

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/CS/CS/HB 221 Out-of-Network Health Insurance Coverage  
**SPONSOR(S):** Health & Human Services Committee; Appropriations Committee; Insurance & Banking Subcommittee, Trujillo and others  
**TIED BILLS:** **IDEN./SIM. BILLS:** CS/SB 1442

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	12 Y, 0 N, As CS	Peterson	Luczynski
2) Appropriations Committee	25 Y, 0 N, As CS	White	Leznoff
3) Health & Human Services Committee	12 Y, 1 N, As CS	McElroy	Calamas

### SUMMARY ANALYSIS

A Preferred Provider Organization (PPO) contracts with a network of health providers who participate for an alternative or reduced rate of payment. Generally, the member is responsible only for required cost-sharing if covered services are obtained from contracted (participating, preferred, or network) providers. If a member chooses to obtain services from an out-of-network provider, the member can be billed for the difference between the provider's charges and the PPO's reimbursement. In an Exclusive Provider Organization (EPO) arrangement, an insurance company contracts with providers and insured members must use the participating providers to receive covered benefits, subject to limited exceptions. A Health Maintenance Organization (HMO) provides health care services pursuant to contractual arrangements with preferred providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits.

Current law requires an HMO to provide coverage for emergency services and care without prior authorization and without regard for whether the provider has a contract with the HMO. The HMO must reimburse a nonparticipating provider the lesser of the provider's charges; the usual and customary rate for provider charges in the community; or the rate agreed to between the provider and the HMO. The nonparticipating provider may not collect additional reimbursement from the subscriber. In other words, the provider cannot balance bill the patient. The law does not currently prohibit providers who are not part of a preferred or exclusive provider network from balance billing patients for emergency or nonemergency services.

CS/CS/CS/HB 221 prohibits out-of-network providers from balance billing members of a PPO or EPO for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider. Hospitals, ambulatory surgical centers, and urgent care centers are also prohibited from balance billing. The bill establishes standards for determining reimbursement to the providers and authorizes providers and insurers to settle disputed claims under the statewide provider and health plan claim dispute resolution program

Finally, the bill requires all PPOs to publish a list of their network providers on their websites, and to update the list monthly; requires all PPOs to give subscribers notice regarding the potential for balance billing when using out-of-network providers; subjects certain facilities and licensed health care practitioners to disciplinary action for violations of the prohibition on balance billing; and requires hospitals to publish information on their websites regarding their contracts with plans and providers of hospital-based services.

The bill has a potential negative fiscal impact of \$7 to \$14 million annually on the State Employee Health Insurance Trust Fund and indeterminate fiscal impact on local governments. This is a potential impact to the Trust Fund to be considered through future Self-Insurance Estimating Conferences, and does not require an appropriation.

Except where otherwise provided, the bill provides an effective date of October 1, 2016.

# FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

### A. EFFECT OF PROPOSED CHANGES:

#### Current Situation

##### **Managed Care Organizations**

##### Types<sup>1</sup>

##### *Preferred Provider Organization<sup>2</sup>*

A PPO is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. A PPO is an insurance product. PPO plan members generally see specialists without prior referral or authorization from the insurer. Generally, the member is only responsible for the policy co-payment, deductible, or co-insurance amounts if covered services are obtained from network providers. However, if a member chooses to obtain services from an out-of-network provider, those out-of-pocket costs likely will be higher. An insurer that offers a PPO plan must make its current list of preferred providers available to its members.

##### *Exclusive Provider Organization<sup>3</sup>*

In an EPO arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the participating hospitals or providers to receive covered benefits, subject to limited exceptions.

