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 516
INTRODUCER:	Senators Bean and Garcia
SUBJECT:	Health Insurance Coverage for Emergency Services
DATE:	March 30, 2015 REVISED:

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

I. Summary:

SB 516 establishes a payment schedule for emergency services and care provided by out-of-network or non-participating providers to insureds of a preferred provider organization (PPO) or an exclusive provider organization (EPO) and prohibits those providers from collecting or attempting to collect any additional amount or balance billing. Plans must reimburse non-participating providers the greater of the amount negotiated with the provider; the amount generally used by the insurer to determine the reimbursement amount (such as usual and customary), or the Medicare rate.

SB 516 requires PPOs and EPOs to provide coverage for emergency care without prior authorization and regardless of whether the provider is in the network. Applicable cost sharing must be the same for network or non-network providers for these services. This is consistent with federal law. The bill defines emergency services and care to include emergency medical transportation services.

Currently, if a health maintenance organization is liable for services rendered to a subscriber by a provider, regardless if the provider is a contracted provider, the HMO is liable for payment of fees to the provider and the subscriber is not liable for payment to the provider. However, there is not a similar statutory prohibition regarding EPOs and PPOs.

II. Present Situation:

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. 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 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. 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.[1] 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. 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 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.

Prehospital Care

The Emergency Medical Transportation Services Act[2] 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.[3] A licensee may not deny a person needed prehospital treatment or transport for an emergency medical condition.[4] A violation may result in denial, suspension, or revocation of a license; reprimand; or fine.[5]

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 a type and level of care appropriate to the patient's medical condition, with

[1] *See* section 395.1041, F.S.
[2] Part III of chapter 401, F.S. (ss. 401.2101 – 401.465, F.S.)
[3] Section 401.25(2)(d), F.S.
[4] Section 401.45, F.S.
[5] Section 401.411, F.S.

separate protocols required for stroke patients.[6] An exception to the general requirement, trauma alerts patients are required by statute to be transported to an approved trauma center.[7]

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 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[8] (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.[9]

Emergency Room Coverage[10]

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,

[6] Section 395.3041(3), F.S.
[7] Section 395.4045, F.S.
[8] 42 U.S.C. 300gg-6.
[9] 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.
[10] 42 U.S.C. s. 300gg-19A.

and cost-sharing. Regulations specify minimum reimbursement that plans must pay a non-network provider for emergency services.[11] 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.

Subsequently, on September 20, 2010, the Centers for Medicare and Medicaid Services issued guidance relating to coverage for emergency services.[12] 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.[13]

Office of Insurance Regulation

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[14] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of chapter 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA pursuant to part III of chapter 641, F.S.[15]

Generally, an HMO member 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, care is covered only if a subscriber sees a provider within the HMO's network, except in the case of an emergency. Florida law requires HMOs 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.[16] If a 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

[11] 45 C.F.R. s. 147.138(b).
[12] *See* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html#Out-Of-Network Emergency Services (last visited March 28, 2015).
[13] *Id.*
[14] Section 20.121(3)(a), F.S.
[15] Sections 641.21(1) and 641.48, F.S.
[16] Section 641.513, F.S.

subscriber is not liable for payment of fees to the provider.[17] The use of a health care provider outside the HMO's network, except for emergency care, generally results in the HMO limiting or denying the payment of benefits for non-network services rendered to the member.[18] 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.[19]

A preferred provider organization (PPO) or network is a group of licensed health care providers the insurer has directly or indirectly contracted for alternative or reduced rates of payment.[20] 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.[21] In an exclusive provider organization (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. [22] The HMOs must pay non-contract providers specified minimum reimbursement for emergency services.[23]

Balance Billing

At some point, many insureds will end up in an emergency room of a hospital. The hospital may be a network provider; however, the physicians practicing at that network hospital may or may not be participating in the same 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

[17] Section 641.3154(1), F.S.
[18] 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 the 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.
[19] Section 641.3154(4), F.S.
[20] Section 627.6471, F.S.
[21] Section 627.6472, F.S.
[22] Sections 627.6405 and 641.31(12), F.S.
[23] Section 641.513, F.S.

