambulance services must reimburse a nonparticipating ambulance service provider for providing such covered ambulance services at a rate that is the lowest of the following:

(a) The rate set or approved, whether in contract, in ordinance, or otherwise, by a local governmental entity in the jurisdiction in which the covered ground ambulance services originated.

(b) Three hundred twenty-five percent of the current published rate for ground ambulance services as established by the federal Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same services provided in the same geographic area.

(c) The ambulance service provider's billed charges.

(3) Payment in full by the insured of his or her applicable copayment, coinsurance, or deductible constitutes an accord and satisfaction of, and constitutes a release of, any claim for additional moneys owed by the insured to the health insurer or to any person or entity in connection with the ground ambulance services.

(4) Copayment, coinsurance, deductible, and other cost-sharing responsibilities paid for a nonparticipating ambulance

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service provider's covered services may not exceed the copayment, coinsurance, deductible, and other cost-sharing responsibilities for a preferred provider as defined in s. 627.6471(1) or a provider that is not an exclusive provider as defined in s. 627.6472(1) for covered services.

(5) An ambulance service provider is considered a provider subject to s. 627.6131, and the claims of the provider are subject to s. 627.6131.

Section 2. Paragraph (h) is added to subsection (5) of section 627.6699, Florida Statutes, to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

(h) A small employer carrier must comply with the reimbursement provisions of s. 627.42398 relating to nonparticipating ambulance service providers.

Section 3. Section 641.31078, Florida Statutes, is created to read:

641.31078 Coverage for out-of-network ambulance services.—

(1) As used in this section, the term:

(a) "Ambulance service provider" means a ground ambulance service licensed pursuant to s. 401.25.

(b) "Out-of-network ambulance service provider" means a provider that is not under contract with a health maintenance organization.

(2) A health maintenance contract that offers individual or group major medical coverage that includes coverage for ground ambulance services must require a health maintenance organization to reimburse an out-of-network ambulance service provider for providing covered ambulance services at a rate that

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is the lowest of the following:

(a) The rate set or approved, whether in contract, in ordinance, or otherwise, by a local governmental entity in the jurisdiction in which the covered services originated.

(b) Three hundred twenty-five percent of the current published rate for ground ambulance services as established by the federal Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same service provided in the same geographic area.

(c) The ambulance service provider's billed charges.

(3) Payment in full by the subscriber of his or her applicable copayment, coinsurance, or deductible constitutes an accord and satisfaction of, and constitutes a release of, any claim for additional moneys owed by the subscriber to the health insurer or to any person or entity in connection with the ground ambulance services.

(4) Copayment, coinsurance, deductible, and other cost-sharing responsibilities paid for an out-of-network ambulance service provider's covered services may not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing responsibilities for covered services received by the subscriber.

(5) An ambulance service provider is considered a provider, and the claims of the provider are subject to s. 641.3155.

Section 4. This act shall take effect January 1, 2025.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause

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and insert:

A bill to be entitled

An act relating to coverage for out-of-network ground ambulance emergency services; creating s. 627.42398, F.S.; defining the terms "ambulance service provider" and "nonparticipating ambulance service provider"; requiring certain health insurers to reimburse nonparticipating ambulance service providers at a specified rate for providing ground ambulance services; providing that certain payments by the insured constitute an accord and satisfaction of and a release of certain claims; prohibiting certain cost-sharing responsibilities paid from exceeding a certain amount; providing that an ambulance service provider and certain claims are subject to certain provisions; amending 627.6699, F.S.; requiring a small employer to comply with certain provisions; amending s. 641.31078, F.S.; defining the terms "ambulance service provider" and "out-of-network ambulance service provider"; requiring certain health maintenance contracts to require a health maintenance organization to reimburse out-of-network ambulance service providers at a specified rate for providing covered services; providing that certain payments by the subscriber constitute an accord and satisfaction of and a release of certain claims; prohibiting certain cost-sharing responsibilities paid from exceeding a certain amount; providing that an ambulance service is considered a provider and certain claims are subject to certain

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provisions; providing an effective date.

By Senator Hooper

21-00606-24 2024568__

A bill to be entitled

An act relating to coverage for out-of-network ground ambulance emergency services; creating ss. 627.42398 and 641.31078, F.S.; defining terms; requiring health insurers and health maintenance organizations, respectively, to reimburse out-of-network ambulance service providers at specified rates for providing emergency services; specifying that such payment is payment in full; providing exceptions; prohibiting cost-sharing responsibilities paid for an out-of-network ambulance service provider from exceeding those of an in-network ambulance service provider for covered services; requiring health insurers and health maintenance organizations, respectively, to remit payment for covered services if such transportation was requested by a first responder or a health care professional; providing procedures for claims; providing an effective date.

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

Section 1. Section 627.42398, Florida Statutes, is created to read:

627.42398 Coverage for out-of-network ground ambulance emergency services.—

(1) As used in this section, the term:

(a) "Ambulance service provider" means a ground ambulance service licensed pursuant to s. 401.25.

(b) "Clean claim" means a claim that has no defect of

21-00606-24 2024568__

impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment which prevent timely payment from being made on the claim.

(c) "Covered services" means those emergency ambulance services that an enrollee is entitled to receive under the terms of a health insurance policy. The term does not include air ambulance services.

(d) "Out-of-network" means a provider that does not contract with the health insurer of the enrollee receiving the covered health care services.

(2) A health insurance policy must require a health insurer to reimburse an out-of-network ambulance service provider for providing covered services at a rate that is the greatest of any of the following:

(a) The rate set or approved, whether in contract, in ordinance, or otherwise, by a local governmental entity in the jurisdiction in which the covered services originated.

(b) Three hundred and fifty percent of the current published rate for ambulance services as established by the federal Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same service provided in the same geographic area; or the ambulance service provider's billed charges, whichever is less.

(c) The contracted rate at which the health insurer would reimburse an in-network ambulance provider for providing such covered services.

(3) Payment made in compliance with this section is payment in full for the covered services provided, except for any

copayment, coinsurance, deductible, or other cost-sharing responsibilities required to be paid by the enrollee. An ambulance service provider may not bill the enrollee any additional amount for such paid covered services.

(4) Copayment, coinsurance, deductible, and other cost-sharing responsibilities paid for an out-of-network ambulance service provider's covered service may not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing responsibilities for covered services received by the enrollee.

(5) A health insurer shall, within 30 days after receipt of a clean claim for covered services, promptly remit payment for covered services directly to the ambulance service provider and may not send payment to an enrollee. A health insurer must remit payment for the transportation of any patient by ambulance as a medically necessary service if the transportation was requested by a first responder or a health care practitioner as defined in s. 456.001.

(6) If the claim is not a clean claim, the health insurer must, within 30 days after receipt of the claim, send a written notice acknowledging the date of receipt of the claim and informing the ambulance service provider of one of the following:

(a) That the insurer is declining to pay all or part of the claim, and the specific reason or reasons for the denial.

(b) That additional information is necessary to determine if all or part of the claim is payable, and the specific additional information that is required.

Section 2. Section 641.31078, Florida Statutes, is created to read:

641.31078 Coverage for out-of-network ground ambulance emergency services.—

(1) As used in this section, the term:

(a) "Ambulance service provider" means a ground ambulance service licensed pursuant to s. 401.25.

(b) "Clean claim" means a claim that has no defect of impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment which prevent timely payment from being made on the claim.

(c) "Covered services" means those emergency ambulance services that a subscriber is entitled to receive under the terms of a health maintenance contract. The term does not include air ambulance services.

(d) "Out-of-network" means a provider that is not a provider under contract with the health maintenance organization of the subscriber receiving the covered health care services.

(2) A health maintenance contract must require a health maintenance organization to reimburse an out-of-network ambulance service provider for providing covered services at a rate that is the greatest of the following:

(a) The rate set or approved, whether in contract, in ordinance, or otherwise, by a local governmental entity in the jurisdiction in which the covered services originated.

(b) Three hundred and fifty percent of the current published rate for ambulance services as established by the federal Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same service provided in the same geographic area; or the ambulance service provider's

billed charges, whichever is less.

(c) The contracted rate at which the health maintenance organization would reimburse an in-network ambulance provider for providing such covered services.

(3) Payment made in compliance with this section is payment in full for the covered services provided, except for any copayment, coinsurance, deductible, or other cost-sharing responsibilities required to be paid by the subscriber. An ambulance service provider may not bill the subscriber any additional amount for such paid covered services.

(4) Copayment, coinsurance, deductible, and other cost-sharing responsibilities paid for an out-of-network ambulance service provider's covered services may not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing responsibilities for covered services received by the subscriber.

(5) A health maintenance organization shall, within 30 days after receipt of a clean claim for covered services, promptly remit payment for covered services directly to the ambulance service provider and may not send payment to a subscriber. A health maintenance organization must remit payment for the transportation of any patient by ambulance as a medically necessary service if the transportation was requested by a first responder or a health care practitioner as defined in s. 456.001.

(6) If the claim is not a clean claim, the health maintenance organization must, within 30 days after receipt of the claim, send a written notice acknowledging the date of receipt of the claim and informing the ambulance service

provider of one of the following:

(a) That the health maintenance organization is declining to pay all or part of the claim, and the specific reason or reasons for the denial.

(b) That additional information is necessary to determine if all or part of the claim is payable, and the specific additional information that is required.

Section 3. This act shall take effect July 1, 2024.

EMERGENCY MEDICAL TRANSPORTATION COSTS IN FLORIDA

Sha'Ron James
INSURANCE CONSUMER ADVOCATE

JUNE 2018

MESSAGE FROM THE ADVOCATE

Protecting insurance consumers by ensuring a healthy consumer-insurance company relationship is the fundamental purpose of insurance regulation. This simple premise guides the actions of government regulators, stakeholders, and advocates at every step in the process. The Office of the Insurance Consumer Advocate was created in 1992 to provide a voice to the insurance consumer and to serve Floridians by actively engaging with stakeholders to find consumer-focused solutions to the challenges policyholders face. Over the past 25 years, the Office has initiated, supported, and advanced many legislative programs aimed at homeowners, automobile, health, and workers' compensation insurance to promote and facilitate trust and balance in the industry. The work of the Office has compelled companies to treat consumers more fairly and make good on their promise to make consumers whole, especially when faced with unexpected peril.

In my role as Florida's Insurance Consumer Advocate, I have been most vocal on issues where consumer trust has been eroded, or consumers are left without recourse and need innovative solutions to protect them in their time of need. One such issue relates to the surprise medical bills consumers face after receiving critical and life-saving emergency medical transportation by aeromedical and ground ambulance providers. In 2016, I formed the Emergency Medical Transportation Working Group to assess the impact of emergency medical transportation costs to Florida's insurance consumers, gather information, and analyze data in a thoughtful, deliberative, and collaborative manner. The Emergency Medical Transportation Working Group brought industry stakeholders together in an effort to gain a balanced perspective on the air and ground ambulance industry and help provide solutions to protect consumers from financial distress after suffering from a medical emergency.

In this report, you will find an overview of the regulatory approaches currently in place related to emergency medical transportation, stakeholder feedback, and my office's independent recommendations formed from the crucial information and input provided by stakeholders throughout the process. You will also find data and a trend analysis by one of our featured partners, FAIR Health, Inc., an independent and nationally recognized non-profit known for its robust repository of healthcare claims data and award-winning consumer tools that help bring clarity to healthcare costs and health insurance claims data. FAIR Health, Inc. was an integral partner in assisting the Office's historic efforts to combat the practice of balance billing in the emergency medical services context. I am pleased that FAIR Health, Inc. has again partnered with our office to bring clarity to the issue of emergency medical transportation costs for Florida's insurance consumers.

I would like to thank the members of the Emergency Medical Transportation Working Group for their transparency as well as their commitment to this issue and our mission of addressing the challenges impacting Florida insurance consumers. I would like to offer a special thank you to the first responders and emergency medical professionals that provide the life-saving services that are critical to the health, safety, and welfare of our state. I would also like to thank the many consumers who took the time to write, call, and share their personal experiences. I am proud of this office's proactive, innovative, and resourceful approach to addressing consumers' insurance issues and release this report to further focus this important public policy conversation back to the experience of the Florida insurance consumer, who we are all here to serve.

Sincerely,

Sha'Ron James

Sha'Ron James
Florida's Insurance Consumer Advocate

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EXECUTIVE SUMMARY

Emergency medical transportation is a life-saving service that impacts all Floridians, including the uninsured, privately insured, and those covered by federal healthcare programs. In October 2016, the State of Florida's Office of the Insurance Consumer Advocate formed the Emergency Medical Transportation Working Group (EMT Working Group) to gather information, analyze data, and assess the impact of emergency medical transportation (EMT) costs to Florida's privately insured consumers. The EMT Working Group's focus centered on addressing the needs of Florida's insurance consumers by identifying solutions to address concerns faced by ground and aeromedical ambulance services, the insurance industry, state and local authorities, and ultimately the insurance buying public.

Before 2016, Florida families covered by private insurance were financially impacted by the practice of balance billing – where medical providers bill patients for the difference between insurer reimbursements and the charge for services in emergency situations. Although recently prohibited in Florida, balance billing protections do not extend to EMT services such as ground and air ambulances, for which consumers often face unexpected charges. By paying their premiums and deductibles, private insurance consumers have the reasonable expectation that they and their families will be covered if they need emergency medical transportation. Many Florida consumers are shocked to learn that air and ground EMT services are often considered out-of-network by their healthcare plans, and that they owe several hundred or, in some cases, thousands of dollars for the use of these services.

Since there are currently no explicit federal protections against balance billing, some states, such as Florida, have taken action to protect their citizens by passing their own balance billing laws or providing some protections with limitations. However, expenses associated with emergency medical transportation are not included in these protections.

Informed by the EMT Working Group's year-long commitment to gathering information and data to assess the impact of EMT costs to Florida's insurance consumers, the Insurance Consumer Advocate puts forth several recommendations to protect Florida's insurance consumers from surprise emergency medical transportation costs:

BAN AEROMEDICAL BALANCE BILLING

Stakeholders must recognize the challenges consumers face when dealing with out-of-network aeromedical balance bills. Although this life-saving service is crucial for patients who need to quickly be transported to a facility for care, the cost of the service is extremely expensive and leaves consumers financially debilitated. Steps must be taken to deregulate the aeromedical industry from federal regulation, so that states may more appropriately regulate the market to address consumer needs.

REFORM GROUND EMT BILLING MODELS

The current billing model used for ground EMT should be reformed. By shifting to a value-based model for ground EMT, ambulance companies will be able to charge for medical services and treatments without the requirement of transporting the patient to a medical facility. This would be a significant change from the fee-for-service model which requires that the patient be transported in order for the provider to be reimbursed for the emergency medical care. The fee-for-service model prevents EMT services from billing an insurance company for the critical care without having transported the patient. Transforming the billing model would allow ground EMT services to recoup emergency medical costs from insurance companies and mitigate the need to balance bill consumers.

INCREASE ACCESS TO IN-NETWORK EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

Consumers should have increased access to in-network EMT providers in order to decrease the likelihood of surprise medical bills. Providers and insurance companies must work together to improve value, efficiency, and use of health care services to reduce costs. Collaborative contracting efforts between EMT providers and insurance companies are integral in reducing the likelihood that consumers are left paying out-of-network prices for life-saving transportation to a medical facility. Regulators should also include and monitor emergency medical transportation in its network adequacy standards.

IMPROVE TRANSPARENCY & CONSUMER EDUCATION

Local governments, providers, and stakeholders should commit to educating the public in order to:

(1) Combat perceptions about the role of taxes in funding local ground EMT services.

(2) Explain the shift to for-profit, privatized EMT providers, especially for air ambulance services.

(3) Make transparent the rate justifications and billing practices of EMT providers.

(4) Provide useful, comparative information for consumers considering purchasing insurance plans with emergency transport coverages.

Emergency medical transportation services are a life-saving, fundamental part of the healthcare landscape for Florida citizens. These critical services preserve life and improve health and safety, but they must also be accessible and affordable to those with private insurance. Consumers should not be surprised with a substantial bill during the aftermath of a medical emergency. Solutions should center on the consumer experience and put the burden on EMT service providers and insurance companies to work out their differences concerning payment for this life-saving service. Dealing with a financial crisis after suffering an emergency medical event can be debilitating for Floridians and must be addressed.

OFFICE OF THE INSURANCE CONSUMER ADVOCATE

The Office of the Insurance Consumer Advocate (OICA) was created by the Florida Insurance Commissioner in 1990. In 1992, the Florida Legislature codified the position under Section 627.0613, Florida Statutes. The Insurance Consumer Advocate reports directly to the Chief Financial Officer, but is not otherwise under the authority of the Department of Financial Services or any employee of the Department. The OICA generally represents the interest of the public and has the authority to intervene before the Division of Administrative Hearings (DOAH), the Department of Financial Services (DFS), the Office of Insurance Regulation (OIR), and any forum in matters that arise under the jurisdiction of either DFS or OIR. Specifically, activities of the OICA include:

- Representing the general public and insurance consumers and recommending specific action or findings to DFS or OIR in regulatory matters under consideration.
- Appearing in proceedings or actions before DFS, OIR, DOAH, or arbitration panel.
- Recommending to DFS or OIR any position deemed by the Insurance Consumer Advocate to be in the public interest and in the best interests of insurance consumers.
- Increasing consumer awareness and assisting consumers in matters affecting insurance issues.
- Serving as a member of statutory boards, commissions, or ad hoc entities related to Florida's insurance markets.

- Performing legal research, seeking public input, and developing proposed legislation that serves the interests of Florida's insurance consumers.
- Reviewing and analyzing proposed legislation for purposes of preparing public testimony to support or oppose legislation affecting insurance consumers.

To find out more information about the insurance issues that the OICA tracks, including relevant news, communications, and resources from the Department of Financial Services, please visit our website at myfloridacfo.com/division/ica/.