##### *Health Maintenance Organization<sup>4</sup>*

An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. The network is made up of providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for out-of-network services rendered to the member.<sup>5</sup>

#### Regulation

The Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations, and other risk-bearing entities.<sup>6</sup> To operate in Florida, an HMO must obtain a certificate of authority from OIR.<sup>7</sup> The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from OIR, an

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<sup>1</sup> See generally FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers*, available at: [http://ahca.myflorida.com/MCHQ/Health\\_Facility\\_Regulation/Commercial\\_Managed\\_Care/chmo.shtml](http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/chmo.shtml) (last visited February 13, 2016).

<sup>2</sup> See generally s. 627.6471, F.S.

<sup>3</sup> See generally s. 627.6472, F.S.

<sup>4</sup> See generally part I of chapter 641, F.S.

<sup>5</sup> Section 641.31(38), F.S., creates an exception to this general rule. It 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 nonparticipating 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 nonparticipating provider.

<sup>6</sup> s. 20.121(3)(a)1., F.S.

<sup>7</sup> ss. 641.21(1) and 641.49, F.S.

HMO must receive a Health Care Provider Certificate from AHCA pursuant to part III of ch. 641, F.S.<sup>8</sup> As part of the certification process used by AHCA, 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.<sup>9</sup>

The Florida Insurance Code requires health insurers and HMOs to provide an outline of coverage or other information describing the benefits, coverages, and limitations of a policy or contract. This may include an outline of coverage describing the principal exclusions and limitations of the policy.<sup>10</sup>

### **Balance Billing<sup>11</sup>**

Balance billing describes the situation where a health care provider seeks to collect payment from a patient for the difference between the provider's billed charges for a covered service and the amount that the managed care organization paid on the claim. Before the rise of managed care, consumers with insurance typically expected some balance billing. Under traditional indemnity insurance, the insured paid the provider directly then sought reimbursement from the insurer. The insurer reimbursed, minus any cost sharing, up to the policy amount. If the reimbursement was below the billed charge, then the patient would not be fully reimbursed.

Today, most people with private insurance are covered by a managed care organization (MCO). Members must utilize the services of network providers to minimize out-of-pocket expenses. Typically, contracts between network providers include a "hold harmless" provision that protects members from being balance billed by a network provider for covered services. In consenting to these provisions, participating providers generally agree not to seek reimbursement from a member beyond payment of applicable cost-sharing requirements, such as copayments, co-insurance, or deductibles.

A member may choose to seek care from a nonparticipating provider, for example from a specialist regarded as an expert in the field. A member may utilize out-of-network providers unknowingly while receiving care at a network hospital. While radiologists, anesthesiologists, pathologists, and increasingly emergency room physicians are hospital-based physicians, generally they are not hospital employees and may or may not contract with the same MCOs as the hospital. Likewise, a member may receive—and be billed for—services from a nonparticipating provider if the member's network physician consults with a nonparticipating specialist. This is generally referred to as "surprise billing." Finally, a member may receive out-of-network care from an out-of-network hospital as a result of an emergency transport.

An analysis conducted for the California HealthCare Foundation in 2006 of 1.2 million residents with employer-sponsored commercial (private) insurance found that almost 11 percent of those studied used out-of-network services at some point during the year. Most out-of-network utilization occurred as a result of a hospital admission, or an emergency department visit without admission. The average balance bill (across facilities, physicians, and other professional providers) was \$1,289 in addition to the average patient cost-sharing amount of \$433. The average balance bill for an inpatient admission averaged \$6,812.<sup>12</sup>

According to a recent study conducted by the Kaiser Family Foundation and the New York Times, one in five (20 percent) of U.S. adults ages 18-64 *with insurance* report that they or someone in their household had problems paying a medical bill.<sup>13</sup> Of those, 75 percent say that the amount they had to

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<sup>8</sup> ss. 641.21(1) and 641.48, F.S.

<sup>9</sup> s. 641.495, F.S.

<sup>10</sup> s. 627.642, F.S.

<sup>11</sup> See generally CALIFORNIA HEALTHCARE FOUNDATION, *Unexpected Charges: What States Are Doing About Balance Billing* (April 2009), available at <http://www.chcf.org/publications/2009/04/unexpected-charges-what-states-are-doing-about-balance-billing> (last visited February 13, 2016).

