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 Health Policy

BILL:	SB 1442
INTRODUCER:	Senator Garcia
SUBJECT:	Out-of-network Health Insurance Coverage
DATE:	January 27, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Pre-meeting**
2.			BI	
3.			AP	

I. Summary:

SB 1442 establishes a payment process for emergency services and care provided by out-of-network or nonparticipating providers to insureds of a preferred provider organization (PPO) or an exclusive provider organization (EPO) and prohibits those insurers from collecting or attempting to collect any additional amount or balance billing. The bill also aligns the existing emergency services coverage provision for health maintenance organizations (HMO).

The bill provides that if emergency services are provided, or nonemergency services are provided in a participating facility by a nonparticipating provider and the insured is unable to choose a participating provider:

- The HMO, EPO, and PPO plans must reimburse nonparticipating providers the greater of:
  - The amount negotiated with an in-network provider in the same community where the services were provided;
  - The usual and customary rate received by a provider for the same services in the community; or
  - The amount that would have been paid under Medicare for the service.
- The nonparticipating provider may not collect or attempt to collect any additional amount or balance bill the insured.

The bill requires insurers to provide coverage without a prior authorization determination and regardless of whether the provider is a participating provider. Applicable cost sharing must be the same for participating or nonparticipating providers for the same services. The bill requires an insurer that contracts with certain facilities to disclose to its subscribers whether those facilities contract with nonparticipating providers.

A nonparticipating provider licensed under chapter 395 who treats patients for nonemergency conditions is required to disclose to the patient, in writing, before providing medical services,

whether the patient will be billed directly for services and to provide a written estimate for such services.

The bill adds compliance with these new provisions as a condition of licensure for hospitals, surgical centers, and urgent care centers. The bill also adds noncompliance with the provisions by practitioners as grounds for discipline by the Department of Health.

The effective date of the bill is October 1, 2016.

II. Present Situation:

Individual purchase insurance coverage generally with the purpose of protecting themselves from future expenses, or in the case of health insurance, the anticipation of unexpected medical bills or large health care costs. Looking at two examples of coverage, preferred provider organization (PPOs) and exclusive provider organization (EPOs) insurers contract with health care providers at set reimbursement rates for covered medical services. Under these types of coverage, an insured individual would only be responsible for any applicable co-payments, co-insurance, or deductibles if services are obtained from a contracted provider. However, if the insured receives services from a non-contracted provider and the provider does not reach a reimbursement agreement with the PPO or EPO insurer, the provider may balance bill the insured for the difference between the cost of the services and what the PPO or EPO paid for the services. If the insured did not knowingly use a non-contracted provider, especially in an emergency services situation, the bill is often not expected and is often called a "surprise bill."

A recent survey by the Kaiser Family Foundation found that among insured, non-elderly adults, nearly seven in ten individuals with unaffordable out-of-network medical bills did not know that the health care provider was not part of their plan's network at the time they received care.[1] In these situations, having insurance did not necessarily protect individuals from unaffordable medical bills. In the same survey, one in five working age, insured Americans reported trouble paying medical bills that caused serious financial challenges and the number was higher within the uninsured, 53 percent.[2] Among the insured, 26 percent said they received unexpected claims denials; and 32 percent said they received care from an out-of-network provider their insurance would not cover.[3] Insured individuals with higher deductible health plans were more likely to report medical bill issues than those with lower deductible plans (26 percent compared to 15 percent).[4]

For HMO subscribers, providers of emergency and non-emergency services are prohibited from balance billing the subscriber if the service is a covered service. The subscriber is liable for any co-payments, co-insurance, or deductibles. For services to be covered by the HMO, subscribers

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[1] Kaiser Family Foundation, *Surprise Medical Bills* (January 2016), *available at* http://kff.org/private-insurance/issue-brief/surprise-medical-bills/ (last visited Jan. 27, 2016).
[2] Kaiser Family Foundation, *New Kaiser/New York Times Survey Finds One in Five Working Age Americans With Health Insurance Report Problems Paying Medical Bills* (January 5, 2016) *available at* http://kff.org/health-costs/press-release/new-kaisernew-york-times-survey-finds-one-in-five-working-age-americans-with-health-insurance-report-problems-paying-medical-bills/ (last visited Jan. 27, 2016).
[3] Id.
[4] Id.

must generally obtain services from a contracted provider or obtain prior authorization from their HMO.