The Role of the Insurance Consumer Advocate

The Insurance Consumer Advocate (ICA), as an independent authority to the insurance regulatory bodies of the state, is uniquely positioned to recommend policy solutions on behalf of the consumers of the state of Florida. This independent structure allows the OICA to maintain its autonomy, enables it to raise concerns and directly examine issues impacting Florida's insurance consumers. The ICA's mission is to balance between a viable, competitive insurance market that responds to consumers' needs for accessible and affordable insurance products that protect their lives, health, and safety.

In furtherance of this mission, the ICA formed the Emergency Medical Transportation Working Group (EMT Working Group) to gain a clear understanding on the scope of the issues concerning emergency medical transportation services and costs. The following issues and recommendations are the ICA's independent analysis based on information and data presented at the year-long EMT Working Group meetings. The ICA also requested and solicited commentary from consumers which helped frame the issue and the ICA's ultimate recommendations.

EMT WORKING GROUP

The Insurance Consumer Advocate (ICA) formed the Emergency Medical Transportation Working Group (EMT Working Group) in October 2016 to gather information, analyze data, and present perspective on the impact of emergency medical transportation costs to Florida's insurance consumers. The members of the EMT Working Group consisted of stakeholders such as emergency medical transporation service professionals, the insurance industry, hospitals, medical professionals, public social services, regulators, and other consumer advocates. The EMT Working Group met over the course of a year to present information and recommendations to inform the work of the ICA in addressing consumer-focused solutions to the issue.

The EMT Working Group was successful in providing over nine hours of testimony for public use and consumption over the course of four separate meetings. The EMT Working Group's introductory meeting was held on October 17, 2016, and featured consumer experience testimony and a presentation from the National Association of Insurance Commissioners on state responses to air emergency medical transportation regulation. The second meeting, focusing on ground emergency medical transportation, was held on February 28, 2017, and featured presentations on the operational landscape, pricing, and reimbursement. On June 13, 2017, the third meeting was held to highlight air ambulance emergency medical transportation in Florida and provided a robust discussion on patient care within the air ambulance context. The concluding meeting of the EMT Working Group was held on October 31, 2017, and focused on consumer testimonies and recommendations on both ground and air ambulance emergency medical transportation. Presentations and data were provided by stakeholders, industry presenters, national associations, and the non-profit, FAIR Health, Inc. (FAIR Health). Additionally, consumer comments and feedback were solicited in each meeting resulting in over 45 direct consumer experiences communicated to the EMT Working Group members. Each EMT Working Group meeting was publicly noticed and meetings two, three, and four were televised and available to view on the Florida Channel.

Members of the EMT Working Group

Office of the Insurance Consumer Advocate
Sha'Ron James, Insurance Consumer Advocate

Office of the Insurance Consumer Advocate
Jennifer Pettineo, Chief Counsel

Florida Department of Financial Services, Division of Consumer Services
Tasha Carter, Director

Florida Office of Insurance Regulation
Chris Struk, Life & Health Policy Advisor

America's Health Insurance Plans
Joy M. Ryan, Meenan P.A.

Florida Aero Medical Association
Jeffery See, Regional Vice President, Air Methods

Florida Ambulance Association
Joe Scialdone, EMS Billing Manager, Escambia County

Florida Association of Counties
Mac Kemp, Deputy Chief of Clinical Affairs, Leon County Emergency Medical Services

Florida Association of Health Plans
Wences Troncoso, Vice President and General Counsel

Florida Blue
David Pizzi, Director, Political and External Relations

Florida College of Emergency Physicians
Dr. Kristin McCabe-Kline, Chief of Staff, Florida Hospital

Florida Hospital Association
Lecia Behenna, Director of Finance

Florida League of Cities
Chief Dan Azzariti, Fire Chief, Plant City

Florida CHAIN[1]
Anne Swerlick, Policy Director

The EMT Working Group's meeting dates, agendas, presentations, information, and other pertinent materials can be found on the ICA's website at myfloridacfo.com/Division/ICA/EmergencyMedicalTransportation.htm.

Disclaimer

The ICA is appreciative of the EMT Working Group's commitment to bring focus to this issue by presenting clear viewpoints and information for public use and consumption. Many important ideas and recommendations were exchanged on how to best assist the consumer who has suffered from an emergency medical event and trusts that their health insurance plan will cover the cost.

After analyzing all relevant information and input, the ICA identified several significant findings. These issues and recommendations are highlighted in this report in an effort to offer balanced solutions to the issue of emergency medical transportation cost and insurance coverage in Florida. It is important to note that while the materials and perspectives amassed by the EMT Working Group constitute the basis for this report, the presentation of information and any policy recommendations are solely the position of the Florida Office of the Insurance Consumer Advocate.

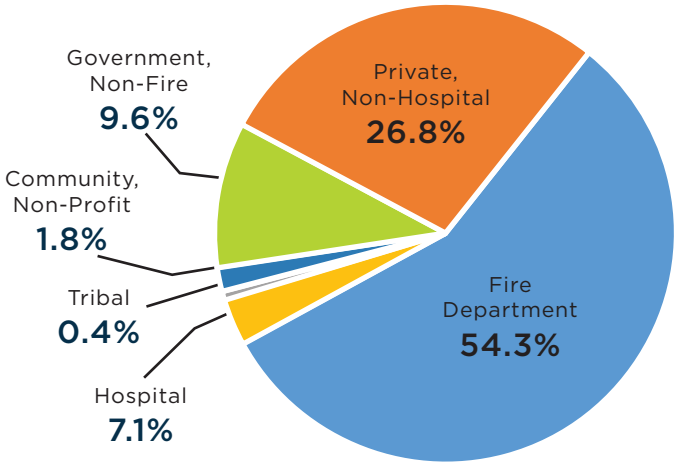
Additionally, research for this report, in part, is based on healthcare charge data compiled and maintained by FAIR Health. The Florida Department of Financial Services, Office of the Insurance Consumer Advocate, is solely responsible for the research and conclusions reflected in this report. FAIR Health is not responsible for the conduct of the research or any of the opinions expressed in this report.[2]

EMT LANDSCAPE

EMT Landscape

Emergency medical transportation (EMT) services provide life-saving ground and air medical care, first aid services, and outreach to the community. The goal of most emergency medical providers is to provide treatment and access to hospitals, trauma centers, cardiac and stroke centers, burn centers, neonatal and pediatric intensive care centers, and other critical care facilities. Emerging in the 1960s in response to significant increases in automobile accidents, the EMT industry grew from merely moving patients to, from, and between medical facilities to providing life-saving, advanced medical services.[3] Today, EMT technicians and paramedics receive more extensive education in the biological processes of the human body as well as certifications in various advanced medical treatment techniques.

The equipment and clinical staff necessary to provide the aforementioned array of critically-needed medical services in ground and air EMT industries results in massive annual costs to the healthcare system. The operation and financing of ambulance services are complicated and vary widely throughout the country. The idea that EMT is a free public service is a common misconception among consumers. In reality, EMT is rarely funded by local governments solely based on tax revenue. As healthcare becomes increasingly privatized, and services/equipment become more expensive, there is a greater concentration of independent providers. With the exception of Medicare and Medicaid, the rate is set by independent EMT providers and any reimbursement for that rate is determined by the insurer. This results in patients' financial responsibility being reliant not only on the type of insurance coverage they have, but also on the terms agreed to by insurance companies and the providers, within applicable state and federal guidelines.



Florida's Licensed EMS Transport Agencies[5]

Ground Ambulances

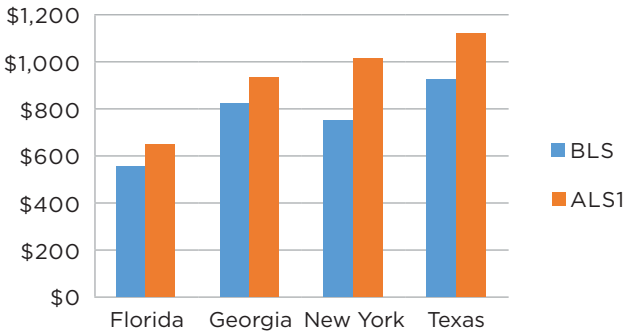
In Florida, there are currently 240 licensed basic life support (BLS) and advanced life support (ALS) emergency medical services (EMS) providers.[4] Data provided during the second meeting of the Emergency Medical Transportation Working Group (EMT Working Group) showed that the majority of ground ambulance providers are provided by local counties and cities and are non-profit. Over 50% of the licensed EMS transport agencies are fire departments, and 97% of the licensed EMS transport agencies are non-profit.[5] The pricing for ground ambulance varies by location and by the medical services provided. Pricing also takes into account the EMT provider's funding source. If the EMT provider is not subsidized by a municipality, the consumer could pay the full cost of the service.

In addition to transport, ground EMT providers offer several levels of emergency and non-emergency medical services. According to the Centers for Medicare & Medicaid Services Manual System, ground ambulance medical services can be categorized into seven different levels.

Levels of Ground Ambulance Medical Services

1	**Basic Life Support (BLS) Non-Emergency**	Transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state.
2	**Basic Life Support (BLS) Emergency**	When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response. Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.
3	**Advanced Life Support, Level 1 (ALS1) Non-Emergency**	Transportation by ground ambulance and the provision of medically necessary supplies and services including the provision of an ALS assessment by ALS personnel or at least one ALS intervention. An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.
4	**Advanced Life Support, Level 1 (ALS1) Emergency**	When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response.
5	**Advanced Life Support, Level 2 (ALS2)**	Transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including: (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids), or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed a. Manual defibrillation/cardioversion; b. Endotracheal intubation; c. Central venous line; d. Cardiac pacing; e. Chest decompression; f. Surgical airway; or g. Intraosseous line.
6	**Specialty Care Transport (SCT)**	Interfacility transportation of a critically injured or ill patient by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a patient's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training.
7	**Paramedic Intercept**	Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only BLS level of service is dispatched to transport a patient. If the patient needs ALS services, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.[6]

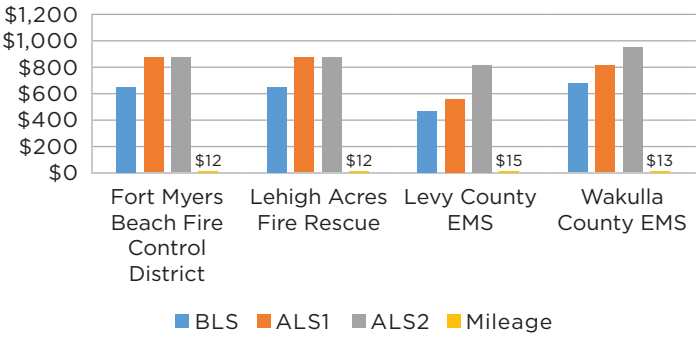
Basic Life Support and Advanced Life Support, Level 1 Emergency Transport



Data from: FAIR Health, Inc.[7]

In addition to the charge for services provided, there is often a mileage charge included. According to the data collected by FAIR Health, Inc. (FAIR Health), the average charge for BLS emergency transport in Florida was $557. In comparison, according to FAIR Health's data, the average charge for BLS emergency transport was $824 in Georgia, $752 in New York, and $930 in Texas, all of which are higher than Florida's average charge. While Florida's average charge for BLS emergency transport was $557, pricing still varies across the state.

Florida Ground EMS Transport Fees FY 2016



Data provided at the request of the ICA

For instance, In the Lakeside/Lake City/Live Oak area of Florida, the average charge for BLS emergency transport was $463. However, in the Tallahassee/Pensacola/Panama City area, the average charge was higher at $680. Miami's average charge was $630, and Tampa's average charge was $590. The Spring Hill/Palm Harbor area of Florida had an average charge of $526, which was higher than the Lakeside/Lake City/Live Oak area, but still lower than Tallahassee/Pensacola/Panama City, Miami, and Tampa.[7]

When looking at ALS1 emergency transport, Florida has an average charge of $653. In comparison to Georgia, New York, and Texas, Florida had the lowest average ALS1 emergency transport. ALS1 emergency transport was $938 in Georgia, $1,028 in New York, and $1,126 in Texas. As was the case with BLS emergency transport, Florida also had the lowest average for ALS1 emergency transport when compared to Georgia, New York, and Texas. Florida's average ALS1 cost was $653, which was on the low end when compared to Georgia's $938, New York's $1,028, and Texas' $1,126.

When looking at areas across Florida, the Lakeside/Lake City/Live Oak area had an average charge of $591. Unlike with the BLS emergency transport, of the five areas, Spring Hill/Palm Harbor had the lowest ALS1 average at $562. The Tallahassee/Pensacola/Panama City area reported an average charge of $827. Miami and Tampa had average ALS1 charges of $783 and $725, respectively.[8]

Overall, looking at other states such as Georgia, New York, and Texas, Florida had the lowest average charge for both BLS and ALS1 emergency transport. However, while Florida may have a lower average than some states, it is important to remember that the average cost in different areas of Florida can vary greatly, as is evident by the Tallahassee/Pensacola/Panama City area having an average ALS1 emergency transport charge of $827 and the Spring Hill/Palm Harbor area having an average charge of only $562.

Air Ambulances

Situated in both the aviation and healthcare sectors, the air ambulance industry is regulated by a complex network of oversight authorities. Stakeholders list federal agencies such as the Federal Aviation Administration, U.S. Department of Health and Human Services, National Highway Traffic Safety Administration (NHTSA), and state-level regulators such as Bureaus of Emergency Medical Services, individual counties, and other blood carrier and pharmacological regulators. However, none of these referenced regulators oversee the financial or billing aspects of the services provided.

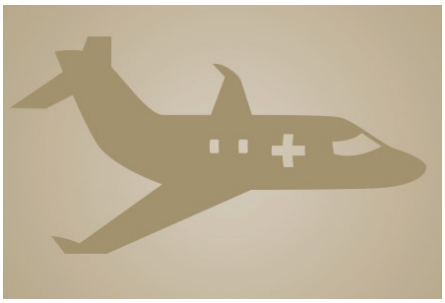
"When we're talking about the actual aviation services, making sure that the aircraft is maintained, keeping the flight crew well trained, well equipped; especially trained pilots…all the licensed certification and training, those are all fixed costs. And whether we are flying a patient, flying 10 patients a day or 1 patient a day, or not flying at all that day, those costs continue and they remain each and every day that we're in operation." – Chad McIntyre, TraumaOne Flight Services

Pricing

Currently, the Florida Department of Health lists 37 companies as licensed air EMS providers in the state of Florida.[9] Typically, there are three types of business models for air ambulance providers: (1) hospital-based, (2) independent, and (3) government operator.[10] Hospital-based models are controlled by a hospital and government operators are controlled by a state or municipal government or military unit. However, the independent models are not run by any specific medical facility or government entity and are independent for-profit or non-profit providers.

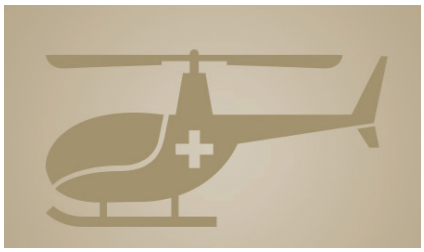
In addition to the types of business models for air ambulance providers, there are also different categories of air ambulance services. According to the Centers for Medicare & Medicaid Services Manual System there are two categories of air ambulance services:

Fixed-Wing (airplane)



A fixed-wing air ambulance is furnished when the patient's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed-wing air ambulance may be necessary because the patient's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, preclude such rapid delivery to the nearest appropriate facility.