<sup>12</sup> *Id.* at 4.

<sup>13</sup> Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton and Mollyann Brodie, *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey*, Jan. 2016, at 1, available at [http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey/?utm\\_campaign=KFF%3A+2015+December+KFF+NY+Times+Medical+Debt&utm\\_source=hs\\_email&utm\\_medium=email&\\_hsenc=p2ANqtz-811G5oUaaAYr6uoEChnST13pyBbh3AXerbZqYy-sz9DT7TXvXwILDcoV9tYHvY36G5i73DIRghX6-J-AViQkugXJhEnA&\\_hsmi=24816172](http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey/?utm_campaign=KFF%3A+2015+December+KFF+NY+Times+Medical+Debt&utm_source=hs_email&utm_medium=email&_hsenc=p2ANqtz-811G5oUaaAYr6uoEChnST13pyBbh3AXerbZqYy-sz9DT7TXvXwILDcoV9tYHvY36G5i73DIRghX6-J-AViQkugXJhEnA&_hsmi=24816172) (last visited February 13, 2016).

pay for insurance copays, deductibles, or coinsurance was more than they could afford.<sup>14</sup> Another 32 percent say they received care from an out-of-network provider that their insurance did not cover. For many, the bills were a surprise. Sixty-nine percent indicated that they were unaware that the provider was not in their plan's network when they received the care.<sup>15</sup>

### Current Prohibitions on Balance Billing

Currently, balance billing is prohibited for services provided under Medicaid;<sup>16</sup> workers' compensation insurance;<sup>17</sup> by an exclusive provider who is part of an EPO;<sup>18</sup> or by a provider who is under contract with a prepaid limited service organization.<sup>19</sup> In addition, the law provides that an HMO is liable to pay, and may not balance bill, for covered services provided to a subscriber whether or not a contract exists between the provider and the HMO.<sup>20</sup> 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.<sup>21,22</sup>

### Florida Insurance Consumer Advocate

On October 15, 2015, the Insurance Consumer Advocate held a forum to solicit testimony from stakeholders on the issue of balance billing. On November 18, 2015, the Consumer Advocate presented her recommendations for legislation to implement the findings of the forum to the House Subcommittee on Insurance & Banking:<sup>23</sup>

- Hold consumers harmless (prohibit “balance billing”) in emergency and “surprise billing” situations.
- Establish an alternative dispute resolution process to allow nonparticipating providers to challenge the amount of payment received from an insurer.
- Conduct a study of network adequacy requirements applicable to insurers.
- Require disclosure in all contracts for services involving network providers of the potential billing consequences of using out-of-network providers.
- Require insurers to update their provider directories on a timely basis.
- Require hospitals to make data available regarding hospital-based providers who are not in the network.

### Effect of Changes Related to Balance Billing

The bill prohibits out-of-network hospitals and ASCs from balance billing members of a PPO or EPO for emergency services or for nonemergency services when the nonemergency services are provided in a

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<sup>14</sup> *Id.* at 11.

<sup>15</sup> *Id.* at 12.

<sup>16</sup> s. 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. (E-mail from Josh Spagnola, Legislative Affairs Director, Florida Agency for Health Care Administration, excerpting relevant provisions from the Handbook and the CORE contract (March 16, 2015) (on file with the House Insurance & Banking Subcommittee).

<sup>17</sup> s. 440.13(13)(a), F.S.

<sup>18</sup> s. 627.6472(4)(e), F.S.

<sup>19</sup> s. 636.035(3) - (4), F.S.

<sup>20</sup> ss. 641.315(1) and 641.3154(1), F.S.