Current law also prohibits balance billing of HMO subscribers for emergency services obtained from non-contracted providers even when the subscriber is unable to obtain prior authorization for such services. When such services are obtained from a non-contracted provider, the statute establishes the reimbursement rate for the provider as the lesser of the provider's charges, the usual and customary charges for similar services in the community where the services were provided, or the charges mutually agreed to by the HMO and the provider within 60 days of the claim submittal.

Access to Emergency Services and Care

Hospital Care

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay.[5] The EMTALA imposes specific obligations on hospitals participating in the Medicare program and 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 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 upon the patient's request, the hospital must transfer the patient to another appropriate facility. A hospital that violates EMTALA is subject to civil penalty; termination of its Medicare agreement; or civil suit by a patient who suffers personal harm. The EMTALA does not provide for civil action against a hospital's physicians.

Florida law imposes a similar duty.[6] The law requires the Agency for Health Care Administration (AHCA) to maintain an inventory of the service capability of all licensed hospitals that provide emergency care in order to assist emergency medical services (EMS or ambulance) providers and the public in locating appropriate medical care. If the hospital is at capacity or does not provide the required 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 expressly prohibited from basing treatment and care on a patient's insurance status, economic status, or ability to pay. 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 guilty of a second degree misdemeanor for a knowing or intentional violation. Physicians who violate the act are also subject to disciplinary action against their license; or civil action by another hospital or physician suffering financial loss.

In February 2015, the Department of the Treasury released a new regulation impacting charitable hospital organizations. The regulation is based on requirements from the Patient Protection and

[5] 42 U.S. Code §1395dd. *Examination and treatment for emergency medical conditions and women in labor.*
[6] *See* section 395.1041, F.S.

Affordable Care Act of 2010 (PPACA) which requires certain hospitals to conduct a community health needs assessment and adopt an implementation strategy once every three years, to establish a written financial assistance policy (FAP), and a written policy related to care for emergency medical conditions.[7] The hospital organization is also required to make reasonable efforts to determine whether an individual is eligible for assistance under a FAP before engaging in extraordinary collection activities.[8] In general, the final regulation requires charitable hospitals to:

- Limit charges to no more than the amounts generally billed to patients with insurance;
- Establish and disclose financial assistance policies;
- Abide by reasonable billing and collection requirements; and
- Perform a community health needs assessment at least every 3 years.

Prehospital Care

The Emergency Medical Transportation Services Act[9] similarly regulates the services provided by emergency medical technicians, paramedics, and air and ground ambulances. The act establishes minimum standards for emergency medical services personnel, vehicles, services, and medical direction, and provides for monitoring of the quality of patient care. The standards are administered and enforced by the Department of Health. Ambulance services operate pursuant to a license issued by the department and a certificate of public convenience and necessity issued from each county in which the provider operates.[10] A licensee may not deny a person needed prehospital treatment or transport for an emergency medical condition.[11] A violation may result in denial, suspension, or revocation of a license; reprimand; or fine.[12]

In general, the medical director of an ambulance provider is responsible for issuing standing orders and protocols to the ambulance service provider to ensure that the patient is transported to a facility that offers the type and level of care appropriate to the patient's medical condition, with separate protocols required for stroke patients.[13] An exception to the general requirement, trauma alert patients are required by statute to be transported to an approved trauma center.[14]

Federal Patient Protection and Affordable Care Act (PPACA)

On March 23, 2010, President Obama signed into law Public Law No. 111-148, the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, President Obama signed into law Public Law No. 111-152, the Health Care and Education Affordability Reconciliation Act of 2010, amending PPACA. The PPACA provided fundamental changes to the U.S. health care system by requiring health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any

[7] Internal Revenue Service, *Internal Revenue Bulletin: 2015-5, Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return,* (February 2, 2015) *available at* https://www.irs.gov/irb/2015-5_IRB/ar08.html (last visited Jan. 27, 2016).
[8] Id.
[9] Part III of chapter 401, F.S. (ss. 401.2101 – 401.465, F.S.)
[10] Section 401.25(2)(d), F.S.
[11] Section 401.45, F.S.
[12] Section 401.411, F.S.
[13] Section 395.3041(3), F.S.
[14] Section 395.4045, F.S.

health-related factors. The PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, and other requirements.