Rotary-Wing (helicopter)



A rotary-wing air ambulance is furnished when the patient's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary-wing air ambulance may be necessary because the patient's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by rotary-wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.[11]

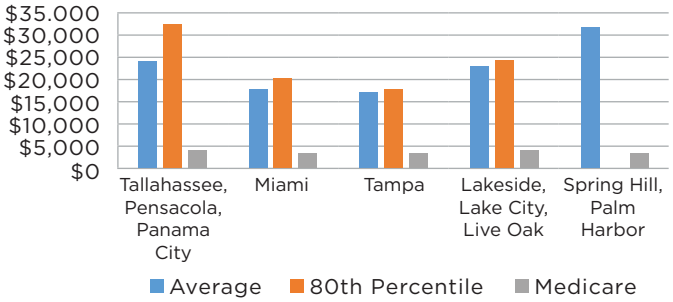
According to the National Association of Insurance Commissioners, the average air ambulance trip in the U.S. is 52 miles and costs between $12,000 to $25,000 per flight.[12] Taking that pricing into consideration, the Air Charter Guide, a directory for the air charter industry, reports that the average cost to rent a Boeing 737 is between $4,600 to $10,000/hour.[13] A majority of air ambulance transports are for moving patients between hospital facilities, one-third are for transporting victims from the scene of an accident to a hospital, and the remainder are for other purposes such as organ transports or specialty care flights (for example, pediatric and neonatal patients).[14]

FAIR Health provided the EMT Working Group data on the cost of air medical transportation. This data is indicative of information during the period of October 1, 2015 through September 30, 2016. The data shows the average bill for a fixed-wing airplane transport in Florida was $15,828, while the U.S. 80th percentile[15] was at $22,500. When comparing Florida to other states, Georgia's average charge was $11,661, New York's was $17,226, and Texas' was $18,238. Comparatively speaking, Florida has a lower average charge than New York and Texas, but Florida's average charge was more than $4,000 higher than Georgia for a fixed-wing transport.[16]

Delving further, FAIR Health provided fixed-wing data on four regions in Florida. Of the four regions, Miami reported the lowest average charge for a fixed-wing transport at $5,715. The Spring Hill/Palm Harbor area had an average charge of $12,911, and the Tallahassee/Pensacola/Panama City area's average charge was $24,872. Tampa's average charge was $30,000, though the data included only one flight in the area during the timeframe.[17]

Using the FAIR Health data again, the average bill for a rotary-wing helicopter transport in Florida was $21,221. As with fixed-wing, this is also below the U.S. 80th percentile at $29,036. While Georgia had the lowest average charge for fixed-wing transport, Florida holds the lowest average charge for rotary-wing transport. Georgia's average charge for rotary-wing transport was $24,660, New York's was $25,857, and Texas' was $22,652.[18]

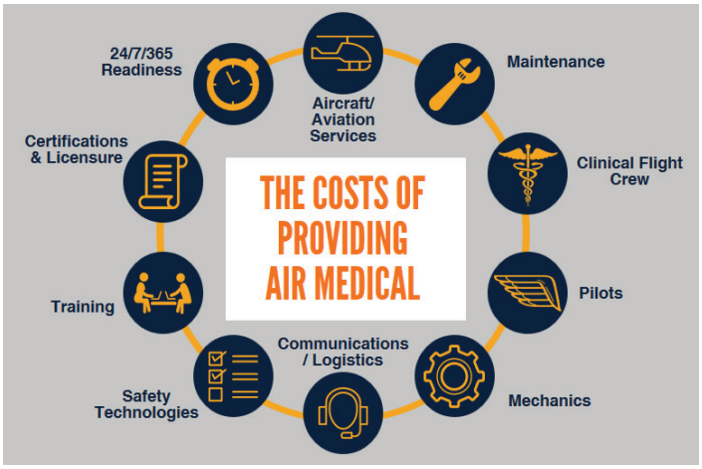
Regional Ambulance (Helicopter) Amount Comparisons
October 1, 2015 - September 30, 2016



Data from: FAIR Health, Inc.[16]

Data was provided on five areas of Florida for the average charge from a rotary-wing transport. The Tampa area had the lowest average charge at $17,443. Miami's average charge was $18,169, and the Lakeside/Lake City/Live Oak area's average charge was $23,359. The Tallahassee/Pensacola/Panama City area had an average charge of $24,378, and the Spring Hill/Palm Harbor area had the highest average charge at $32,024.[19]

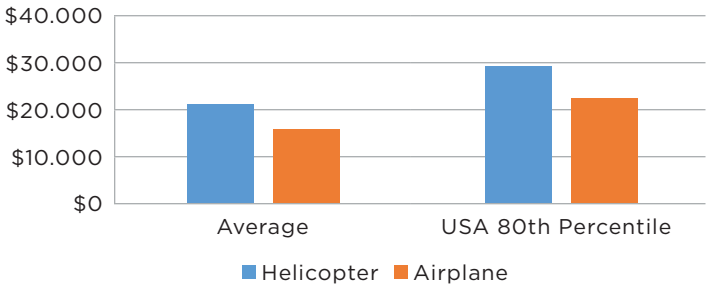
An air ambulance base houses the physical equipment and staff necessary to provide year-round, life-saving services. Air EMT providers are primarily concerned with maintaining quality, year-round operations of their bases in anticipation of any medical crises requiring their services, while simultaneously making a profit. The Air Medical Services Cost Study Report published March 24, 2017, found that the median annual cost for



The Costs of Providing Air Medical[20]

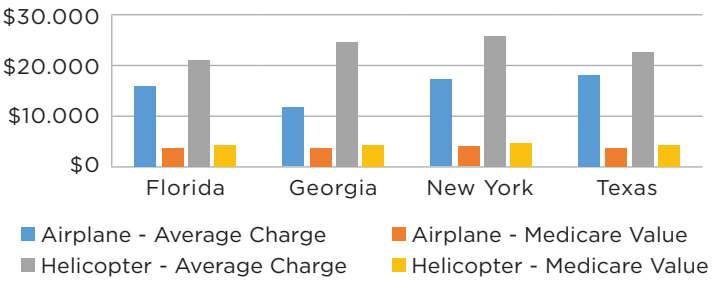
a base was $2,969,360. When comparing the median annual cost of a base for for-profit and non-profit independent programs, there was not much of a difference, with for-profit bases having a median cost of $2,951,968, and non-profit bases having a median cost of $2,986,776.[21] The majority of this cost (82%) is fixed and must be recovered in revenue each year for the program to maintain its service delivery. Air Methods, the largest air medical provider in the world, has 386 EMS and 62 tourism aircraft in the U.S. Air Methods services 48 states with 289 bases. According to Air Methods, the average direct cost to operate a 24/7/365 air medical base that performs 300 transports a year is $2,769,820.[22] The total operating costs for air medical services are not covered by payors in the aggregate.

State to National Ambulance Amount Comparisons
October 1, 2015 - September 30, 2016

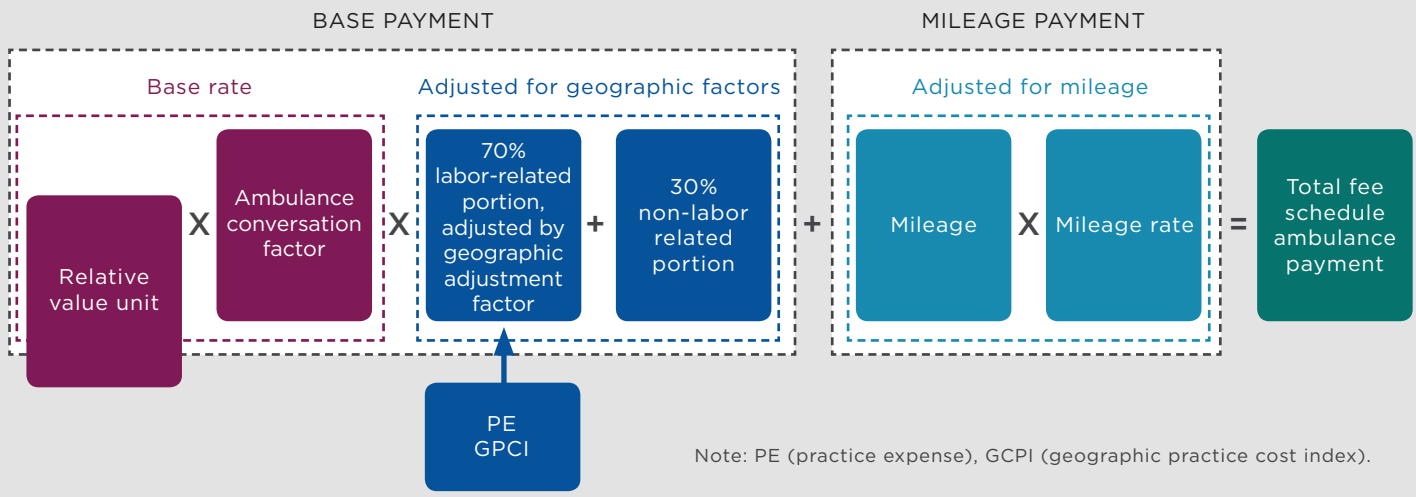


Data from: FAIR Health, Inc.[19]

State Ambulance Amount Comparisons
October 1, 2015 - September 30, 2016



Data from: FAIR Health, Inc.[19]



Note: PE (practice expense), GCPI (geographic practice cost index).

Base Payment[23]

"A benefit of an insurance plan is determined at the time of purchase. So, when we submit our claim, it's not up to the provider to determine how much of their cost share is, it's truly up to the insurance company plan that dictates that." – Joe Scialdone, Florida Ambulance Association

Insurance

Health insurance is one of the most important investments Americans make. However, obtaining the proper type and level of coverage can be complex for even the most knowledgeable consumer. Within applicable federal and state guidelines, insurance plans and coverage amounts are determined by insurance companies and may not be uniform across plan types. There may be particular restrictions on medical care or procedure types depending on plan specifics. There may also be high costs associated with the coverages such as deductibles, copayments, and co-insurance rates required for benefits to be applicable. Florida Blue, one of the largest health insurance providers in Florida, reported that their allowed amount is the lesser of the provider's billed amount for services or an amount established by Florida Blue based on several factors:

- Payment for services under Medicare and/or Medicaid
- Payment often accepted by providers in Florida or comparable markets
- The cost of providing the service
- Payment that does not encourage network non-participation

Provider Networks

Florida Blue reported that in the area of ground EMT, there is little to no network in place because of the lack of competition in the market. Usually, there are one to three providers in most counties, little negotiating opportunity over the cost of care, and, therefore, a resulting high volume of consumers balance billed for services rendered.

Florida Blue also reported, as of the EMT Working Group's June 2017 meeting, that there were no contracted emergency aeromedical transportation service providers in the state of Florida. Despite the network frailty, Florida Blue stated that they remained committed to entering into contracts with air ambulance providers when the terms include fair and reasonable allowances for services, offered protection to their members from balance billing, and enabled Florida Blue to offer affordable health care options. To date, Florida Blue has been unsuccessful at negotiating with aeromedical providers due to considerable differences between proposed contracted allowances and the related mileage. This has been the case for both rotary and fixed-wing transports.

Consumer Impact

Given all of the different variables and contracting considerations, one thing is certain in the purchase of health insurance – the benefits offered by a particular plan are determined at the time of purchase, and the consumer has very little, if any, negotiating ability over plan specifics.

Consumers must be certain of the terms and conditions set by insurance companies when receiving medical treatment, and consumer education plays a major role in this understanding. There is great benefit for consumers when they are armed with a comprehensive understanding of how their deductible/copays are applied and what types of events/treatments are not covered by their insurance policy. During or after an emergency is not an ideal time for consumers to be educated on the coverage specifics of their insurance plan by either the provider or the consumer's insurance company. Likewise, this is not an ideal time for the insurance company to explain their contract terms and potentially harm the relationship they have with their customer. It is also not an ideal business plan for medical provider's funding goals, given that some consumers will not have the financial wherewithal to pay the balance bill.

SCOPE OF THE PROBLEM

EMERGENCY MEDICAL TRANSPORTATION COSTS FOR FLORIDA INSURANCE CONSUMERS

A Critical and Life-Saving Service

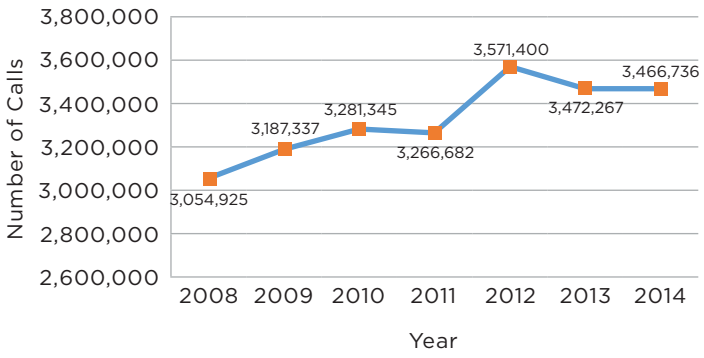
The services provided by the emergency medical services (EMS) and emergency medical transportation (EMT) industry are paramount in saving the lives of consumers every day. In 2011, the National Center for Chronic Disease Prevention and Health Promotion published a survey of nine states regarding EMS practices for heart disease and stroke. 76.7% of EMS providers contacted in Florida responded to the survey (this was the highest response rate of the nine states surveyed). The Florida respondents reported a total of 2,003,612 EMS calls in 2008. That amounts to an average of 5,474 calls each day in Florida during the 2008 leap year. Of these more than two million calls, 174,864 were for chest pain, 21,708 were for cardiac arrest, and 44,328 were for stroke.[24] In total for the survey, almost 250,000 Floridians were saved or given critical medical treatment by EMT providers during 2008.

The Florida Department of Health's 2014 Florida Emergency Medical Providers Licensure and Call Volume Report showed 3,466,736 incidents during 2014.[25] When comparing the call volume against Florida's 2014 population, an estimated 17.8% of Floridians needed the critical medical services EMT providers are trained to deliver.[26]

"911, again, is a social safety net, and we have to be there to provide this level of service." – Chief Dave Dyal, Fire Chief of Stuart, Florida

Without the EMS/EMT industry, Floridians would be void of a critical health care service that is often the first point of contact for many people suffering an acute medical event. Every day, thousands of calls are responded to and life-saving measures are taken to ensure the health of the population.

Florida EMS Incident Volume[25]



Balance Billing

Consumers buy private health insurance coverage to protect themselves and their families from the high-cost of health care. They expect that if they pay their premiums and use in-network medical providers and healthcare facilities, insurance companies will cover the costs of medically necessary care beyond consumers' specified copayments, coinsurance, and deductibles. However, when patients are treated by out-of-network providers during visits to in-network hospitals or facilities, they may receive unexpected bills for the difference between what the medical provider charged for the service and what the insurance company reimbursed. This practice is called "balance billing."

Balance billing typically occurs after a consumer suffers an emergency medical event. The consumer experiences a medical emergency and is transported to the nearest medical facility for care. The facility may have non-contracted, out-of-network providers that render care to the consumer in the emergency context. Providers such as radiologists, anesthesiologists, pathologists, and other emergency room doctors are generally identified in this scenario and balance bill the patient to recover the balance between the service charge and the amount reimbursed by insurers. Beyond the emergency context, consumers may also find themselves in scenarios in which they are treated unexpectedly by an out-of-network provider and billed beyond their applicable deductible, copay, or coinsurance amount.

The practice of a healthcare provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge is called "balance billing."

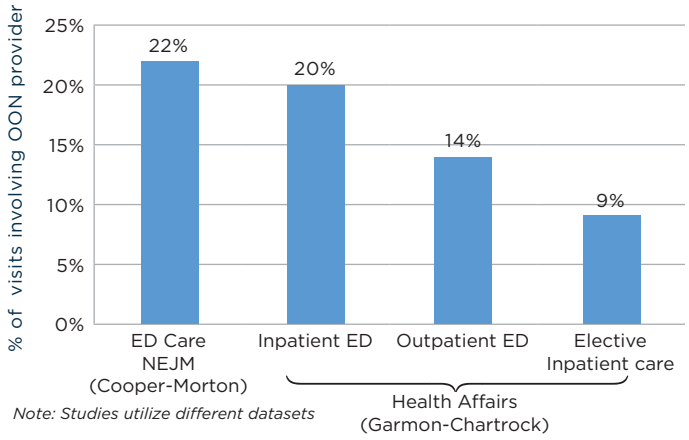
In the examples below, the consumer would receive balance bills because some or all of the services rendered by out-of-network medical providers were not paid in full by their private insurance company:

- A consumer may visit an in-network physician and then be referred to a healthcare specialist for additional tests or surgery who may be out-of-network.
- A consumer who has scheduled surgery at an in-network facility, with an in-network surgeon might later find out that the anesthesiologist was out-of-network.
- A consumer who goes through a surgical procedure using in-network providers may find themselves being transported to another medical facility by an out-of-network ground or air EMT.

Of the three (or more) parties involved – consumers, insurers, and medical providers – the burden of interpreting and disputing balance bills falls exclusively on the consumer, adding financial stress to their already existing health crisis.

The incidence rate of balance billing is unclear because providers are not obligated to report many aspects of their operations or financial practices, thus making most data sources incomplete. For both government and academic publications, research on balance billing practices consistently point to data limitations as a barrier to providing rigorous examination of healthcare and insurance providers' contracts and rates. Information on whether providers send their patients balance bills or seek to collect them is often withheld for proprietary reasons from regulators and consumers alike.

Percentage of Care Likely Leading to Surprise Medical Bill[27]



Note: Studies utilize different datasets

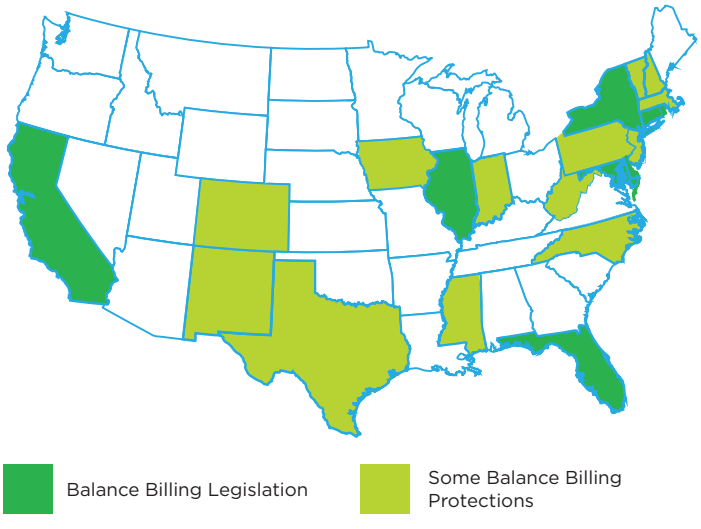
Given these limitations, two major nationwide studies have been published on the incidence rate regarding balance billing. These studies were conducted by Health Affairs and the New England Journal of Medicine. Both studies found that 20% of emergency department (ED) visits that resulted in admission to an in-network facility were likely to expose the patient to an out-of-network physician.[27]

In 2015, a nationwide study from Consumers Union found nearly one-third of privately insured Americans received an unanticipated medical bill when their health plan paid less than expected for medical services within the past two years.[28] Even if the consumer takes every precaution in selecting an in-network hospital or provider, there is no certainty that the specialists on staff, providers in the emergency department, or the emergency medical transport services are staffed by in-network providers.

The balance billing war between providers and insurance companies has led to consumers being strapped with unanticipated health care bills and powerless to negotiate a resolution. Many consumer groups have called for proactive regulations to address this concerning phenomenon. With no explicit federal protections against balance billing, some states have passed consumer-focused legislation to combat the practice.[29] However, many services such as air and ground emergency medical transportation remain out-of-network for healthcare plans and are not covered by these state reforms. Despite some states' steps to protect patients against balance billing, consumers may still find they owe several hundred or, in some cases, thousands of dollars for the emergency medical transportation they took to the nearest medical facility for care.

Balance Billing and State Approaches to an Important Consumer Issue

Federal law does not currently protect consumers from balance billing. Instead, states have worked to protect consumers in certain emergency scenarios where consumers are unaware they may be subject to unexpected charges. Currently, six states have passed legislation using a comprehensive approach for protecting consumers including California, Connecticut,



Data from: The Commonwealth Fund[29]

Florida, Illinois, Maryland, and New York. Another 15 states offer protections with some limitations including Colorado, Delaware, Indiana, Iowa, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont, and West Virginia. Most states with laws or regulations that include limited balance billing protections are considering bills in future legislative sessions to expand consumers' existing fundamental protections. While one may applaud the legislative process for assisting consumers in mitigating the challenges associated with balance billing, the need for regulatory remedies may significantly decrease if insurers and providers resolved billing differences without involving the consumer.