<sup>21</sup> *But see Joseph L. Riley Anesthesia Associates v. Stein*, 27 So. 3d 140, 145 (Fla. 5th DCA 2010). The Fifth DCA has held that an authorization issued to a contract provider for services (surgery) in a hospital is deemed an authorization for a hospital-based provider of medically necessary services (anesthesia) that are provided under an exclusive contract without regard for the existence of a contract with the HMO. In other words, if the main service is authorized, related services provided under an exclusive contract are deemed authorized and balance billing is prohibited. *See also* Rule 69O-191.049, F.A.C. (prohibiting hospital-based physicians from balance billing an HMO subscriber who receives covered services in a network hospital.)

<sup>22</sup> *See also* FLORIDA MEDICAL ASSOCIATION, *Balance Billing*, [http://www.flmedical.org/LRC\\_Balance\\_billing.aspx](http://www.flmedical.org/LRC_Balance_billing.aspx) (last visited February 13, 2016).

<sup>23</sup> INSURANCE CONSUMER ADVOCATE, *Recommendations for a Balanced Approach to Unexpected Medical Expenses*, Florida House of Representatives Insurance and Banking Subcommittee (Nov. 18, 2015) (on file with the Insurance & Banking Subcommittee).

network hospital and the patient had no ability and opportunity to choose a network provider. The effect is to eliminate balance billing in the emergency and “surprise” billing scenarios. This would mean consumers who have PPO or EPO coverage would only be responsible for billing differences in circumstances where they knowingly opted to receive out-of-network care. Under the bill, the protections for members of HMOs would remain unchanged.

The bill also subjects hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers and licensed health care practitioners to disciplinary action for violations of the prohibition on balance billing.

## **Current 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. 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.<sup>24</sup> A hospital that violates EMTALA is subject to civil monetary penalty,<sup>25</sup> termination of its Medicare agreement,<sup>26</sup> or civil suit by a patient who suffers personal harm.<sup>27</sup> EMTALA does not provide for civil action against a hospital’s physicians.

Florida law imposes a similar duty.<sup>28</sup> The law requires 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.

### **Payment for Emergency Services and Care**

#### **Florida Law**

A PPO must charge a member the same copayments for emergency care whether the care is provided by a participating or nonparticipating provider.<sup>29</sup>

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<sup>24</sup> 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 February 13, 2016).

<sup>25</sup> 42 U.S.C. § 1395dd(d)(1).

<sup>26</sup> 42 C.F.R. § 489.24(f).

<sup>27</sup> 42 U.S.C. § 1395dd(d)(2).

<sup>28</sup> See s. 395.1041, F.S.

<sup>29</sup> s. 627.6405(4), F.S.

An EPO plan must ensure that emergency care is available 24 hours a day and 7 days a week. Insurers issuing exclusive provider contracts must pay for services provided by non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.<sup>30</sup>

An HMO must provide coverage without prior authorization for prehospital transport or treatment or for emergency services and care<sup>31</sup> that is rendered by either a participating or nonparticipating provider.<sup>32</sup> An HMO must charge a subscriber the same copayments for emergency care whether the care is provided by a participating or nonparticipating provider.<sup>33</sup>

The law requires HMOs to pay nonparticipating providers specified minimum reimbursement for emergency services. Specifically, HMOs must reimburse providers the lesser of:<sup>34</sup>

- The provider's charges;
- The usual and customary provider charges for similar services provided in the community; or
- The charge mutually agreed to by the HMO and the provider.

Reimbursement is net of any applicable copayment.

#### *Statewide Provider and Health Plan Claim Dispute Resolution Program*

The Statewide Provider and Health Plan Claim Dispute Resolution Program (Program) was established in 2000 to provide assistance to contracted and non-contracted providers and health plans for resolution of claim disputes.<sup>35</sup> Under the Program, AHCA contracts with a resolution organization<sup>36</sup> to timely review and consider claim disputes submitted by providers and health plans and to recommend to AHCA an appropriate resolution of those disputes.<sup>37</sup> AHCA does not have authority to evaluate the recommendation of the resolution organization and must enter a final order adopting it within 30 days of receiving it.<sup>38</sup>

Disputed claims must be in one of three categories and must meet certain jurisdictional monetary thresholds.<sup>39</sup>

1. Hospital inpatient services claims: \$25,000 for HMO contracted hospitals and \$10,000 for non-contracted hospitals.
2. Hospital outpatient services claims: \$10,000 for HMO contracted hospitals, and \$3,000 for non-contracted hospitals.
3. Professional services claims: \$500.

