Committee on Health Policy

CS/CS/CS/HB 221 — Health Care Services

by Health and Human Services Committee; Appropriations Committee; Insurance and Banking Subcommittee; Rep. Trujillo and others (CS/CS/CS/SB 1442 by Appropriations Committee; Banking and Insurance Committee; Health Policy Committee; and Senator Garcia)

The bill prohibits an out-of-network provider from balance billing members of a preferred provider organization (PPO) or an exclusive provider organization (EPO) for covered emergency services or covered nonemergency services. The bill establishes a payment process for insurers to provide reimbursement for such out-of-network services.

The bill amends the claims resolution process to add several mandatory components and voluntarily steps to resolve billing issues between providers and insurers. The parties may make offers and the other party has 15 days to accept once received. If the party does not accept the offer and the final order amount is greater than 90 percent or less than 110 percent of the offer amount, the party receiving the offer must pay the final order amount to the offering party and is deemed the non-prevailing party.

The bill requires insurers to provide coverage for emergency services 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. An insurer is solely liable for the payment of fees to a non-participating provider for covered nonemergency services other than any applicable copays, deductibles and coinsurance when such services are provided in a facility that has a contract with the insurer for the nonemergency services and would have otherwise been obligated to provide services under the contract, and the insured does not have the opportunity to choose a participating provider at the facility. Insurers or health care providers may not balance bill the insured.

The bill also provides that willful noncompliance by a provider (health care practitioners subject to regulation under ch. 456, 458, or 459, F.S.) with the balance billing provisions for covered emergency services and nonemergency services, are grounds for discipline by the Department of Health (DOH) if such noncompliance occurs with such frequency as to constitute a general business practice. Other specified providers (hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers) are required to comply with the balance billing provisions as a condition of licensure.

Additionally, the bill provides that willfully failing to comply with the balance billing provisions with such frequency as to constitute a general business practice is defined as an unfair method of competition and an unfair or deceptive act or practice.

In order to put the public on notice, hospitals are required under the bill to maintain information on their websites with contact information for practitioners and practice groups contracting with the hospital. The website must also provide notice that services may be provided in the hospital by practitioners who bill separately from the hospital and that such practitioners might or might not participate with the same health insurance carriers as the hospital. The bill adds compliance

with these new provisions as a condition of licensure for hospitals, surgical centers, and urgent care centers.

Insurers must also provide on its website, by specialty, a current listing of all participating providers, their address, phone numbers, languages spoken, hospital affiliations, and board certifications. Such lists must be updated monthly with additions and terminations.

Effective January 1, 2017, certain insurance policies must include a specific disclosure warning insureds that limited benefits will be paid when nonparticipating providers are used.

The bill requires a health insurance plan or health maintenance contract to provide coverage for the treatment of Down syndrome through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services.

The bill also provides more detailed provisions relating to the use of a uniform prior authorization form that was also enacted in HB 423 during this Session. The bill expressly provides that the provisions in this act control regardless of the order in which the bills are enacted. In this bill, the prior authorization form, if applicable, must be used beginning January 1, 2017, or six months after rules adopting the prior authorization form take effect, and specific elements to be included in the two-page form are provided.

If approved by the Governor, these provisions take effect July 1, 2016, except where otherwise provided.
Vote: Senate 39-0; House 118-1