The remaining 29 states and the District of Columbia do not have consumer protection laws regarding balance billing. Some of these states have addressed it on a regulatory level by acting informally as arbiters when a dispute arises. In these cases, insurance and/or healthcare regulators mediate disputes between providers and insurers to determine acceptable payment levels or encourage insurers to pay balance billed charges to help consumers resolve billing disputes. However, informal approaches are notoriously inconsistent in application and effectiveness, and they do not offer long-term solutions as the healthcare industry continues to change.

Joining a handful of other states in comprehensive reform measures, Florida's legislature passed House Bill 221 in 2016, which took effect on July 1, 2016. This significant, consumer-focused legislation helps to hold the consumer harmless in times of medical need and helps the consumer to better understand their health care coverage. The bill prohibited out-of-network providers from balance billing members of Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO) networks when they receive emergency services or covered non-emergency services. Additionally, the bill required hospitals to publish information on their websites naming contracted insurance companies and providers. The legislation further required all insurers to publish a list of their network providers, including specified demographic information, and to update the list with reported changes monthly. Many consumer-centered protections were incorporated into the bill; however, it did not address costs associated with balance billing for emergency ground transportation or emergency air ambulance services.

- Researchers found that 14% of emergency room visits and 9% of hospital stays were likely to produce a surprise bill.
- The risk is even greater for patients admitted to the hospital via the emergency room, in which case 20% of such patients were likely to receive bills.[27]

In fact, there are very few state laws that protect consumers from emergency transportation bills. Passed in 2017, California's Assembly Bill 72, provides protection from surprise medical bills when consumers follow the rules of their insurance policy by going to an in-network facility for care. However, the law only applies to non-emergency transportation services if the transportation resulted from services provided at an in-network facility. In Washington, Senate Bill 6129 was proposed during the 2017-18 Session to create a ground ambulance transport fund to provide for additional payments to ambulance transport providers for Medicaid services. The monies in this fund may be used to enhance federal financial participation for ambulance services under the Medicaid program and to provide additional reimbursement to ambulance transport providers. New York's Assembly Bill 3338 (2017) aims to specifically reform the state's workers' compensation law by establishing a fee schedule for the costs of ambulance services provided to an injured employee. As state approaches to the overall balance billing question expand, more and more states will be looking to address all forms of unexpected medical bills, including those related to emergency medical transportation.

Stakeholder Perspectives

The passion with which stakeholders have supported or opposed the practice of balance billing is not new. News media in the U.S. have followed disputes and attempts to regulate balance billing practices since the mid-1980s. In the 1990s, when removing similar caps on Medicare billing was considered at the federal level, newspapers featured headlines stating:

- "Medicare Pay Shift a Sick Idea"[30]
- "Worried Sick: Medical bills can bankrupt middle class"[31]
- "'Alarm letters' scare retirees with false warnings of being cut from Medicare"[32]
- "Doctors Charged 27% More than Medicare Pays"[33]

Over the years, news reports on hearings and committees concerned with balance billing describe citizens and stakeholders vying for leverage in the fight against escalating health care costs. In 1989, *The Palm Beach Post*[34] described one such hearing held by the Florida Task Force on Elderly Access to Health Care where citizens urged stakeholders to recommend legislation that would require doctors to accept Medicare rates as payment in full for medical services. In accepting the Medicare rate, citizens argued that balance billing practices would be eliminated by establishing fee limitations for physicians and related medical services. Doctors responded with emotional appeals that their treatments and provision of services helped patients and saved lives. In sum, the arguments were "not about healthcare, but almost entirely about money, how much the doctors should have and how much the patients could spend."[35]

Debates on mitigating rising health care costs have continued for several decades and have included the complex, dynamic relationship between health insurance consumers and those who provide life-saving transport and medical services. In the 1990s, media interest in the cost of emergency medical transport and services increased when consumers voiced concerns over exorbitant billing practices. News reporters began to bridge the ongoing disputes about balance billing with new and mounting distress regarding the costs of EMT services, with stories about:

- "Unpaid bills at $700,000"[36]
- "Ambulance bills upset residents"[37]
- "Calling 911: Who Should Pay the Bill?"[38]
- "10,000 ambulance bills unpaid: State learns River Rescue bills for advanced services"[39]

This ongoing trend of matching consumer grievances with those of medical physicians, insurance companies, federal regulators, and EMT services providers continues to influence healthcare policy decisions today.

Similarly, during the course of the Emergency Medical Transportation Working Group's engagement, the Insurance Consumer Advocate heard from representative stakeholders on their perspective regarding unexpected charges from emergency transport services in Florida. The main component of the balance billing dispute – a provider's charges versus an insurance company's reimbursement rate – was discussed from various respective viewpoints and with equally matched fervor.

> **"If a patient doesn't pay the bill, or the insurance company in most cases refuses to pay the bill, or pays only a very, very small percentage, that is shifted over to the tax payers." – Chief Dan Azzariti, Florida League of Cities**

Most emergency transportation providers communicated great concern with the concept of prohibiting balance billing for EMT services. As all emergency services for Florida residents are not alike, emergency transportation providers expressed concern that cutting the ability to balance bill would severely impact the readiness, quality of service, and response time to residents. Most providers cited the ability to balance bill as crucial due to low reimbursement rates from

uninsured patients, federal payers, and private insurers. Ground EMT stakeholders argued that a prohibition on balance billing without an increase in insurer reimbursement may lead to an increase in the tax base requirement or a cut in services and equipment. Some stakeholders communicated a desire for legislation requiring insurers to pay a minimum amount on all EMT calls. Air EMT providers also communicated concern regarding base availability, readiness, and response time if a balance billing prohibition were implemented in Florida. Overall, providers suggested a holistic approach to the billing dispute issue and felt that the approach should be exclusive of prohibiting balance billing.

"Florida Blue has worked tirelessly to negotiate in good faith with all emergency service providers on behalf of our customers. And we will continue to do so. Unfortunately, these negotiations have not led to extensive agreements. Worse, in some cases, true negotiations, which we term as an exchange or debate over what we consider reasonable terms of reimbursement, has not occurred because some providers refuse to discuss future prices until old billing disputes are resolved." – David Pizzi, Florida Blue

From the health insurer perspective, stakeholders addressed a need for more economical, efficient, and competitive ways to charge for EMT services. For example, America's Health Insurance Plans suggested that, as part of the requirements for continuing education, states should inform first responders, law enforcement, dispatchers, and others who may be responsible for deciding on a transportation method for a patient, of the appropriate circumstances for air ambulance dispatch. The more stakeholders are educated on patient care and emergency protocols, the more likely the most medically suitable and cost-effective transportation provider will be utilized. Other stakeholders addressed and emphasized the need for quality contract negotiations between insurers and EMT providers, so that consumers are not harmed by unexpected medical transportation bills. Some stakeholders involved in the process called for, and supported, a balance billing ban to be applied to the emergency services industry, including ground and air transportation.

Regulators, consumer groups, and advocates have long stressed the need for the consumer to be left out of the fight between providers and insurers over the cost of emergency transportation services. As stakeholders communicated, balance billing effects can cause severe financial distress for many insurance consumers. As consumers pay more out-of-pocket for medical care than ever before, they should not be additionally burdened with surprise charges. These stakeholders advocated for the immediate removal of the consumer from the frustration of negotiating the balance billing issue, so that providers and insurers are better incentivized to come to a resolution.

These various perspectives formed the ultimate discussion points and basis for exploration into the impact Florida's EMT services have on insurance consumers. Each perspective was critically examined, matched with information and data, debated, and passionately advocated.

Fair Health and the Issue of Ambulance Costs

February 2018

By **Robin Gelburd**
President, FAIR Health

Robin Gelburd, JD, is the president of FAIR Health, a national, independent, nonprofit organization with the mission of bringing transparency to healthcare costs and health insurance information. FAIR Health possesses the nation's largest collection of private healthcare claims data, which includes over 25 billion claim records contributed by payors and administrators who insure or process claims for private insurance plans covering more than 150 million individuals. FAIR Health also holds separate data representing the experience of more than 55 million individuals enrolled in Medicare. Certified by the Centers for Medicare & Medicaid Services (CMS) as a Qualified Entity, FAIR Health receives all of Medicare Parts A, B and D claims data for use in nationwide transparency efforts.

In 2017, FAIR Health was privileged to assist the Florida Insurance Consumer Advocate's Emergency Medical Transportation Working Group by presenting data on ground and air ambulance costs and claim frequency in Florida as compared to other states and the nation. Analysis of state-specific data to support consideration of policy on important issues, such as ambulance costs, is one of the services FAIR Health is able to offer states as a national, independent, nonprofit organization dedicated to bringing transparency to healthcare costs and health insurance information. This article will describe how FAIR Health has been active in helping Florida and other states; what the major issues are concerning ground and air ambulance costs; and what state and federal legislation is currently being proposed to address those issues.

FAIR Health and Florida

FAIR Health's database of over 25 billion privately billed medical and dental claims, the largest collection of private insurance claims in the nation, is kept current with the addition of new claims at a rate of 2 billion per year. Contributed by approximately 60 insurers and claims administrators nationwide, the claims constitute the records of plans covering over 150 million individuals. In Florida alone, we have 1.3 billion claims from 2002 to the present, including 125 million records in 2016 alone, from 56 contributors.

Separately, FAIR Health holds extensive Medicare data. The Centers for Medicare & Medicaid Services (CMS) has certified FAIR Health as a Qualified Entity (QE), so that we now hold all claims under Medicare Parts A, B and D for all 55 million Medicare beneficiaries from 2013 to the present for use in nationwide transparency efforts. As part of the requirements for QE status, CMS determined that the FAIR Health private claims repository possesses data that are representative of each of the 50 states and the District of Columbia.

From the private claims data FAIR Health collects, we produce two lines of percentile benchmark products: charge benchmarks based on actual, non-discounted billed fees for services and allowed amount benchmarks that are imputed based on the actual, negotiated amounts that constitute the in-network fees for services. All FAIR Health benchmarks are geographically

specific, so the benchmarks for a given geographic area (called a geozip) are based on the claims data for services rendered in that specific geozip. FAIR Health has data for 493 geozips nationwide, including 23 geozips in Florida, allowing us to make granular analyses reflecting the healthcare market economy in a particular area and time.

For example, in one of our 2017 presentations to the Florida Department of Financial Services, we were able to compare average charge, 80th percentile charge and CMS rates for procedure code A0427 (advanced life support, emergency transport, level 1) in a subset of Florida geozips, including those for Lakeside, Lake City and Live Oak (320); Tallahassee, Pensacola and Panama City (323); Miami (331); Tampa (336); and Spring Hill and Palm Harbor (346).

While FAIR Health does not determine, prescribe or recommend any specific benchmark as a usual and customary rate (UCR), the payment standards for healthcare services in a number of jurisdictions reference FAIR Health benchmarks; UCR is instead determined by the relevant state or federal statute, health program or insurance plan design, as the case may be. Our independence and neutrality and the robustness and quality of our data enable us to help states with many policy issues, including those concerning ambulance costs.

Ambulance Costs

Costs for ambulance services can be high for several reasons. Ground ambulances and their crews must be available 24 hours a day, seven days a week. They carry sophisticated equipment and have stringent requirements for trained personnel. The costs of air ambulances, whether airplanes or helicopters, are often much higher than ground ambulances, because aircraft are more expensive to operate and maintain than ground vehicles and require flight personnel in addition to specialized medical crew.

Private or public insurers often bear a portion of the costs of ambulance services, but a substantial part of these costs is borne by uninsured patients or by insured patients who receive ambulance services from a provider outside their health plan's network. Receiving services from an out-of-network provider can easily happen when a patient in a medical emergency calls 911 and the dispatcher sends an ambulance without regard to whether the provider is in the patient's network. Often, the result is that the insurer pays only a small part, if any, of the ambulance bill, and the patient is left to pay the balance, in what is called balance billing.

Increasingly, state lawmakers are trying to address issues related to ambulance costs, including balance billing. One particularly thorny issue is how to reimburse ambulance services (and ensure continued access to these critical services) if consumers are held harmless for amounts exceeding their in-network costs. Those cost issues are difficult enough for ground ambulances, but particularly challenging when dealing with charges for air ambulances. The difficulty dealing with air ambulance rates is due to a long-standing federal law, the Airline Deregulation Act of 1978 (ADA), which prohibits states from regulating prices, routes or services of air carriers. To date, several federal courts have rejected state efforts to regulate air ambulance charges, ruling that the ADA preempts state regulation of air ambulances.

Legislative Proposals on Air Ambulance Costs

Currently, legislative proposals to address air ambulance costs are pending on both the state and federal levels. For example, on February 28, 2017, Senator Jon Tester of Montana introduced the Isla Rose Life Flight Act (S471), federal legislation that would end ADA preemption of state or local laws or regulations related to air ambulances. The bill was referred to committee and no further action has been taken. Several state legislatures have passed or are considering legislation urging members of the US Congress to act to eliminate preemption of state action with respect to air ambulance rates so that states can regulate reimbursement for air ambulance services. Pennsylvania, Montana and Utah each

passed laws in 2017 urging the US Congress to amend the ADA, and similar legislation was just introduced in South Carolina. Colorado also passed a law in 2017 removing a state statutory prohibition on setting standards for air ambulance services preempted by the ADA.

In state legislatures, a number of different approaches are currently being considered with respect to air ambulance costs. Some ambulance-related bills were introduced this year; others remain under consideration from last year's legislative session. In Michigan, HB5219, a bill that passed the state House of Representatives late last year and is now in committee in the state Senate, would impose transparency requirements on air ambulance services when dealing with nonemergency patients. The air ambulance services would have to inform patients or their representatives whether they are a participating provider or out of network with the patient's health plan, give patients a good-faith estimate of the cost and let them know they have a right to be transported by a different method or by an ambulance service that participates in their plan. If the air ambulance service fails to provide this notice or if the patient is an emergency patient, the service must accept the amount covered by the patient's health plan together with any required coinsurance, copays or deductibles as payment in full.

In Virginia, several pending bills would provide transparency for patients. HB777, for example, would require air ambulances to obtain written consent for air transportation from the patient, unless compliance might jeopardize the patient's health or safety or the patient is unable to provide consent. HB778 would require hospitals, before arranging for air ambulance transportation in nonemergency situations, to provide the patient or patient's representative with notice that the patient may have a choice between air or ground transportation and that the patient will be responsible for the charges if the air ambulance service provider is not in the patient's insurance network. Similarly, SB663 would impose disclosure requirements for hospitals before arranging air ambulance transportation, and also would require a good-faith estimate of the range of typical charges for out-of-network air transport services in the patient's geographic area.

Proposals in other states would provide a dispute resolution process to address fee disputes about air ambulance bills. In Hawaii, HB915 would require healthcare facilities, when transferring a patient to another facility via air ambulance, to request services first from an air ambulance provider contracted with the patient's insurer. If such services are not available, the healthcare facility must notify the insurer of the use of a non-contracted air ambulance service. If the insurer and the facility disagree whether such use was appropriate, the bill calls for the two to attempt mediation, which, if unsuccessful, is to be followed by binding arbitration.

In Kentucky, HB395 proposes an independent dispute resolution (IDR) program for insurers and air ambulance service providers. To avoid ADA preemption, HB395 would make participation in the IDR program by air ambulance service providers voluntary (via a process of registration), and states that such voluntary agreement constitutes a waiver of the provider's ability to challenge the IDR program based on federal preemption. Another provision of the bill would require an insurer's health plan to have an adequate network of air ambulance service providers in the state, or the insurer will not be permitted to set air ambulance reimbursement at an amount that is less than the average rates published by registered air ambulance service providers. Under the proposed legislation, registered air ambulance service providers also would be prohibited from balance billing an insured person, reporting a payment delinquency to a credit agency, obtaining a property lien or taking "any other action adverse to the insured" with respect to the disputed amount.

Medicare payments for air ambulance services are the subject of other state legislative efforts. For example, in South Carolina, H4679 would require all individual and group health insurance

policies and health maintenance organizations to cover air ambulance services deemed medically necessary by a physician. The coverage must pay the Medicare rate for such services plus 15 percent, with the provisions retroactive five years from effective date. In Florida, S1572 asks the US Congress to address "egregious underpayment by Medicare" for air ambulance services on the grounds that this "destabilizes the reimbursement environment for air medical providers." The bill urges Congress to pass federal legislation, HB3378/SB2121, which would require reporting of certain data by air ambulance service providers for purposes of reforming Medicare reimbursement for such services.

Legislative Proposals on Ambulance Services in General

In New York, S06363 would add "ambulance services" to the definition of "emergency services," would expand the existing IDR process to include ambulance services and would prohibit balance billing of insured patients who have received ambulance services. A different New York bill, A07717/S00363, specifies that insurers who cover ambulance services must pay nonparticipating ambulance service providers at rates negotiated between them, or else "at the usual and customary charge, which shall not be excessive or unreasonable."

In West Virginia, SCR20 would request the federal government to review and update Medicaid rates for ground and air ambulance services, and to establish an annual process for reviewing those rates.

Legislative Proposals on Ground Ambulances

In Washington, SB6129, which specifically excludes air ambulances, would provide for the creation of an ambulance transport fund to be used to enhance federal financial participation for ambulance services under the Medicaid program, and to provide additional reimbursement to, and to support quality improvement efforts of, ambulance transport providers.

In New York, A03338 would amend the workers' compensation law to establish a fee schedule covering the costs of ambulance services provided to injured employees and to clarify that the employer or its insurer is liable for the payment of such services. The bill excludes air ambulance services "to the extent preempted by federal law."