The resolution organization reviews all properly filed claim disputes unless the disputed claim:<sup>40</sup>

- Is related to interest payment;
- Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process;
- Is related to a health plan that is not regulated by the state;

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<sup>30</sup> s. 627.6472, F.S.

<sup>31</sup> "Emergency services and care" include the medical screening, examination, and evaluation to determine whether an emergency medical condition exists and the care, treatment, or surgery necessary to relieve or eliminate the emergency medical condition. s. 641.47(8), F.S.

<sup>32</sup> ss. 641.31(12) and 641.513(1)(a), F.S.

<sup>33</sup> s. 641.31097(4), F.S.

<sup>34</sup> s. 641.513(5), F.S.

<sup>35</sup> s. 408.7057, F.S., and *Statewide Provider and Health Plan Claim Dispute Resolution Program Annual Report*, AHCA, February 2016.

<sup>36</sup> "Resolution organization" is a qualified independent third-party claim-dispute-resolution entity selected by and contracted with AHCA. s. 408.7057(1)(c), F.S. AHCA selected MAXIMUS, Inc. as the resolution organization.

<sup>37</sup> s. 408.7057(2)(a), F.S.

<sup>38</sup> s. 408.7057(4), F.S.

<sup>39</sup> 59A-12.030, F.A.C.

<sup>40</sup> s. 408.7057(2)(b), F.S.

- Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;
- Is the basis for an action pending in state or federal court; or
- Is subject to a binding claim-dispute-resolution process provided by contract entered into prior to October 1, 2000, between the provider and the managed care organization.

AHCA is required to file a yearly report on the Program to the Governor and Legislature.<sup>41</sup> In 2015, nine claim disputes were filed under the Program with disputed amounts ranging from approximately \$1,800 to \$35,000.<sup>42</sup> One of the claims was deemed eligible and the amount was settled.<sup>43</sup> Three claims are currently under review and the remaining five claims were either withdrawn, dismissed or deemed ineligible.<sup>44</sup>

### Patient Protection and Affordable Care Act (PPACA)

PPACA was signed into law on March 23, 2010.<sup>45</sup> Among its sweeping changes to the U.S. health care system are requirements for 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. PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, coverage for adult dependents, and other requirements.<sup>46</sup>

PPACA requires that coverage for emergency services must be provided without prior authorization and regardless of whether the provider is a network 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. In addition, plans must reimburse out-of-network providers the greater of:

- The median in-network rate;
- The usual and customary reimbursement, calculated using the plan's formula; or
- The Medicare rate.<sup>47</sup>

Grandfathered health plans are exempt from these requirements.<sup>48</sup> PPACA does not prohibit balance billing. A guidance document from the U.S. Department of Labor has characterized the requirements as "set[ting] forth minimum payment standards...to ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient." The guidance further states that the minimum payment requirements do not apply if state law prohibits balance billing or the plan is contractually responsible for payment.<sup>49</sup>

### Effect of Changes Related to Payment for Emergency Services and Care and Nonemergency Services and Care

<sup>41</sup> s. 408.7057(2)(g)2, F.S.

<sup>42</sup> *Statewide Provider and Health Plan Claim Dispute Resolution Program Annual Report*, AHCA, February 2016.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, H.R. 3590, 11<sup>th</sup> Cong. (March 23, 2010). On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.

<sup>46</sup> Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act. 42 U.S.C. 300gg et seq.

<sup>47</sup> 45 C.F.R. s. 147.138(b).