Essential Health Benefits

The PPACA requires coverage offered in the individual and small group markets to provide the following categories of services[15] (essential health benefits):

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.[16]

Emergency Room Coverage[17]

On June 28, 2010, the Department of Health and Human Services issued final regulations relating to coverage for emergency services. Such coverage for emergency services is not subject to prior authorization, regardless of whether the provider is a network or participating provider. Services provided by out-of-network providers must be provided with cost sharing that is no greater than that which would apply for a network provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. Regulations specify minimum reimbursement that plans must pay a non-network provider for emergency services.[18] Plans are required to pay out-of-network providers a reasonable rate, which is defined to be the greatest of the following:

- The amount negotiated with in-network providers for the emergency service furnished (if the plan has more than one negotiated amount with providers for a particular service, the basis for payment would be the median amount);
- The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing; or
- The amount that would be paid under Medicare for the emergency services.

[15] 42 U.S.C. 300gg-6.
[16] These provisions do not apply to grandfathered plans, as defined in 42 U.SC. s. 18011. Pursuant to s. 627.402, F.S., a "grandfathered health plan" has the same meaning as provided in 42 U.S.C. s. 18011, subject to the conditions for maintaining status as a grandfathered health plan specified in regulations adopted by the federal Department of Health and Human Services in 45 C.F.R. s. 147.140. "A non-grandfathered health plan" is a health insurance policy or health maintenance organization contract that is not a grandfathered health plan and does not provide the benefits or coverages specified under s. 627.6561(5)(b)-(e), F.S.
[17] 42 U.S.C. s. 300gg-19A.
[18] 45 C.F.R. s. 147.138(b).

Subsequently, on September 20, 2010, the Centers for Medicare and Medicaid Services issued guidance relating to coverage for emergency services.[19] If a state law prohibits balance billing, plans and issuers are not required to satisfy the payment minimums set forth in the regulations. Similarly, if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, the plan or issuer is not required to satisfy the payment minimums. In both situations, however, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to such amounts, to prevent inadvertent payment by the patient. Nonetheless, even if state law prohibits balance billing, or if the plan or issuer is contractually responsible for amounts balance billed, the plan or issuer may not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.[20]

Balance Billing

At some point, many insureds will end up in an emergency room of a hospital. Even if the hospital is a network provider, physicians practicing at that network hospital may or may not be participating in the same insurance network. In many instances, physicians practicing within a hospital are not employees of the hospital and do not participate in the same insurance plans or HMOs as the hospital.

Generally, insureds of PPO and EPO plans may access specialists within a network without a prior referral or authorization from the insurer. However, if an insured obtains services from an out-of-network provider, and that provider does not reach an agreement with the insurer on a reimbursement amount for the service, the provider can balance bill the patient for the difference between the billed charges of the provider and the amount the insurer paid on the claim. There is no prohibition against a non-network provider balance billing an insured covered by a health insurance policy under chapter 627, F.S.

If an HMO is liable for services rendered, the provider may not balance bill for covered services provided to a subscriber whether or not a contract exists between the provider and the HMO.[21] However, an HMO is liable for services rendered if the provider obtains authorization from the HMO prior to providing services. Thus, a provider can balance bill if authorization is denied or if the provider does not seek prior authorization.[22]

[19] *See* Centers for Medicare and Medicaid Services, The Center for Consumer and Insurance Oversight, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html#Out-Of-Network Emergency Services (last visited March 28, 2015).
[20] *Id.*
[21] Sections 641.315(1) and 641.3154(1), F.S.
[22] *See also* FLORIDA MEDICAL ASSOCIATION, *Balance Billing*, http://www.flmedical.org/LRC_Balance_billing.aspx (last visited March 28, 2015).

Balance billing is prohibited currently for services under Medicaid,[23] workers compensation insurance,[24] by an exclusive provider who is part of an EPO,[25] or by a provider who is under contract with a prepaid limited service organization.[26]

Agency for Health Care Administration

The AHCA licenses and regulates hospitals, ambulatory surgical centers, home health agencies, clinical laboratories, nursing homes, assisted living facilities, and all other types of health care providers under ch. 395, F.S. The AHCA is responsible for inspections and investigations as part of the licensure process, including inspections to investigate emergency access complaints.[27]