As legislators and other policy makers around the country consider the costs of ambulance services, FAIR Health is ready to help Florida, other states and the federal government by providing data that can enhance their understanding and consideration of the issues arising from ambulance costs.

ISSUES AND RECOMMENDATIONS

The Office of the Insurance Consumer Advocate brought stakeholders together in an effort to gain perspective on the air and ground ambulance industry to help provide solutions to protect consumers from financial distress after suffering a medical emergency. After meeting with stakeholders over the course of a year, the Insurance Consumer Advocate (ICA) considered various issues presented, stakeholder viewpoints, and recommendations. Ultimately, the ICA identified four major findings that impact the issue of emergency medical transportation costs and consumers' ability to rely on their health insurance plan to cover all medical costs when an emergency arises. The recommendations made here are the result of the ICA's independent analysis of each issue after considering all input made by stakeholders, interested parties, and consumers.

Implicit in this document are assumptions about the nature and future of emergency medical transportation (EMT) services and the environment in which EMT will exist. These assumptions are that EMT services will continue in their present existence as a touchpoint between the public safety, public health, and healthcare systems, and that they will continue to exist in current form into the future. For purposes of this report, the assumption has also been made that EMT ground services will continue to be provided at the local level and that air ambulance services will still be regulated by federal authority. In terms of funding, the assumption is made that applicable federal and/or local funding and financial support for EMT services will remain either constant or decrease due to the trend in fiscal restraint in the foreseeable future. As such, this report only addresses private insurance consumers, and does not seek to address the concerns of the uninsured or those covered by federal healthcare programs.

Of particular importance to the lens through which these recommendations are made is the assumption that there is currently a lack of comprehensive, available information regarding emergency medical transport systems and outcomes. Because of the diverse nature of its makeup, EMT research is fragmented and is often conducted on one particular emergency medical services system. Additionally, the emergency medical services industry has rapidly expanded in the last 30 years, despite slow progress in developing related research. The time and resources required to complete the research necessary are beyond the scope of the Emergency Medical Transportation Working Group's (EMT Working Group) mission and beyond the scope of the Florida Office of the Insurance Consumer Advocate's dedicated purpose. Therefore, it will be necessary for the purposes of this report to rely on the information presented at the EMT Working Group meetings and other limited information in order to make recommendations in the best interest of Florida insurance consumers.

Issue #1: Consumer Hardship

Consumers continue to express frustration over balance billing of emergency medical transport charges. This practice occurs when consumers are in a vulnerable, emergency state with no time to make choices or have options presented in the fight to save their lives. Because of this, policymakers have taken measures to remove consumers from the industry fight over the notion of "fair" compensation for services rendered. However, consumer feedback solicited during the Emergency Medical Transportation Working Group (EMT Working Group) highlighted the drastic financial strain that consumers face when saddled with an emergency transport bill.

Direct feedback from consumers solicited by the Insurance Consumer Advocate's EMT Working Group showed a high general lack of knowledge over the funding mechanisms for the emergency health care services provided at the local level. Feedback also showed that consumers were frustrated over the coverage restrictions in their insurance plan and did not understand why their insurance plan was not reimbursing the total charges. Generally, consumers did not express frustration over the amount of the charge itself or whether the charge seemed "fair" for the service provided. However, many expressed the notion that they would have expressly denied transport if they had known they would be out-of-pocket for some, or all, of the cost of transport.

With regards to ground transportation, the general lack of knowledge over the funding mechanisms and reimbursement measures impacts consumers frequently. According to EMT Working Group stakeholders, consumers can expect to be balance billed for services when the provider requests payment of services and is reimbursed according to the insurer's usual, customary, and reasonable rates (UCR).[40] As FAIR Health reports, the average Florida charge for a ground ambulance service with Basic Life Support is $557.[41] From an affordability standpoint, many consumers have expressed frustration over being responsible for the balance of the costs, and are under the impression that either local taxes or healthcare insurance should have covered them in their time of need.

Direct feedback from consumers on emergency air medical transport centered largely on the frustration of being saddled with an extremely high bill after experiencing a very traumatic medical event. Consumers again seemed to lack a general understanding of current funding models for private air ambulance transport. The current, privatized business model of air medical transport relies on being able to bill for service, aircraft, and staff. Air ambulance companies will often charge above what insurance companies will pay, resulting in many insurance consumers being unable to cover the difference. Air ambulance companies want to increase the consistency of reimbursement for their billed amounts, while retaining a margin of profit in order to maintain or expand their services and quality. Without the assurance of payment paired with what many air ambulance companies deem inadequate, and with low reimbursements from Medicare and Medicaid, meeting operating costs and making a profit create an urgency that sustains aggressive billing practices.

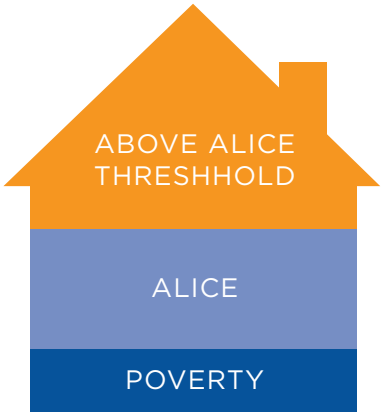
Air ambulance companies frequently lobby for immediate financial relief from increases in government reimbursements for the transportation of Medicare and Medicaid patients. However, in pursuing these alternative financial solutions, air ambulance companies do not decry their aggressive balance billing practices against private insurance consumers – who pay 231% of the median cost per transport.[42] Nationwide, for-profit air ambulance companies seek the highest possible government reimbursements and pursue balance billing payments to a degree that can result in bankruptcy and foreclosure for those consumers billed.

The air medical transportation industry was once provided primarily by local municipalities, similar to ongoing ground medical transport, and billing issues were not as prevalent as they are now. The Aviation Deregulation Act of 1978 (ADA) created an environment where invoking federal preemption has prevented efforts for collaboration and contracting with other stakeholders in the broader emergency medical transportation (EMT) landscape. States that attempt to pass consumer protection legislation are immediately challenged using the ADA as precedent, making regulation of the air medical transport industry and protection of insurance consumers largely unsuccessful. Passage of the ADA, although intended for increasing competition among commercial airlines, has attracted tremendous capital from private investors seeking to harness the inability of regulation by states for financial gain.

As an essential health care service, however, air ambulance companies face escalating healthcare costs, along with training pilots and clinical crews, maintaining licensures and certifications, acquiring new technologies for emergency services, and more. The financial motivation for privatizing a public health service fundamentally changes the intent of providing those emergency medical services, which leads to aggressive billing practices and collections. While members of the air medical transportation industry recognize that this type of billing is unsustainable for meeting operational and healthcare costs, there is no indication that they intend to discontinue balance billing insurance consumers.

In 2017, Senator Jon Tester of Montana introduced the Isla Rose Life Flight Act (S471). This federal legislation would end ADA preemption of state or local laws/regulations related to air ambulances. The bill was referred to committee and no further action was taken in 2017, however, the bill was reintroduced in 2018. Several state legislatures are considering or have passed legislation urging members of the U.S. Congress to eliminate preemption of state action with respect to air ambulance rates so that states can regulate reimbursement for air ambulance services. Pennsylvania, Montana, and Utah each passed laws in 2017 urging the U.S. Congress to amend the ADA, and similar legislation was introduced in South Carolina in 2018. Colorado also passed a law in 2017 removing a state statutory prohibition on setting standards for air ambulance services preempted by the ADA. Until federal attempts at deregulation are successful, consumers will continue to have little recourse when saddled with an extremely high, unexpected bill.

The Insurance Consumer Advocate remains concerned over the frequency and severity of both air and ground balance bills given the diverse and often income constrained population of Floridians. From an affordability standpoint, consumers cannot continue to be saddled by unexpected medical bills while navigating other issues that impact their financial stability. Other socioeconomic issues such as the rising cost of housing, transportation, child care, and food are straining the working Floridian who struggles to earn enough to provide stability to their family. The United Way of Florida, a network of 31 community based organizations, has studied this issue. From 2007 to 2012 alone, Florida became less affordable and the cost of basic housing, child care, transportation, food, and health care increased by 13%. In Florida, 67% of jobs pay less than $20 per hour, with three-quarters of those paying less than $15 per hour.[43] Geographically speaking, nearly 50% of Central Florida families do not earn enough to consistently cover the basic living expenses highlighted by the United Way's definition of asset limited, income constrained, employed (ALICE)



Florida 7.5M Households[45]

threshold.[44] In Miami-Dade County, when the basic needs of families are accounted for (housing, child care, food, transportation, health care, taxes, etc.), the budget for a family of four is $56,760 per year (for a single person that amount is $22,488).[45] Floridians simply cannot continue to afford any surprises in the form of medical bills after utilizing their already strained budgets to provide for health care coverage for their families.

Ground EMT Collections: Best Practices

Due to the frequency of balance bills experienced by Florida consumers in the ground emergency transport landscape, the Insurance Consumer Advocate recommends that steps be taken to better engage with the consumer on billing and collection practices by providers. Providers must be more transparent in dispelling the myth of full tax funding and provide consumers with more information about the EMT service costs in their area. Still, more can be done to assist the consumer after they have suffered an emergency medical event and are billed for their transport service. After contacting their insurance company and finding that the bill will not be satisfied, consumers may feel lost in the negotiation process. To complicate matters, some ground EMT providers contract with collection agencies to seek payment on balance bills, inserting another player into the maze of resolving the bill. Some providers may even send unresolved bills to collections, negatively impacting a consumer's credit in the process.

Some comments received directly by consumers expressed a lack of knowledge of the collections process while expressing frustration over the amount of the cost. One way to provide information to consumers is to directly publish any and all third-party collection agencies that the provider works with for accounts receivable. Second, providers should clearly designate on the balance bill a contact number for the provider, collection service, or third-party that has the authority to resolve the bill as well as a notice about available financial hardship program. Providers should also clearly outline any financial hardship policies, programs, or collection practices (such as payment plans and credit card policies) commonly made with patients on their website for review. Clarity about the best point of contact, and information on the most common resolution methods and/or financial assistance programs available to consumers will lessen the financial/emotional response to the balance bill and likely result in positive outcomes.

Recommendation: Ban Aeromedical Balance Billing

Due to the severity in financial hardship experienced in the air emergency transport landscape, the ICA recommends that steps be taken to deregulate the air ambulance industry from coverage under the federal ADA, giving states the authority to prohibit the practice of balance billing consumers. This position has been supported by many stakeholder groups, including the National Association of Insurance Commissioners, consumer advocacy groups, various state regulators, and more. Some states have already taken measures to alleviate unexpected medical bills for emergency medical transportation services. For example, during their 2016 session, West Virginia enacted air ambulance legislation that applied exclusively to the state's public health employee insurance plan. Their legislation used the Medicare reimbursement rate for various services as a cap on the amount that non-contracted air ambulance services may collect. This effectively prohibited balance billing in the air EMT context, but only as applied to state employees or their dependents.

In a report published by the U.S. Government Accountability Office on July 27, 2017, it was recommended that federal collection of air ambulance data be analyzed to study objectives and address risks.[46] Such risks include unfair or deceptive practices. While transparency and study are important, the most effective remedy to provide consumers with robust protection is through clarification of the ADA to allow any state to enact or enforce a law or regulate relations to network participation, reimbursement, price transparency, and balance billing for an air carrier that provides air ambulance services. Therefore, the ICA joins with other state regulators in supporting data collection at the state level and ultimately deregulating the air ambulance industry from coverage under the federal ADA.

"The majority of the problems we have here are not based on the EMS provider, it's based on the insurance industry's unwillingness to pay what they should be paying. High deductibles, raising of insurance premiums, and all those others things do leave a negative impact on the consumer." – Chief Dan Azzariti, Florida Leagues of Cities

Federal deregulation will help states address their population's needs, address state level market concerns, and ban the practice of balance billing to protect consumers from extreme financial hardship after suffering a medical event. As with most healthcare issues, inadequate payment from federal payers and uninsured patients impact the industry's ability to thrive and play a role in the rates charged to insured consumers. Medical professionals use air EMT services to transport critically ill patients to the nearest facility for care without regard for the patient's ability to pay. The ICA supports the industry's ability to continue providing services to all patients. However, the funding challenges should not be placed on the backs of insured consumers who purchase insurance to protect them from high medical costs. It is up to both providers and insurers to work out the billing dispute reasonably through contracting and not involve the consumer struggling to regain their medical and financial footing.

Issue #2: Fee-For-Service Modeling in Ground EMT Services

The ground emergency medical transportation (EMT) industry has been built on its primary role – providing transport from the place of medical emergency to the nearest facility for care. This role is the centerpiece to its billing structure that has existed since the industry's inception. EMT providers bill based on a fee-for-service model. That is, services provided are itemized and paid for separately. However, most payers require that the patient be transported to a facility in order for the provider to receive payment. Fee-for-service revenue comes from five main sources: Medicare, Medicaid, private insurance companies, private paying patients, and special service contracts.[47]

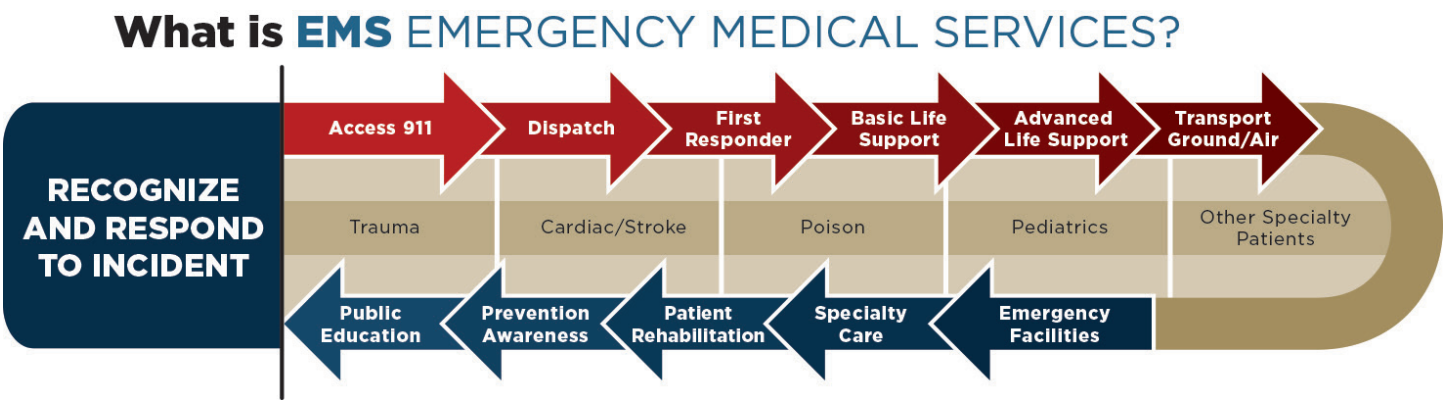
Treatment by a first responder without transport can be an effective means to deliver necessary care to a patient. The emergency transport industry has expanded to provide first responder type services combining life-saving technology, medical training, equipment upgrades, and other available medical services folded into its transport capabilities. The transport vehicle that shows up to take care of an individual is an outfitted, mobile life-saving device. The individuals that come to a patient's aid are no longer transport personnel, they are highly skilled health care providers.

As ground EMT transportation has expanded in its offerings, the billing structure for the service has remained unchanged. Largely, ground EMT providers only bill for their services when a transport is completed. This means that a large number of emergency calls can end up with no patient transport, even though some services (responding to the call, providing health care services on site, etc.) may have been provided. As one of the Emergency Medical Transportation Working Group (EMT Working Group) members reported for his area, over 20% of the dispatched ambulance responses end in treatment but no transport of the patient, which means the EMT provider will not receive any payment for these calls and treatments.[48] Overall, it is estimated that 25% to 30% of all dispatched ambulances in Florida involve treatment but no transport.[49]

"But out of all these services and medical care options that are provided by EMS agencies across the state of Florida, insurance only pays for transport. Only when we transport."
– Mac Kemp, Florida Association of Counties

Stakeholders and members of the EMT Working Group have identified this billing scheme as an antiquated model of reimbursement. The current EMT payment scheme is not reasonably aligned with its self-proclaimed mission to be faster and more efficient first contacts in patient health care. Continuing in a fee-for-service model and subscribing to a comprehensive first responder mission are incompatible, and leave EMT services unable to adequately fund their programs without relying on cost shifting to consumers. The funding system of emergency medical services needs to therefore adapt to realign with the current goals and mission of the industry.

The Insurance Consumer Advocate (ICA) finds that the existing ground EMT model has not evolved as community needs for emergency and non-emergency health care have changed. This evolution will continue to be necessary as trends in increasing health care costs, overuse of emergency rooms, and the need for long-term care services rise. Increasingly, emergency medical services are becoming the social safety network for many communities in that they provide some level of primary care for patients that experience any type of medical, emotional, or mental health issue. Often, EMT transport services are dispatched along with police when an unknown



issue is reported by a 911 caller. The unknown factor when this dispatch occurs is whether the transport service is actually rendered, or whether the emergency medical service providers will be called on to assist a 911 reporter with whatever personal, and maybe not physical, need arose for the call. EMT and its medical services are becoming more fully integrated into the overall healthcare system, and the need exists for the EMT billing structure to change accordingly.

Some insurers have already taken steps to change their billing practices so that medical services rendered at the scene are covered regardless of transport. Starting January 1, 2018, Anthem Blue Cross Blue Shield (Anthem BCBS) will begin reimbursing some emergency medical services (EMS) providers for medical treatments even if the EMS provider does not transport the patient. For Anthem BCBS, this program will be offered for Healthcare Common Procedure Coding System (HCPCS) A0998-coded 911 responses in 14 states: California, Colorado, Connecticut, Georgia, Indian, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin.[50] The ICA encourages other providers, insurance companies, and healthcare professionals to closely study the effects of the Anthem BCBS decision and promote the growth and evolution of the EMT industry by providing real comprehensive reimbursement for the life-saving services rendered to patients.