<sup>48</sup> For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. Grandfathered health plan coverage is tied to the individual or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010. (PPACA § 1251; 42 U.S.C. § 18011; 45 C.F.R. § 147.140).

<sup>49</sup> U.S. Dept. of Labor, Employee Benefits Security Administration, *FAQs About the Affordable Care Act Implementation Part I*, <http://www.dol.gov/ebsa/faqs/faq-aca.html> (last visited February 13, 2016).

The bill defines “emergency services” as the services and care to treat an “emergency medical condition,” as that term is defined in s. 641.47, F.S., related to HMOs. The bill defines “nonemergency services” as the services and care to treat a condition other than an “emergency medical condition.”

The bill creates a new subsection of law that establishes requirements for PPOs and EPOs related to coverage for emergency care. The requirements mirror federal law and are similar to state law applicable to HMOs. Specifically, the bill:

- Prohibits prior authorization;
- Requires coverage whether service is provided by a participating or nonparticipating provider; and
- Requires cost-sharing to be the same whether services are provided by a participating or nonparticipating provider.

The bill sets reimbursement to nonparticipating providers of both emergency and nonemergency services according to the methodology currently applicable to HMOs when reimbursing out-of-network providers of emergency services and care. Specifically, the bill requires a health plan to reimburse a provider at:

- The billed amount;
- An amount that is reasonable reimbursement for the services and care; or
- A charge mutually agreed to by the insurer and the nonparticipating provider.

Reimbursement is net of any applicable copayment or coinsurance. A nonparticipating provider cannot be reimbursed an amount greater than that determined under the methodology in the bill for either emergency services or nonemergency services.

If there is a dispute between the provider and the insurer regarding payment, the dispute may be resolved in one of two methods:

- A court of competent jurisdiction; or
- The voluntary dispute resolution process in s. 408.7057, F.S.

The bill amends s. 408.7057, F.S., regarding the statewide provider and health plan claim dispute resolution program. The provider or the insurer may make an offer to settle the claim dispute and the party to whom the offer is directed has 15 days to accept the offer once it is received. If the offer is not accepted and the Agency for Health Care Administration (AHCA) issues a final order that is more than 90 percent or less than 110 percent of the offer, the entity that did not accept the offer must pay the final order amount plus all accrued interest and shall be considered the non-prevailing party. The AHCA final order is subject to judicial review pursuant to s. 120.68, F.S. If the offer is made by the provider, the total offer amount must be greater than 110 percent of the reimbursement amount received by the provider. If the offer is made by the insurer, the total offer amount must be less than 90 percent of the alleged overpayment amount sought from the provider. Both parties may agree to settle the disputed claim at any time, for any amount, regardless of whether an offer to settle was made or rejected.

The bill includes various transparency provisions for PPOs which:

- Require all PPOs to publish their network provider lists, including specified demographic information, on their websites, and to update the lists with reported changes monthly; and
- Require all PPO contracts to include a notice regarding the implications of using an out-of-network provider and the potential for balance billing;

The bill also includes various transparency provisions for hospitals which require hospitals to publish information on their websites regarding:

- The plans with which the hospital contracts; and



- Providers of hospital-based services with which the hospital has contracted and how those providers may be contacted.

The bill applies the provisions of s. 627.64194, F.S., including sole liability for emergency services, sole liability for nonemergency services in certain circumstances, provider reimbursement requirements, and dispute resolution processes to group, blanket, and franchise health insurers.

**B. SECTION DIRECTORY:**

**Section 1:** Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.

**Section 2:** Amends s. 395.301, F.S., relating to itemized patient bill; form and content prescribed by the agency; patient admission status notification.

**Section 3:** Amends s. 408.7057, F.S., relating to the statewide provider and health plan claim dispute resolution program.

**Section 4:** Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.

**Section 5:** Amends s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.

**Section 6:** Amends s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.

**Section 7:** Amends s. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices defined.

**Section 8:** Creates s. 627.64194, F.S., relating to coverage requirements for services provided by nonparticipating providers; payment collection limitations.