The AHCA also regulates quality of care provided by HMOs and EPOs. Before receiving a certificate of authority from the Office of Insurance Regulation (OIR), an HMO or EPO must receive a Health Care Provider Certificate from the AHCA pursuant to part III of ch. 641, F.S.[28] As part of the review process to receive a Health Care Provider Certificate for any given area, the plans must demonstrate the ability to provide quality of care consistent with the prevailing standards of care.[29]

Office of Insurance Regulation

The OIR licenses and regulates the activities of insurers, HMOs, and other risk bearing entities.[30]

Generally, an HMO member (subscriber) must use the HMO's network of health care providers in order for the HMO to provide payment of benefits. Unlike other health plan types, services are covered only if a subscriber sees a provider within the HMO's network, except in the case of an emergency. Florida law requires HMO's to provide coverage without prior authorization for emergency care, based on a determination by a hospital physician or other personnel, provided by either a contract or non-contract provider.[31] If an HMO is liable for services rendered to a subscriber by a provider, contracted or non-contracted, the HMO is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider.[32] The use of a health care provider outside the HMO's network, except for emergency care, generally results in the HMO limiting or denying payment of benefits for non-network services rendered to the

[23] Section 409.907(3)(j), F.S.; Medicaid managed care plans and their providers are required to comply with Provider General Handbook, which prohibits balance billing. In addition, the Statewide Medicaid Managed Care Contract (Core Provisions of the MMA Contract - Nov. 1, 2015 version, pgs. 104-105) establishes minimum requirements for contracts between the managed care plans and its contracted providers. The contract prohibits the provider from seeking payment from the enrollee for any covered services, except for co-payments, and to look only to the managed care plan for payment.
[24] Section 440.13(13)(a), F.S.
[25] Section 627.6472(4)(e), F.S.
[26] Section 636.035(3)-(4), F.S.
[27] Section 395.0161(1)(e), F.S.
[28] Sections 641.21(1) and 641.48, F.S.
[29] Section 641.495, F.S.
[30] Section 20.121(3)(a), F.S.
[31] Section 641.513, F.S.
[32] Section 641.3154(1), F.S.

member.[33] Further, a provider, regardless of whether contracted or not with the HMO, may not collect or attempt to collect money from a subscriber of an HMO for payment of services for which the HMO is liable, if the provider in good faith knows or should know that the HMO is liable.[34]

APPO or network is a group of licensed health care providers the insurer has directly or indirectly contracted for alternative or reduced rates of payment.[35] An exclusive provider is a provider of health care, or a group of providers of health care, that has entered into a written agreement with an insurer to provide benefits under a health insurance policy.[36]

In an EPO, an insurance company contracts with hospitals, physicians, and other medical facilities. Insureds of an EPO must use the contracted hospitals or providers to receive covered benefits from this type of plan. Providers within an EPO or PPO network are prohibited from billing or otherwise seeking reimbursement from or recourse against any policyholder. Insurers issuing exclusive provider contracts must cover services provided by out-of-network providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.

Insurers and HMOs may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments.[37] The HMOs must pay non-contract providers specified minimum reimbursement for emergency services.[38]

The Florida Insurance Code requires insurers and HMOs to provide a description of coverage, benefits, coverage, and limitations of a policy or contract. This document may include an outline of coverage explaining the principal exclusions and limitations of the policy.[39]

Statewide Provider and Health Plan Claim Dispute Resolution Program

The Statewide Provider and Health Plan Claim Dispute Resolution Program was established within the AHCA by the 2000 Legislature to provide assistance to contracted and non-contracted providers and HMOs, insurers, prepaid health clinics, EPOs, and Medicaid prepaid health plans for resolution of claim disputes that are not resolved by the provider and the plan.[40]

Section 408.7057, F.S., requires the AHCA to contract with a third party resolution organization to timely review and consider claim disputes and to submit recommendations to the AHCA. The AHCA's responsibility is to issue a final order adopting the recommendation of the resolution organization. The AHCA entered into a contract with MAXIMUS to review claim disputes and

[33] Section 641.31(38), F.S., authorizes an HMO to offer a point-of-service benefit. The benefit, offered pursuant to a rider, enables a subscriber to select, at time of service and without referral, a noncontract provider for a covered service. The HMO may require the subscriber to pay a reasonable co-payment for each visit for services provided by a noncontract provider.
[34] Section 641.3154(4), F.S.
[35] Section 627.6471, F.S.
[36] Section 627.6472, F.S.
[37] Sections 627.6405 and 641.31(12), F.S.
[38] Section 641.513, F.S.
[39] Section 627.642, F.S.
[40] Chapter 2000-252, Laws of Fla.