"EMS is not a business; EMS is health care."
– Mac Kemp, Florida Association of Counties

Recommendation: Reform Ground EMT Billing Models

Insurance companies and ground EMT service providers should move to a value-based billing model. By shifting to a value-based model for ground transportation, providers can charge for treatment that does not specifically include transportation of the patient. Treatment by a first responder without transport can be an effective means of delivering necessary care to a patient. This would be a reversal of the current fee-for-service model which requires that the patient be transported and prevents EMT services from billing an insurance company for care if no transport is provided. As an emerging healthcare trend, value-based reimbursement is a comprehensive payment model that bases a provider's payment on the value of care delivered.[51] Often, this model includes an incentivized payment structure that is tied to improved patient experience and clinical outcomes. This type of coordinated care creates a system that values quality over the quantity of services provided.[52]

"I really do believe and our association does believe that we need to move to a value-based contracting system. To move to a value-based contracting system you have to hit that last word, contracting." – Wences Troncoso, Florida Association of Health Plans

This type of fee structure is currently being promoted by federal payers that want to promote organizational models that reward coordination, quality, and cost management. As the trend emerges, many plans and providers are entering into some form of alternative payment model with an emphasis on value. These programs and their degree of adoption are highly dependent on market dynamics, stakeholder relationships, institutional features, and other factors.[53] However, the degree of uptake in modernizing the payment model is complex when contracting relationships between stakeholders have historically taken a "win-lose" approach.

"A lot of patients don't need to be transported to the emergency room, they don't need that ambulance bill to be transported, that don't need that huge emergency room bill. They need other services that actually provide better care for them in the long run." – Mac Kemp, Florida Association of Counties

Revamping the fee structure would allow EMT services to recoup costs from insurance companies. It would also allow EMT services to continue expanding and raising the standards for health care by implementing the services necessary to benefit a community's population. Greater access to health care at all levels is a way to increase affordability and sustainability for the future. If billing models provide reimbursement to EMS providers for on scene care, there may be a long-term cost savings to insurers, ultimately benefiting consumers. As insurers like Anthem BCBS begin to apply the value-based model to EMT services, further evaluation is needed to determine the long-term effectiveness and impact on the quality of care. Although critics may argue that there may be a lot of administrative strife in revamping the system to fit changes in how EMT services are currently being delivered, the ICA finds that Florida consumers will benefit from the transition to a value-based, or more comprehensive modeling structure, for emergency medical transportation services.

Issue #3: Out-Of-Network Providers

Emergency medical transportation (EMT) providers and insurance companies should engage in meaningful, good-faith contract negotiations in order to keep services in-network with improved oversight by regulators to ensure greater network adequacy for consumers. Testimony provided at the Emergency Medical Transportation Working Group (EMT Working Group) meetings identified plans with a limited number of available in-network providers, otherwise known as "narrow network" plans, as a major issue. The effect of narrow network participation results in consumers being balance billed for services. The balance billing issue exists primarily because EMT providers are unwilling to negotiate the terms of what they consider a fair price, and insurance companies are unwilling to negotiate the terms of what they consider a fair reimbursement rate for service. Although Florida's legislation dealing with balance billing, House Bill 221, prohibited balance billing for care received at emergency facilities and in-network hospitals by out-of-network providers, patients transported via ground or air ambulances may still receive unexpected bills. This places consumers and their families directly in the middle of a fight between two very powerful industries.

Network Adequacy

Network adequacy is the ability of an insurer to provide consumers with timely access to a sufficient number of in-network providers. Insurers generally define the number of providers in their networks, while regulators are tasked with overseeing network adequacy requirements and exploring access disparities among communities. Historically, oversight of network adequacy has varied significantly from state to state, and in many cases, has not kept up with changes in health plan designs. With the emergence of the Affordable Care Act, many insurers offered health plans with lower premiums in exchange for limited access to healthcare providers. This trend created complex challenges for regulators responsible for ensuring that consumer interests and access to care were protected.[54]

2013 Florida Map[57]

In 2015, The National Association of Insurance Commissioners (NAIC) published the Health Benefit Plan Network Access and Adequacy Model Act, which lists standards for the creation and maintenance of in-network providers by insurers to help ensure network adequacy. According to the Health Benefit Plan Network Access and Adequacy Model Act, "A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay."[55] The Act goes on to include the network adequacy recommendation that, "Covered person shall have access to emergency services twenty-four hours per day, seven days per week."[56]

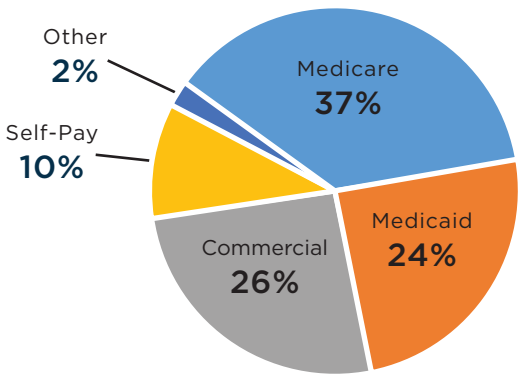
Network adequacy is not regulated at the federal level and only a handful of states provide regulation at the state level. The primary tool regulators use to monitor network adequacy is through consumer complaint data.[58] States monitor and

track the number and details of complaints in an effort to supervise network adequacy among insurers. In Florida, general network adequacy oversight is not under the purview of the Florida Office of Insurance Regulation. The Agency for Health Care Administration licenses Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs) and has been tasked with network adequacy oversight. For plans offered through the Affordable Care Act health exchange, network adequacy is not governed on a state level.

While regulating network adequacy at the state or federal level comes with its own hurdles, consumers are shouldering the burden of this issue. When consumers are faced with an inadequate network, they are forced to use out-of-network providers which may lead to their insurer not paying a medical bill and the consumer receiving a large balance bill that they are now responsible for, even though they have health insurance. Regulators, insurers, and medical providers all have a responsibility to their consumers to ensure they have reasonable access to the health care for which consumers are paying premiums. If medical providers and insurers are not willing to reasonably negotiate, the consumer is stuck in the middle paying both an insurance premium and out-of-network medical costs. Insurers and medical providers should strive to achieve the network goals provided by the NAIC in its Health Benefit Plan Network Access and Adequacy Model Act, and regulators and policymakers should ensure that consumers have a medical network that is reasonably accessible and able to meet their needs, including access to emergency services and transportation.

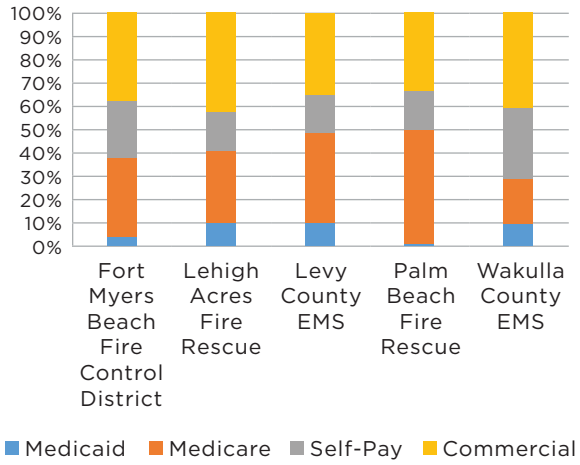
The contracting challenge centers around a differing perspective on how the rate is initially derived. In Florida, all providers seeking to provide basic life support and/or advanced level life support need a Certificate of Public Convenience and Necessity (COPCN) license. Due to COPCN license requirements, all provider fee schedules are approved by the local county or governing municipality. The fee schedule established is the same for each patient in a "one price fits all" scenario and is applied equally regardless of the payment source. Therefore, considerations are made for both insured and uninsured patients when setting rates. For insured consumers, requests for payment of services using approved fee schedules are adjudicated per the patient's health plan and may result in a balance that is then passed on to the consumer for reimbursement.[59]

Payor Mix of Emergent Transports
AAMS 2015 Study



Data from: Air Medical Services Cost Study Report[60]

Payor Mix
2015-2016



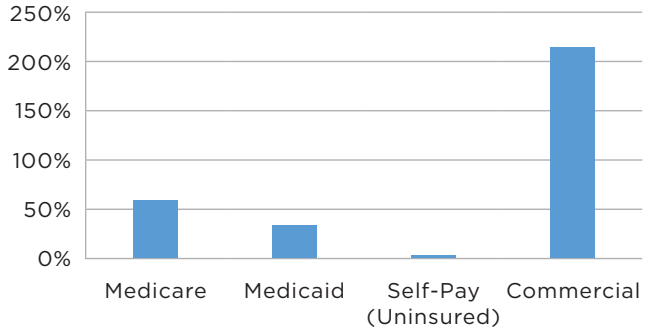
It is common practice for providers to balance bill consumers because of revenue shortfalls experienced by servicing Medicaid and Medicare subscribers. Stakeholders commented that before 2002, the Medicare base schedule reflected rates that more aligned with a provider's usual and customary charges. However, after 2002, the reimbursement shifted away from the provider's

cost for service to the insurer's usual, customary, and reasonable rates. EMT providers point to the significant losses in revenue they experience from federally-regulated caps on Medicaid and Medicare payments as one justification for balance billing privately insured patients to recoup their losses. While the industry must adhere to Medicaid and Medicare requirements for ground and air EMT services, there are no standardized rate regulations for providing services to privately insured consumers.

EMT providers also commented from a rate and reimbursement perspective regarding attempts to contract with insurers to become in-network providers. If a provider becomes in-network and contracts with an insurer, the total reimbursement is defined by the contract and is paramount to all applicable state statutes, rules, and billing regulations. Contracted reimbursements may lead to complexities for providers and may not encourage contracting efforts given the matrix of reimbursement schedules and billing regulations via Medicaid, Medicare, Florida statutory rates, and others. For example, if an EMT provider responds to an automobile accident and provides a patient service, the reimbursement rate for that service may be different based on whether the patient is uninsured, insured through a federal program, or insured commercially. Under the Florida Personal Injury Protection (PIP) statutory guidelines, rates for certain services are set at an allowable rate. If the EMT provider's mileage rate for that service call is lower than the allowable rate under the Florida Statute, the provider is essentially giving up needed dollars. The EMT provider may give up more if it is a contracted provider, because insurers typically pay 80% of the statutory rate. Essentially, by maintaining its non-contracted status, the EMT provider saves a rate setting inconvenience because the insurer will determine reimbursement per the patient's health care plan. Any remaining balance is then passed to the consumer for collection.

"In Leon County, we recently conducted a certified study of our billing and receipts from insurance, and we found that among patients that actually have insurance, and not all patients do, that insurance pays only on average, about 50% of the actual cost of providing services." – Mac Kemp, Florida Association of Counties

Percentage of Costs Covered



Data from: Air Medical Services Cost Study Report[60]

Air Ambulances

The Air Medical Services Cost Study Report showed that in 2015, the annual cost for 191 air medical providers, with a total of 545 bases, was funded by multiple payment sources. The bill for service is priced differently based on the patient's payment method. On average, Medicare patients are billed 59% of the cost for services, Medicaid is billed 34%, uninsured patients are billed 3%, and insured patients are billed 231% of the costs. This data was based on a $10,199 median cost per transport for all payers.[60] Privately insured payers are paying almost four times more than Medicare and almost seven times more than Medicaid.

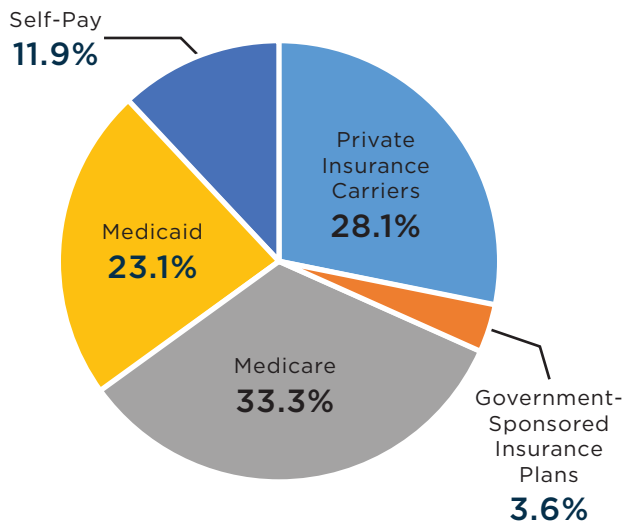
In 2015, one-third of air ambulance companies reported negative profit margins (meaning, they did not make a profit nor receive payment enough to maintain their operations). In this case, cost containment measures shift the burden of treating

uninsured patients and receiving inadequate payment from governmental payers onto other payers (the private insurers and self-pay market). Without regulations on rates, routes, or billing practices, air ambulance companies are free to establish varying rate structures for different types of payers – urban, rural, Medicare, Worker's Compensation, uninsured, privately insured, self-payers – to support the recoupment of costs.

The picture is much the same for Air Methods when looking at their 2014 numbers. The Air Medical Services Cost Study Report reported the sample payer mix was comprised of 37% of payers being Medicare, 24% being Medicaid, and 26% being commercial insurers. The remaining 12% were comprised of Other and Self-Pay payers. During 2014, Air Methods reported a similar mix of payers, with 28.1% of their payers being commercial insurers, and 33.3% and 23.1% from Medicare and Medicaid, respectively.[61] For both the Air Medical Services Cost Study Report and Air Methods, more than half of their patients are paying with Medicare and Medicaid. Stakeholders report that this has a negative effect on their operating margins, due to the low reimbursements rates for Medicare and Medicaid.

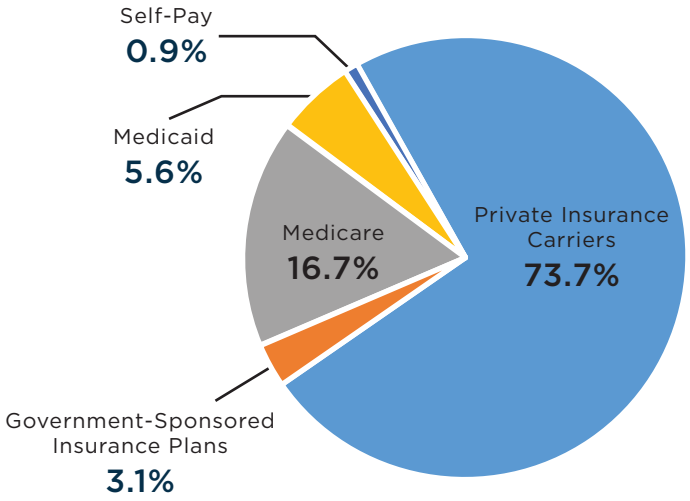
Air ambulance companies around the country have been excluded from legislation prohibiting balance billing because of current federal preemption regulations on rates, routes, and

Air Methods - 2014 Transport Mix



Data From: Air Methods[61]

Air Methods - 2014 Revenue Mix



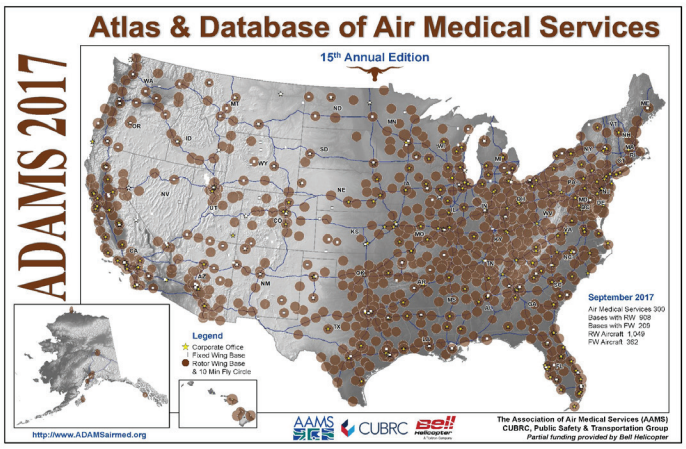
Data From: Air Methods[61]

services resulting from the Airline Deregulation Act of 1978 (ADA). The ADA aimed to increase competition in air passenger service by giving consumers the option to select their flights based on criteria including ticket prices, travel routes, and schedules. This act was passed prior to the development of emergency air transportation; therefore, it lacks any differentiation between current air ambulance systems and commercial airline practices. Unlike the commercial travel sector and most economic theories in general, air ambulance competition may increase costs. This is because the high fixed cost of business – aircraft, pilots, and trained medical staff – remains the same regardless of competition levels. However, the demand (i.e., patient transports) in an area may remain relatively constant even though competition and the number of providers may have increased. When competition in the industry increases, the fixed costs remain and must be paid from a smaller number of flights completed per provider, which in turn, can lead to higher prices billed to patients by the provider.[62]

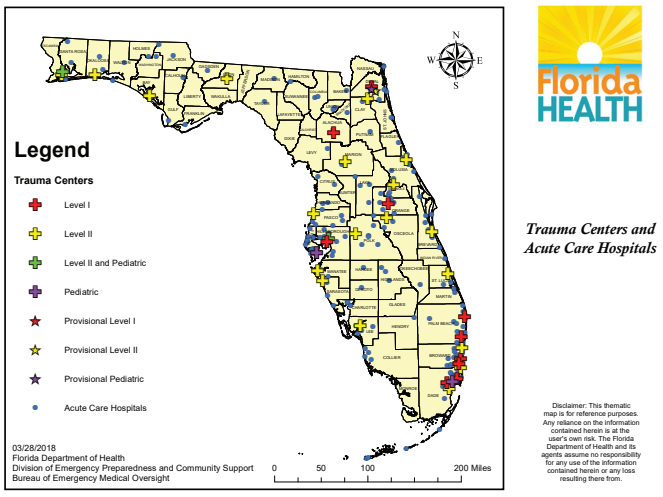
An air ambulance base needs a particular volume of patients to transport in order to meet the financial requirements of keeping a base open. Adding competition between aeromedical bases may decrease the number of patients transported for each base, which in turn decreases revenue for each base. As a result, the same patients are being served by an overpopulation of providers in a given area – driving up the cost of service in order for the bases to meet their operating revenue needs and remain open.[63] A combination of increased bases and the current centralized federal regulations governing the industry may have helped air ambulance service costs to skyrocket.[64] The current cost of air ambulance services has caused a myriad of problems for patients as they receive immense bills and often incur severe debt, despite having insurance coverage.