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.[24] However, the statute further qualifies the prohibition by saying that 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.[25]

Statewide Provider and Health Plan Claim Dispute Resolution Program

The Statewide Provider and Health Plan Claim Dispute Resolution Program was established within the Agency for Health Care Administration (agency) by the 2000 Florida Legislature to provide assistance to contracted and non-network 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.[26]

Section 408.7057, F.S., requires the agency to contract with a resolution organization to timely review and consider claim disputes and to submit its recommendation to the agency. The agency's responsibility is to issue a final order adopting the recommendation of the resolution organization. The agency entered into a contract with MAXIMUS to review claim disputes and MAXIMUS has been reviewing claim disputes since May 1, 2001. The cost of the program is borne by users of the dispute program. The entity that does not prevail in the agency's final order must pay the review cost. 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.[27] The following claim disputes can be submitted by physicians, hospitals, institutions, other licensed health care providers, HMOs**,** PHCs, 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).
- Hospitals and physicians are required to aggregate claims (for one or more patients for same insurer) by type of service to meet certain thresholds:
  - Hospital Inpatient Claims (contracted providers) $25,000
  - Hospital Inpatient Claims (non-networkd providers) $10,000
  - Hospital Outpatient Claims (contracted providers) $10,000

[24] Sections 641.315(1) and 641.3154(1), F.S.
[25] *See also* FLORIDA MEDICAL ASSOCIATION, *Balance Billing*, http://www.flmedical.org/LRC_Balance_billing.aspx (last visited March 28, 2015).
[26] Chapter 2000-252, Laws of Florida.
[27] Section 408.7057, F.S., requires the agency 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 Banking and Insurance Committee).

- Hospital Outpatient Claims (non-contracted)	$ 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.
- Claim disputes that are subject to an internal binding managed care organization's resolution process for contracts entered 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.
- Medicaid claim disputes that are part of a Medicaid fair hearing.
- Claims related to health plans not regulated by the state of Florida.
- Claims filed more than 12 months after final determination by health plan or provider.

Claim 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 in the remaining four cases.

III. Effect of Proposed Changes:

Section 1 creates section 627.64194, F.S., relating to coverage for emergency services.

The section defines the term, "coverage for emergency services," to mean coverage provided by a health insurance policy for "emergency services and care" as that term is defined in s. 641.47, F.S., or emergency medical transportation services, which include transport by an ambulance, emergency medical services vehicle, or air ambulance, as those terms are defined in s. 401.23, F.S. The bill defines the term, "participating provider" to mean a "preferred provider," as defined in s. 627.6471, F.S., and an "exclusive provider," as defined in s. 627.6472, F.S.

The bill provides that coverage for emergency services:

- May not require a prior authorization determination.
- Must be provided regardless of whether the service is furnished by a participating or nonparticipating provider.
- 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 bill establishes a payment methodology for emergency services and care provided by noncontract providers to insureds of a PPO or EPO plan and prohibits those providers from collecting or attempting to collect any additional amount. The bill requires that an insurer must reimburse a nonparticipating provider the greater of the following:

- The amount negotiated with a participating provider or a nonparticipating provider for the service, excluding any coinsurance amount or copayment imposed by a participating provider on the participant, beneficiary, or enrollee.
- The amount calculated under the methodology generally used by the insurer to determine the reimbursement amount to a nonparticipating provider for the service, such as the usual, customary, and reasonable amount, reduced only by a coinsurance amount or copayment that applies to a participating provider.
- The amount that would be paid under Medicare for the service, reduced only by a coinsurance amount or copayment that applies to a participating provider.

The bill prohibits these providers from balance billing, thereby applying the same prohibition to PPOs and EPOs as currently applies to HMOs.

Section 2 provides that the bill takes effect October 1, 2015.

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 non-network providers.

Non-network providers rendering emergency services to a patient insured under a PPO or EPO may experience a reduction in revenues due to the prohibition on balance billing.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

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.