MAXIMUS has been reviewing claims disputes since May 1, 2001. The cost of the program is borne by the users of the program. The non-prevailing entity in AHCA's final order must pay the review costs. In cases where both parties prevail in part, the review cost must be shared. The review costs are determined by MAXIMUS and depend largely on the complexity of the cases submitted.

Eligible Claims.[41] The following claim disputes can be submitted by physicians, hospitals, institutions, other licensed health care providers, HMOs, EPOs, PHPs, major medical expense health insurance policies offered by a group or an individual health insurer, and PPOs:

- Claim disputes for services rendered after October 1, 2000.
- Claim disputes related to payment amounts only (provider disputes payment amounts received or HMO disputes payback amounts).
- Hospital and physicians are required to aggregate claims (for one or more patients for same insurer) by type of service to meet certain thresholds:[42]
  - Hospital Inpatient Claims (contracted providers) $25,000
  - Hospital Inpatient Claims (non-contracted providers) $10,000
  - Hospital Outpatient Claims (contracted providers) $10,000
  - Hospital Outpatient Claims (non-contracted providers) $3,000
  - Physicians $500
  - Rural Hospitals None
  - Other Providers None

The following types of claims are ineligible for the program:

- Claims for less than minimum amounts listed above for each type of service.
- Claim disputes that are the basis for an action pending in State/Federal court.
- Claims disputes that are subject to an internal binding managed care organization's resolution process for contracted enter into prior to October 1, 2000.
- Claims solely related to late payment and/or late processing.
- Interest payment disputes.
- Medicare claim disputes that are part of Medicare managed care internal grievance or that qualify for Medicare reconsideration appeal.
- Claims related to health plans not regulated by the state of Florida.
- Claims filed more than 12 months after final determination by the health plan or provider.

Claims Disputes Caseload. During 2014, only 25 claim disputes were filed for consideration. Nine of the 25 claim disputes were accepted as eligible claims for review. At year end, one case was settled, four cases were under review, and the plans opted out of the remaining four cases.[43]

[41] Section 408.7057, F.S., requires the AHCA to submit an annual report to the Governor and the Legislature on the status of the program. *See* Agency for Health Care Administration. *Statewide Provider and Health Plan Claim Dispute Resolution Program Annual Report - February 2015* (on file with the Senate Committee on Health Policy).
[42] Claim thresholds are established by Rule 59A-12.030, F.A.C.
[43] Id.

III. Effect of Proposed Changes:

Section 1 - amends s. 395.003, F.S., to require compliance by hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers with the provisions of ss. 627.64194 and 641.513, F.S., as a condition of licensure. Section 627.64194, F.S., is a new section of law that requires coverage for out-of-network emergency services by PPO and EPO plans.

Section 2 -amends s. 456.072, F.S., to add grounds for discipline of a licensee of the Department of Health who serves as an officer or director of a business, or group practice as defined in s. 456.053, F.S.,[44] and fails to comply with the provision s. 627.64191, F.S., or s. 641.513, F.S. with such frequency as to constitute a general business practice.

Section 3 - creates s. 627.64194, F.S., to expand protection for out-of-network coverage of emergency services to subscribers of PPO and EPO networks. Under this sections, the following terms are defined:

- *Coverage for emergency services* means coverage provided by a health insurance policy for "emergency services and care" as defined in s. 641.47, F.S..[45]
- *Participating provider* means a "preferred provider" as defined in s. 627.6471[46] and an "exclusive provider" as defined in s. 627.6472,F.S.,[47] including provider facilities.

The bill requires the insurer to provide coverage for emergency services that:

- May not require a prior authorization determination;
- Must be provided regardless of whether the service is furnished by a participating or nonparticipating provider; and
- May impose a coinsurance amount, copayment, or limitation of benefits requirement for a nonparticipating provider only if the same requirement applies to a participating provider.

The insurer is liable for payment of fees to the provider, not the insured, other than applicable copayments and deductibles for medical services and care that are:

- Not emergency services and care as defined in s. 395.002, F.S.;
- Provided in a facility licensed under ch. 395, F.S., which has a contract with the insurer; and

[44] "Group practice" is defined as a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association: (1) In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel; (2) For which substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and (3) In which the overhead expenses of and the income from the practice are distributed in accordance with the methods previously determined by members of the group.