One consumer provided testimony to the Insurance Consumer Advocate (ICA) and shared that her husband was air lifted from an emergency room to a hospital due to a massive heart attack. The decision to airlift was made by the emergency room physicians based on the patient's medical condition at the time. The insurance carrier paid the ambulance provider $6,000 for the transport, and the air ambulance provider balance billed the consumer for the remaining $54,000 of the $60,000 transport bill. Another consumer had an accident which required air transport to the nearest trauma hospital. The consumer paid $3,540.71 towards their deductible, and their insurance carrier paid $1,909.62. However, the remainder of the air transport bill, which was $27,447.66, was balance billed to the consumer. All consumers who submitted air ambulance experiences to the ICA for consideration expressed frustration and shock over the high bill, as they were unaware of the likelihood they would be balance billed for the service.

The Atlas & Database of Air Medical Services (ADAMS), a database created by the Association of Air Medical Services and CUBRC's Public Safety and Transportation Group out of Buffalo, New York, covers 92.5% of air medical services in the U.S. with 1,411 aircraft operating from 1,065 bases. ADAMS data shows that from 2010 to 2014, medical Helicopter Emergency Medical Services (HEMS) nationwide increased by more than 10%: from 900 to 1,020. Meanwhile, over the same time period, a report done by the Health Care Cost Institute (HCCI) does not show a proportionate increase in the number of transports per Medicare or private health insurance consumer. During that same timeframe, the number of air ambulance transports per 10,000 members for Medicare Advantage was 0.87 for fixed-wing and 14.07 for rotary-wing air ambulance. By 2014, the numbers had decreased to 0.43 for fixed-wing and 12.00 for rotary-wing air ambulance.



Atlas and Database of Air Medical Services[67]



Trauma Centers and Acute Care Hospitals[68]

A somewhat similar trend is seen for the commercially insured, with 2010 having fixed-wing air ambulance transports at 0.28 and rotary-wing air ambulance transports at 3.01. Data from 2014 showed fixed-wing air ambulance transports increasing to 0.33 but rotary-wing transports decreasing to 2.58.[65] This industry's expansion has improved access to air medical care – increasing the U.S. population coverage within a 15 to 20-minute response area from 71.2% in 2003 to 86.4% in 2016.[66] Across the 50 states and the District of Columbia, 71.9% of interstate, 67.1% of principal arterial miles, and 58.5% of minor arterial miles are now within a 20-minute air medical rotary-wing response.[67] The growth and expansion of emergency air medical services requires higher overhead costs to maintain bases and aircraft, ensure aircraft availability, and provide staffing when emergencies arise.

There has been a very notable expansion of air ambulance providers over the past 15 years. This increase in air ambulance providers has had a profound effect on the cost consumers pay for the service. Some believe the closure of more than 80 rural hospitals since 2010 has helped drive the increase in the number of air ambulance providers.[69] With the increase in for-profit air ambulance bases, the pressure on financial performance has also increased. The pressure for aggressive business models creates an environment that supports air ambulance providers staying out-of-network and not contracting with insurers.[70]

One common argument against regulation of the air ambulance industry, including network adequacy, is the ADA. Due to the ADA, states are unable to regulate the rates, routes, or services of any air carrier, including air ambulance providers.[71] However, network adequacy is still an area regulators and policymakers need to study. Having reasonable access to necessary emergency medical transportation services can best be achieved when both providers and insurers work together.

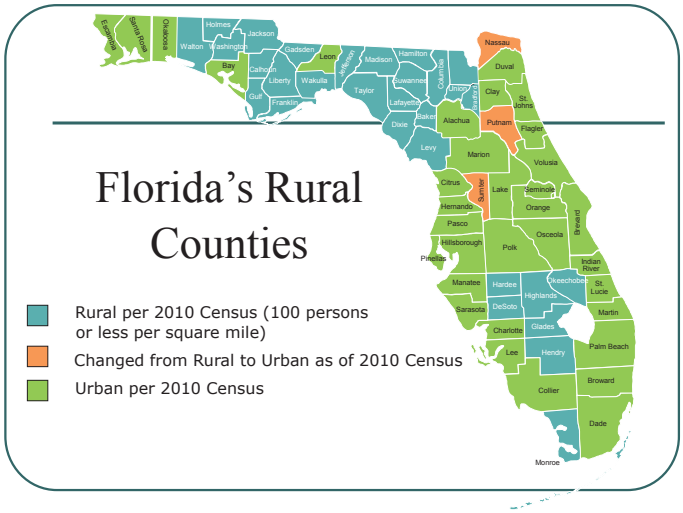
Impact on Rural Communities

Based on the current network of ground and air ambulances, most Floridians are within an hour of a Level I or Level II trauma center.[72] However, it is Florida's rural communities that most rely on emergency air medical services. Across the nation, rural hospitals have been closing at a rate of nearly one per month since 2010, putting those who live outside of metropolitan areas beyond the reach of trauma centers. As of January 2018, in Florida, there are 36 state-verified trauma centers, all of which are located in the most densely populated areas of the state. Even under the best circumstances, a ground ambulance is unlikely to reach the closest trauma

Hospital ER Trauma Center Levels

Level **I**	Level I Trauma Center is a comprehensive regional resource that is a tertiary care facility central to the trauma system. A Level I Trauma Center is capable of providing total care for every aspect of injury – from prevention through rehabilitation.
Level **II**	A Level II Trauma Center is able to initiate definitive care for all injured patients.
Level **III**	A Level III Trauma Center has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations.
Level **IV**	A Level IV Trauma Center has demonstrated an ability to provide advanced trauma life support prior to transfer of patients to a higher level trauma center. It provides evaluation, stabilization, and diagnostic capabilities for injured patients.
Level **V**	A Level V Trauma Center provides initial evaluation, stabilization and diagnostic capabilities and prepares patients for transfer to higher levels of care.

Data From: American Trauma Society[78]



Florida's Rural Counties[77]

center or specialist in the 60-minute time frame physicians call "The Golden Hour."[73] According to physicians and EMT providers, this is the hour immediately following a traumatic injury when medical treatment to prevent irreversible internal damage and optimize the chance of survival is most effective. The addition of air ambulances increases the likelihood that all Floridians will have access to a trauma center within 60 minutes.

Network adequacy can be especially crucial in rural areas where emergency medical services (EMS) have traditionally been handled by volunteers.[74] Over the years, the number of healthcare facilities in rural areas have declined. Since January 2010, the Cecil G. Sheps Center for Health Services Research found that 87 rural hospitals have closed.[75] In turn, this has placed a greater reliance on EMS.

A study done in July 2017 by the American College of Emergency Physicians showed that the average interval between a call to 911 and EMS arriving on the scene was 7 minutes in the U.S. However, if you live in a rural area, you could be waiting much longer for EMS.[76] The study found that the average wait time in urban and suburban areas for EMS was 6 minutes, but the average wait time increased to 13 minutes for those in rural areas. As of 2016, the Florida Department of Health's State Office of Rural Health lists almost half of Florida's counties as rural, meaning per the 2010 Census there were 100 persons or less per square mile.[77] That puts 30 of Florida's 67 counties as rural with the potential for longer EMS wait times for critical, life-saving services. The study by the American College of Emergency Physicians also made a very critical point, stating that when a consumer is suffering from a severe bleed, life-threatening allergic reaction, or cardio-pulmonary arrest, the time it takes for EMS to arrive on the scene can mean life or death.

These statistics highlight the scarcity of available EMT resources and the critical need for patients in rural communities to be able to timely access emergency care. It is undeniable that emergency ground and air medical transportation save lives, and consideration of these services are crucial in evaluating the best interests of Florida consumers.

Recommendation: Increase Access to In-Network Emergency Medical Transportation Providers

The Insurance Consumer Advocate finds that emergency air and ground medical providers and insurers should successfully negotiate contracts that provide fair and reasonable compensation for services, allow Floridians timely access to care, and protect insurance consumers from balance billing. The data presented during the EMT Working Group has shown differing approaches to this recommendation when considering ground versus air notions of fair and reasonable rates.

Ground Ambulances

Data provided by FAIR Health, Inc. shows that on average, Florida EMT charges were comparable to that of other selected state charges. As mentioned earlier, for basic life support emergency transport, Florida had an average cost of $557, while Georgia's average was $824, New York's was $752, and Texas' was $930. However, data also showed a lack of general competition among providers, which is a touchpoint in the conversation over fair and reasonable price points for services. Also, prevalent from the EMT Working Group's discussions is the need for additional rural service providers, and increased reimbursement to fund those operations so they continue to run to benefit the community. Ultimately, a holistic approach to the issue is warranted, with each side presenting their best data points to come to an ultimate, compromised, and fair compensation rate for differing parts of the state.

Air Ambulances

The notion of fair and reasonable air EMT rates dictates a different approach for a few reasons. According to the U.S. Government Accountability Office, air providers' median prices for helicopter air ambulance services have increased substantially over the last four years.[79] The responsibility to cover these rising costs largely falls on the consumer. Ambulance providers demand an enormously high fee, while insurers refuse to pay above their cap for the services. To the surprise of the consumer, the entire outstanding difference is expected to be covered out-of-pocket through balance billing. Due to the high profile of these charges and consumer stories, many states are looking to protect consumers. In 2016-17, the Montana State Auditor's Office put together an air ambulance working group and drafted legislation which would require out of network providers and insurance companies to negotiate with each other directly, rather than using the patient as the middleman. "It's not enough for us to say we're going to ignore this and handle these on a case by case basis where these families are miserable not just because of the health scare, but now because of the financial scare," explained Jesse Laslovich, Montana State Auditor's Office Chief Counsel.

"No providers ever feel like they're ever paid enough for the services that they believe they're providing, and insurers always believe there's wiggle room there in the price." – David Pizzi, Florida Blue

The pricing matrix for air ambulance rates is not transparent and not willingly disclosed by the industry. It is therefore unreasonable to assume that all stakeholders hold the necessary transparent data to be able to discern what constitutes a reasonable rate versus compensation. In fact, the

"People buy insurance for a reason, and we believe in that. Or employers' provider insurance which is a larger majority of the people that are insured, fully insured, in the state of Florida, for a reason. And that is because they expect their insurance to pay bills when they come or when they need services, and we agree with that. However, that requires contracting." – Wences Troncoso, Florida Association of Health Plans

U.S. Government Accountability Office identified this problem as a hindrance in the evaluation of air ambulance rates and recommended that the Department of Transportation "assess available data and determine what information could assist in the evaluation of future complaints" as well as "consider air ambulance consumer disclosure requirements."[80] Without stakeholder commitment to increased transparency on the cost and other components forming their rates, no meaningful contracting negotiations will be able to take place.

Collaboration & Network Adequacy Considerations for Both Ground & Air

Contracting that encourages collaboration among stakeholders is an emerging trend in the healthcare landscape. A growing number of healthcare organizations and insurers are beginning to form these partnerships and recognize that their efforts ultimately improve value, efficiency, and the use of health care services. It also reduces overall health care costs by keeping people healthier and encourages the patient to engage in their health care because expectations are clear and consistent across services. While most would agree that the healthcare system should be accessible with quality care at a low cost, competing priorities and the traditional "win-lose" approach to contracting may interfere in reaching a collaborative goal.[81] Additionally, when there is not a trusting relationship between stakeholders and there are varying viewpoints on the reasonableness of rates, it is easy to understand why traditional methods of contracting can break down. Using a collaborative approach, stakeholders must be more trusting and transparent in the process. They must feel capable of disclosing their organizational strategies, goals, cost of services, and comparative reimbursement rates among provider groups. As attempts to contract using this model unfold, stakeholders may find that they need a neutral third-party to evaluate transparent data, identify any inconsistencies, and promote the successful contracting process. An impartial voice may be needed to identify areas of opportunity, mediate areas of concern, and move parties forward in a manner that yields the best result for policyholders.

Collaborative contracting also promotes network adequacy and provides greater access to care for Floridians, both rural and urban. If stakeholders can effectively manage expectations and create a consensus about what constitutes adequate payment, stability in the EMT landscape can be achieved. Reaching a consensus regarding the reimbursement rate also benefits providers who will know how much they will be paid for various services and can budget accordingly.

It also allows the marketplace to self-regulate instead of pushing regulators to create policies or mechanisms to intervene in disputes between providers and insurers over payment rates, as some states have already done. Consumers should not have to shoulder the burden of analyzing, identifying, and arguing for appropriate charges or reimbursements in order to take themselves out of the balance billing equation. Successful and collaborative contracting among stakeholders who understand the benefits of compromise is a viable solution to this important consumer issue.

Establish Network Adequacy Standards

Florida regulators should include and monitor emergency medical transportation in its network adequacy standards. State regulators have a responsibility to provide meaningful oversight of insurer networks and protect consumers' health and financial wellbeing. Limited information exists with regards to the adequacy of Florida's EMT networks, and further exploration of this issue by regulators is warranted given the fact that there are areas in the state with limited or no providers. If stakeholders are unable to make contracting efforts a priority in the name of consumers' best interests, regulators should address this issue to ensure the best outcome for consumers. Therefore, regulators must ensure adequate access to providers, maintain affordability of coverage, and ensure that there is sufficient transparency for consumers to make fully informed decisions when deciding on their health care options.

Issue #4: Transparency & Consumer Education

Without comprehensive regulation requiring increased industry transparency, consumers with private insurance discover that it can be very difficult to know how much their health care services will cost. The only recourse for the consumer is to price out all possible emergency medical transporation (EMT) providers in their area in advance. Unfortunately, it is virtually impossible for individuals in emergency medical crises to anticipate: (1) when and where an emergency will occur, (2) which provider will arrive, (3) the extent of the medical services they will need, or (4) the hospital, trauma-center, or specialty facility where they will be transported. Florida consumers have reported their frustration to regulators and insurance companies because their out-of-pocket charges range from hundreds of dollars for ground ambulance to thousands for air transport. Most EMT providers charge a base or flat rate for medical services and additional per mile or per minute fees. The charges for these services vary by provider.

While it is impossible to foresee the circumstances of any emergency medical event, consumers have expressed a need for access to information about types and availability of services in their area and how those services are funded. Members of a community should be able to easily access the necessary information to see how their emergency service providers are budgeted, staffed, and utilized when services are needed. Community members should also be educated on the readiness levels, equipment, training, operations, and administrative costs of these services. An important piece of information for community members to know is how the local government budget applies to these critical services and whether a portion of the emergency services budget is attributable to private collection using balance billing.

"In my experience with critically ill patients that end up with a big bill because of a pre-hospital or inter-facility transport, and they don't understand how this could possibly be happening. You know, for those patients, what's not transparent to them is that it's not covered by their insurance. That's what's not clear. Because they think this is the very reason that they buy an insurance product, is because if the unthinkable happens, that then they're covered, and they're safe and taken care of, and they're not in financial ruin." – Dr. Kristin McCabe-Kline, Florida College of Emergency Physicians

Policymakers have addressed the issue of transparency in healthcare in an effort to educate consumers about the overall cost of health care. In 2016, Florida lawmakers passed House Bill 1175 titled "Transparency in Health Care" to require hospitals and surgery centers to provide access to searchable service bundles on their websites. In addition, the law required insurers to provide on their websites a method for plan members to estimate their cost-sharing responsibilities, including both in-network and out-of-network providers. Consumers must also be placed on notice, at the point-of-service, of the potential out-of-network costs. In 2017, Florida lawmakers passed transparency legislation in prescription drug pricing, giving consumers a frequently updated resource with pricing information on prescription drugs in Florida.[82] In the 2018 legislative session, Florida policymakers passed further reform in the area of prescription drug transparency requiring pharmacists to inform customers of less expensive, generically equivalent drugs and advising customers if cost-

sharing obligations exceed the retail price of their prescription.[83] The law also set registration and financial disclosure requirements for pharmacy benefit managers, otherwise known as "PBMs" (an intermediary that negotiates drug prices on behalf of insurers and HMOs), to promote transparency in how PBMs, Health Maintenance Organizations (HMOs) and insurers deliver the best value to patients.[84]

Stakeholder transparency and consumer education are important components in establishing and maintaining a relationship of trust between the policyholder, provider, and insurer.

Recommendation: Improve Transparency and Consumer Education

All stakeholders should work to improve transparency and consumer education in the area of emergency medical transportation. The Insurance Consumer Advocate finds a general lack of consumer understanding of ground and air EMT pricing, billing, and health insurance coverage. Inquiries related to all three were found to be common amongst consumers, with the majority being unable to utilize information to determine the services available in their area, the pricing for the service, or the coverage terms found in their healthcare plan. All stakeholders should commit to educating the public in order to combat misconceptions about the role of taxes in funding local ground EMT services, explain the shift to for-profit/privatized EMT providers especially for air ambulance services, make transparent the rate justifications and billing practices of EMT providers, and provide useful, comparative information for consumers considering purchasing insurance plans with emergency transport coverages. This lack of information and the inability to access it hurts consumers and prevents competition, quality, and efficiency in the marketplace. Insurers and medical providers should therefore make a commitment to be more transparent so consumers can appropriately shop their healthcare options, determine the existence of in-network providers in their area, and anticipate any potential out-of-network costs associated with emergency medical transportation services.

As legislators continue to craft policy to promote healthcare price transparency, efforts to compel access to price information must expand specifically to the EMT landscape. Consumers deserve access to information in order to evaluate their emergency medical needs and lessen the impact of surprise medical bills. Florida policymakers have a responsibility to comprehensively address all forms of health care, including ground and air EMT.