[45] "Emergency services and care" means medical screening, examination, and evaluation by a physician, or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency condition within the service capability of a hospital.

[46] "Preferred provider" means any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment, which shall include any health care provider listed in s. 627.419(3) and (4) and shall provide reasonable access to such health care providers.

[47] "Exclusive provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the insurer to provide benefits under his section, which agreement shall include any health care provider listed in s. 627.419(3) and (4) and shall provide reasonable access to such health care providers.

- Provided by a nonparticipating provider where the insured has no ability and opportunity to choose a participating provider at the facility.

A nonparticipating insurer may not be reimbursed an amount greater than:

- The amount negotiated with an in-network provider in the same community where the services were provided, excluding any in-network copayment or coinsurance required by the insured's policy;
- The usual and customary reimbursement received by a provider for the same service in the community where the service was provided, reduced only by any coinsurance amount or copayment that applies to the provider; or
- The amount that would have been paid under Medicare for the service, reduced only by the any coinsurance or copayment amount that applies to the provider.

An insurer that issues a health insurance policy that provides coverage for medical and related services within a facility licensed under ch. 395, F.S., is required to disclose to its insureds whether the facility contracts with nonparticipating providers. The disclosure may be displayed on the insurer's member website or directly distributed by the insurer to its insureds.

Upon scheduling services or admitting a patient for services for non-emergency services, a facility licensed under chapter 395 is required to disclose, in writing, to the patient the following information:

- The names, office addresses, and telephone numbers of providers who will treat the patient and which of those providers are nonparticipating providers. The facility shall only identify those providers who are reasonably expected to provide specific medical services and treatment to the insured.
- A statement that nonparticipating providers may directly bill patients with health insurance for services rendered within the facility, even after the nonparticipating provider has been reimbursed by the patient's insurer.

A nonparticipating provider who treats a patient for a nonemergency medical condition in a facility licensed under ch. 395, F.S., shall disclose, in writing, to the patients before providing medical services whether the patient will be billed directly for such services and shall provide a written estimate of the amount that will be billed directly. A patient is not liable for any charges by a nonparticipating provider, other than applicable copayments and deductibles that are not disclosed in the estimate.

Section 4- amends s. 641.513, F.S., limiting the reimbursement of emergency care services performed by nonparticipating providers in HMOs to the greater of:

- The Medicare allowable rate;
- The usual and customary reimbursement rate received by a provider for the same service in the community where the service was provided; or
- The amount negotiated with a provider under a contract with a HMO in the same community where the emergency services were provided, excluding any copayment payable by the subscriber pursuant to the contract.

Section 5- provides an effective date of October 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Patients covered by an EPO or PPO will not be subject to balance billing for emergency services provided by nonparticipating providers. For non-emergency services in facilities licensed under ch. 395, F.S., patients will also receive advance notice of which providers are nonparticipating and a cost estimate from the nonparticipating provider who treats the patient. Advance notice of nonparticipating providers and estimated costs should reduce the number of surprise bills and in cases where the patient was previously unaware of the provider's status, provide the patient an opportunity to choose other providers for nonemergency health care services. The facilities may incur additional costs to comply with this notice requirement.

A nonparticipating provider must provide a cost estimate for the cost of the nonemergency services that will be billed directly to the patient. If the nonparticipating provider fails to disclose such information, the patient will not be held liable for those costs. Nonparticipating providers may incur a cost to comply with the required disclosure.

To the extent that the options provided for determining reimbursement of an out-of-network emergency services claim are different than how an insurer or health care provider currently is reimbursed, the formula for reimbursement may have a fiscal impact on the affected party.

C. Government Sector Impact:

SB 1442 adds a new licensing condition for the AHCA to consider when inspecting hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers which may involve additional time to complete an inspection.

The Department of Health may experience additional workload with respect to the new disciplinary grounds.

VI. Technical Deficiencies:

None.

VII. Related Issues:

SB 1442 expands coverage for emergency services for PPO and EPO policyholders and modifies the existing language for HMO subscribers. However, as the bill is currently drafted; the OIR indicates it would not extend coverage to other group health plans.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.003, 456.072, and 641.513.

This bill creates section 627.64194 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.