Consumer Testimonials

My wife fell and broke both kneecaps. She was taken to a hospital 4.5 miles away. The Fire Rescue bill was $681.

I was air lifted to a hospital due to a massive heart attack. My insurance paid the air ambulance provider $6,000, and I received a bill for the remaining balance of $54,000.

I had to call 911 for my husband who was incoherent. While my husband was in a coma, I received a bill for $735 for ambulance services. I found out my insurance doesn't pay for ambulance services.

My husband was taken by air ambulance to a hospital following a seizure and a stroke. Our insurance paid $2,512 of the $28,320 bill.

CONCLUSION: Commitment to the Consumer Voice in all EMT Policy Decisions

Emergency medical transportation (EMT) is a critical life-saving service provided to all Floridians. Families covered by private insurance are financially impacted when air and ground EMT providers bill patients for the difference between insurer reimbursements and the charge for service. A ground ambulance bill that amounts to a month's worth of rent, or an air life flight that may wipe out a college fund or years of saving for retirement results in a lasting financial hardship that deserves a balanced public policy solution and sound industry best-practices. Stakeholders on all sides have passionate viewpoints on the rising cost of health care, including costs related to emergency medical transportation. Each have a valid perspective on patient quality of care, pricing, billing, and funding. Unfortunately, each individual perspective fails to protect the consumer from surprise emergency medical transportation bills.

All stakeholders must work collaboratively to address this critical issue. Due to the severity in financial hardship experienced in the air emergency transport landscape, steps should be taken to deregulate the air ambulance industry from coverage under the federal Aviation Deregulation Act, giving states the authority to prohibit the practice of balance billing. Insurance companies and ground EMT service providers should move to a value-based billing model. By shifting to a value-based model, providers can charge for on-scene care that does not require the patient to be transported. Emergency air and ground medical transportation providers and insurers should engage in collaborative contracting in order to bring providers in-network and provide a fair and reasonable rate for services. Regulators must establish standards to ensure that adequate networks exist, that include emergency medical transportation, providing sufficient access to care for consumers.

Florida, like many states, has a dynamic and complex landscape which requires different emergency medical service models that rely on different funding mechanisms in order to provide quality care. Consumers need a strong voice at the table when discussing emergency medical transportation services. The policy solutions included in this report place the burden on medical providers and insurers to resolve billing disputes and lessen the impact of emergency medical transportation costs to consumers. Florida's Insurance Consumer Advocate is committed to facilitating communication and collaboration among all stakeholders in an effort to develop sound public policy solutions that are in the best interest of Florida's insurance consumers.

Appendix A

Abbreviations

AAMS: Association of Air Medical Services

ADA: Aviation Deregulation Act

ADAMS: Atlas & Database of Air Medical Services

ALICE: Asset Limited, Income Constrained, Employed

ALS: Advanced Life Support

ALS1: Advanced Life Support, Level 1

ALS2: Advanced Life Support, Level 2

Anthem BCBS: Anthem Blue Cross Blue Shield

BLS: Basic Life Support

COPCN: Certificate of Public Convenience and Necessity

DOAH: Division of Administrative Hearings

DFS: Florida Department of Financial Services

ED: Emergency Department

EMS: Emergency Medical Services

EMT: Emergency Medical Transportation

EMT Working Group: Emergency Medical Transportation Working Group

EPO: Exclusive Provider Organization

FAIR Health: FAIR Health, Inc.

GCPI: Geographic Practice Cost Index

HCCI: Health Care Cost Institute

HCPCS: Healthcare Common Procudure Coding System

HEMS: Helicopter Emergency Medical Services

HH: Household

HMO: Health Maintenance Organizations

ICA: Florida's Insurance Consumer Advocate

NAIC: National Association of Insurance Commissioners

NHTSA: National Highway and Traffic Safety Administration

OICA: Office of the Insurance Consumer Advocate

OIR: Florida's Office of Insurance Regulation

PBM: Pharmacy Benefit Manager

PE: Practice Expense

PI: Paramedic Intercept

PIP: Personal Injury Protection

PPO: Preferred Provider Organization

SCT: Specialty Care Transport

UCR: Usual, Customary, and Reasonable Rates

Appendix B

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Appendix C

Policy Resources

- Consumer Testimonials

- Office of the Insurance Consumer Advocate Recommendations Summary Sheet

Office of the
INSURANCE CONSUMER ADVOCATE
Sha'Ron James

CONSUMER TESTIMONIALS

"They still keep billing us"	My wife fell in a parking lot, and soon an EMS unit appeared. They insisted on treating her and told her she must go to a trauma center. She said that I was coming and was going to drive her to the Urgent Care. They insisted she go in the ambulance, they found that she had a broken bone in the wrist. She was treated, and I drove her home. We have been billed numerous times for that unwanted ride to the hospital $903.60. Medicare paid $255.20 but they still keep billing us for $648.40.
"Insurance doesn't pay for ambulance services"	I had to call 911 for my husband who was incoherent, and they sent me the Paramedics. To my shock and horror while my husband was in a coma, I received a bill for $735.00 for ambulance services. I called our insurance company BCBS of Florida, we have Blue Options and told them about it, and I found out that the insurance doesn't pay for ambulance services.
"It seems they are getting paid by taxes and individuals"	My Ford Expedition was hit by a Ford F250 truck that ran a red light and had no lights on and proceeded to hit other cars and end up in someone's front yard. I had to be cut out of the car. I received a bill of just over $900 from the Fire and Rescue. I provided them with my health insurance information. They said they submitted a claim but they are still trying to get me to pay them. It seems they are getting paid by taxes and individuals that don't want their credit ruined.
"I wish I had just called a taxi"	I had a severe asthma attack and I called 911. I was taken to the hospital, where I spent the next four days. At this time, I was covered by BCBS medical insurance. Two years later, I received a bill for $784.00 since EMT provider was "out of network"; BCBS explained the cost bounced back to my deductible which had not been met for that year therefore I was responsible for the emergency transport. It is the only time in my life I have ever required the assistance of 911, and I wish I had just called a taxi.
"Ambulance services, public or private need to come up with a reasonable fee"	I slipped and hit my head and was transported by the hospital. An approximately 10 minute drive to the emergency room cost $800.00. Insurance only covered $150 leaving me responsible for the remainder. I understand that cities need to cover the cost of equipment and staff however, the insurance companies and ambulance services, public or private need to come up with a reasonable fee based on service rendered and distance.
"It becomes a factor in future reactions to consider cost"	My son has severe food allergies. He needed an EpiPen for a reaction and his emergency care plan says to use an ambulance post EpiPen. We did that. Unfortunately our insurance company (BCBS) said the only available ambulance service was 'out of network'. We were charged $850. I am so disappointed as it becomes a factor in future reactions to consider cost and hesitate to use an EpiPen.
"We are 22-year tax paying residents. I do not understand the difference."	My wife fell at the entrance to a clubhouse and broke both kneecaps and could not walk. The Clubhouse staff called 911 and a Fire Rescue vehicle took her to the hospital, 4.5 miles away. The Fire Rescue bill was $681.25. After a one night stay, she was discharged and a private Ambulance Service took her to a rehab facility, 10 miles away and charged her $70. We are 22-year tax paying residents. I do not understand the difference?

Office of the INSURANCE CONSUMER ADVOCATE

Sha'Ron James

RECOMMENDATIONS

BAN AEROMEDICAL BALANCE BILLING

Stakeholders must recognize the challenges consumers face when dealing with out-of-network aeromedical balance bills. Although this life-saving service is crucial for patients who need to quickly be transported to a facility for care, the cost of the service is extremely expensive and leaves consumers financially debilitated. Steps must be taken to deregulate the aeromedical industry from federal regulation, so that states may more appropriately regulate the market to address consumer needs.

REFORM GROUND EMT BILLING MODELS

The current billing model used for ground EMT should be reformed. By shifting to a value-based model for ground EMT, ambulance companies will be able to charge for medical services and treatments without the requirement of transporting the patient to a medical facility. This would be a significant change from the fee-for-service model which requires that the patient be transported in order for the provider to be reimbursed for the emergency medical care. The fee-for-service model prevents EMT services from billing an insurance company for the critical care without having transported the patient. Transforming the billing model would allow ground EMT services to recoup emergency medical costs from insurance companies and mitigate the need to balance bill consumers.

IMPROVE TRANSPARENCY & CONSUMER EDUCATION

Local governments, providers, and stakeholders should commit to educating the public in order to:

(1) Combat perceptions about the role of taxes in funding local ground EMT services.

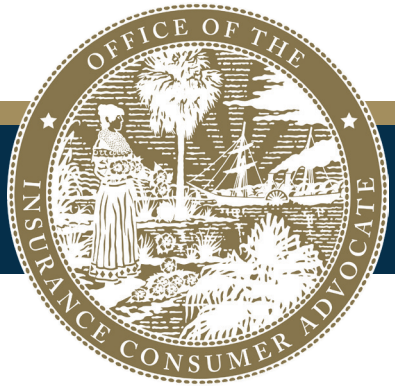
(2) Explain the shift to for-profit, privatized EMT providers, especially for air ambulance services.

(3) Make transparent the rate justifications and billing practices of EMT providers.

(4) Provide useful, comparative information for consumers considering purchasing insurance plans with emergency transport coverages.

INCREASE ACCESS TO IN-NETWORK EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

Consumers should have increased access to in-network EMT providers in order to decrease the likelihood of surprise medical bills. Providers and insurance companies must work together to improve value, efficiency, and use of health care services to reduce costs. Collaborative contracting efforts between EMT providers and insurance companies are integral in reducing the likelihood that consumers are left paying out-of-network prices for life-saving transportation to a medical facility. Regulators should also include and monitor emergency medical transportation in its network adequacy standards.



Florida Office of the Insurance Consumer Advocate

200 East Gaines St.
Tallahassee, FL 32399-0308

The Florida Senate

Committee Agenda Request

To: Senator Jim Boyd, Chair
Committee on Banking and Insurance

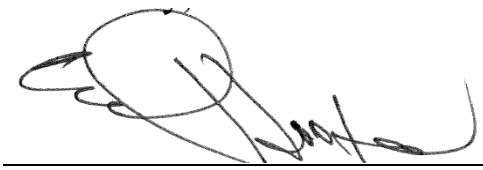
Subject: Committee Agenda Request

Date: December 5, 2023

I respectfully request that **Senate Bill #568**, relating to Coverage for Out-of-network Ground Ambulance Emergency Services, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.



Senator Ed Hooper
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

1-9-24

Meeting Date

Banking & INS

Committee

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

568

Bill Number or Topic

Amendment Barcode (if applicable)

Name Jim Milliean Florida Fire Chiefs Assn. Phone 727-526-5150

Address 4360 55 Ave N Email jmillican@seminolefire.com

Street

St Pete FL 33714

City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

1/9/24
Meeting Date

B & I
Committee

SB 568
Bill Number or Topic

Amendment Barcode (if applicable)

Name Audrey Brown

Phone (850) 559-3905

Address
Street

Email audrey@fahp.net

City State Zip

Speaking: ☐ For ☑ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
FL Association of Health Plans

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to Senate professional staff conducting the meeting

January 9, 2024
Meeting Date

Senate Banking and Insur.
Committee

SB 568
Bill Number or Topic

Amendment Barcode (if applicable)

Name TERENCE RAMOTAR - FLORIDA AMBULANCE ASSOCIATION Phone 786-574-1202

Address 26814 WINGED ELM DRIVE. Email terence.ramotar@gmr.net
Street

WESLEY CHAPEL FL 33544
City State Zip

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 568
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Tuesday, January 9, 2024
TIME: 4:30—6:00 p.m.
PLACE: 412 Knott Building

FINAL VOTE			1/09/2024 1 Amendment 456354 adopted without objection					
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
X		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
9	0	**TOTALS**	RCS	-				
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Military and Veterans Affairs, Space, and Domestic Security, *Vice Chair*
Appropriations Committee on Criminal and Civil Justice
Banking and Insurance
Commerce and Tourism
Fiscal Policy
Rules
Transportation

JOINT COMMITTEES:
Joint Select Committee on Collective Bargaining

SENATOR VICTOR M. TORRES, JR.
25th District

January 9, 2024

Jim Boyd, Chair
Banking and Insurance Committee.
404 S Monroe Street
Tallahassee

Please accept this letter of excusal from myself for the January 9th Banking and Insurance Committee due to an illness. Please accept this letter as a formal request for excusal of this absence. Please let me know if you have any questions or need any additional information.

Respectfully Submitted,

Victor M. Torres, Jr.
Florida State Senator
District 25

REPLY TO:
❒ 101 Church Street, Suite 305, Kissimmee, Florida 34741 (407) 846-5187 FAX: (850) 410-4817
❒ 214 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

Senate's Website: *www.flsenate.gov*

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Commerce and Tourism, *Chair*
Appropriations Committee on Transportation, Tourism, and Economic Development, *Vice Chair*
Appropriations Committee on Agriculture, Environment, and General Government
Banking and Insurance
Fiscal Policy
Judiciary
Transportation

SELECT COMMITTEE:
Select Committee on Resiliency

SENATOR JAY TRUMBULL
2nd District

January 9, 2024

Dear Chair Boyd,

I am respectfully requesting a formal excusal for the upcoming Banking and Insurance Committee meeting today, January 9, 2024. I regret that I will be unable to attend due to my need to return to my district to assist following this morning's storms.

If there are any questions or concerns, please do not hesitate to call my office at (850) 487-5002.

Thank you,

Senator Jay Trumbull

REPLY TO:
❒ 840 West 11th Street, Panama City, Florida 32401 (850) 747-5454
❒ 320 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5002

Senate's Website: *www.flsenate.gov*

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Senate Banking and Insurance Committee **Judge:**

Started: 1/9/2024 4:30:54 PM
Ends: 1/9/2024 5:18:41 PM Length: 00:47:48

4:31:00 PM Chair Boyd calls meeting to order
4:31:05 PM CAA calls roll
4:31:28 PM Quorum present
4:31:36 PM Senators Torres and Trumbull are excused
4:31:45 PM Chair Boyd makes opening remarks
4:31:59 PM Take up Tab 3 - SB 568 by Senator Hooper
4:32:06 PM Senator Hooper explains SB 568
4:33:45 PM Take up delete all amendment #456354
4:33:56 PM Senator Hooper explains the delete all amendment
4:34:41 PM Questions on amendment
4:34:48 PM No questions
4:34:51 PM No appearance cards on amendment
4:34:58 PM No debate on amendment
4:35:09 PM Amendment #456354 adopted
4:35:15 PM Back on bill as amended
4:35:21 PM Questions:
4:35:24 PM Senator Broxson
4:35:49 PM Senator Hooper
4:37:58 PM Senator Broxson
4:38:37 PM Senator Hooper
4:39:22 PM Senator Ingoglia
4:39:48 PM Senator Hooper
4:40:22 PM Senator Ingoglia
4:41:01 PM Senator Hooper
4:41:31 PM Senator Ingoglia
4:41:42 PM Appearance cards:
4:41:46 PM Jim Milligan, FL Fire Chiefs Ass., waiving in support
4:41:55 PM Audrey Brown, FL Association of Health Plans, speaking against
4:43:02 PM Terence Ramotar, FL Ambulance Assoc., speaking for
4:45:34 PM Comment by Senator Ingoglia
4:45:53 PM Senator Mayfield with question to speaker
4:46:02 PM Mr. Ramotar responds
4:46:44 PM Senator Mayfield with follow up question
4:47:04 PM Mr. Ramotar with response
4:47:32 PM Senator Mayfield follow up question
4:47:39 PM Mr. Ramotar responds
4:48:00 PM Back and forth in questions with speaker
4:49:15 PM Debate:
4:49:20 PM No debate
4:49:23 PM Senator Hooper closes on the bill
4:50:32 PM CAA calls roll
4:50:58 PM CS/SB 568 reported favorably
4:51:11 PM Take up Tab 2 - SB 542 by Senator Ingoglia
4:51:21 PM Senator Ingoglia explains the bill
4:52:53 PM Questions:
4:52:56 PM Senator Thompson
4:53:05 PM Senator Ingoglia
4:53:21 PM Senator Thompson
4:53:30 PM Senator Ingoglia
4:55:06 PM Chair Boyd with comments
4:56:16 PM Senator Broxson
4:56:35 PM Senator Ingoglia

4:56:56 PM Senator Powell
4:57:24 PM Senator Ingoglia
4:57:46 PM Senator Powell
4:58:20 PM Senator Ingoglia
4:58:39 PM Senator Powell
4:59:04 PM Senator Ingoglia
4:59:11 PM Senator Powell
5:00:32 PM Senator Ingoglia
5:01:22 PM Appearance cards:
5:01:27 PM Anthony DiMarco, FL Bankers Assoc., speaking against
5:03:03 PM Senator Powell with question to speaker
5:03:22 PM Mr. DiMarco with response
5:03:54 PM Senator Ingoglia with question to speaker
5:04:42 PM Mr. DiMarco responds
5:04:57 PM Back and forth in questions to speaker
5:06:22 PM Debate:
5:06:24 PM Senator Powell
5:07:18 PM Chair Boyd
5:08:10 PM Senator Ingoglia closes on bill
5:09:32 PM CAA calls roll
5:09:58 PM SB 542 reported favorably
5:10:05 PM Take up tab 1 - SB 362 by Senator Bradley
5:10:14 PM Senator Bradley explains the bill
5:10:50 PM Questions:
5:10:54 PM No questions
5:10:57 PM Appearance cards:
5:11:00 PM Mary Thomas, FL Medical Association, waiving in support
5:11:08 PM Dr. Jason Oberste speaking for
5:17:09 PM Chris Lyon, FL Osteopathic Medical Assoc., waiving in support
5:17:20 PM Debate:
5:17:24 PM No debate
5:17:27 PM Senator Bradley closes on bill
5:17:50 PM CAA calls roll
5:18:12 PM SB 362 reported favorably
5:18:27 PM Senator Hutson moves to adjourn
5:18:31 PM Meeting adjourned