**Section 9:** Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment; limitations; coinsurance and deductibles.

**Section 10:** Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment; limitations; coinsurance and deductibles; this section is effective upon becoming law.

**Section 11:** Amends s. 627.662, F.S., relating to other provisions applicable

**Section 12:** Provides an effective date of October 1, 2016, except as otherwise provided.

## **II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT**

**A. FISCAL IMPACT ON STATE GOVERNMENT:**

1. Revenues:

None.

2. Expenditures:

See Fiscal Comments.

**B. FISCAL IMPACT ON LOCAL GOVERNMENTS:**

1. Revenues:

None.

2. Expenditures:

None.

**C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:**

Health care providers may experience a negative fiscal impact from the provisions that prohibit balance billing if these providers currently rely on that practice and do not receive comparable reimbursement as a result of payment received under the standard for reimbursement and arbitration procedure provided in the bill.

The bill will have a positive fiscal impact on consumers due to the prohibition on balance billing. The magnitude of the impact, however, is not known because no data currently exist to quantify the amount collected as a result of the practice.

#### D. FISCAL COMMENTS:

An analysis done by the Department of Management Services, in consultation with actuarial consultants Foster & Foster, indicated a potential negative fiscal impact of \$7 to \$14 million annually on the State Group Insurance Trust Fund.<sup>50</sup> The impact does not require an appropriation; rather it indicates a potential impact to the State Employee Health Insurance Trust Fund to be considered through future Self-Insurance Estimating Conferences. The future impact on premiums is unknown. .

### III. COMMENTS

#### A. CONSTITUTIONAL ISSUES:

##### 1. Applicability of Municipality/County Mandates Provision:

The bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenue in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

##### 2. Other:

None.

##### 3. RULE-MAKING AUTHORITY:

None.

##### 4. DRAFTING ISSUES OR OTHER COMMENTS:

None.

### IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 19, 2016, the Insurance & Banking Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all:

- Removed the provisions in the bill that revise the methodology in current law used by HMOs to reimburse nonparticipating providers of emergency services and care.
- Added definitions of “emergency services,” “nonemergency services,” “facility,” and “nonparticipating provider.”
- Changed the methodology for determining reimbursement to nonparticipating providers of emergency and nonemergency services to:
  - The billed amount;
  - An amount that is reasonable reimbursement for the services and care; or
  - A charge mutually agreed to by the insurer and the nonparticipating providers.

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<sup>50</sup> February 9, 2016, Email from DMS staff on file with the Appropriations Committee; According to Foster & Foster, this is a rough estimate based on a limited amount of time to analyze the bill language, limited supporting data, and the inclusion of very broad assumptions:

- The estimate was developed by reviewing one current contracted carrier's experience with non-participating provider claims in a recent three-month period.
- Non-participating providers who currently accept offers of payment based on contracted rates are assumed to be reimbursed at a level equivalent to their reasonable and customary fees.
- All non-participating providers subject to the bill are assumed to settle for amount 11 percent above their reasonable and customary fees.

Foster & Foster is conducting a more in-depth analysis to fully evaluate the cost impact to the state group insurance program.

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- Prohibits balance billing for nonemergency services that are provided by a nonparticipating provider in a network facility where the patient had no ability and opportunity to choose a participating provider.
- Authorized nonparticipating providers of emergency and nonemergency services to initiate arbitration to determine additional reimbursement. In rendering his or her decision, the arbitrator must consider any documentation submitted by either the insurer or the provider relevant to: specified factors about the patient; the provider's qualifications; other reimbursement methodologies; and prior arbitration decisions.
- Provided that the arbitrator's decision is the amount contained in the final settlement offer from either the provider or the insurer.
- Required the DFS to develop and maintain the list of qualified arbitrators.
- Required all PPOs to publish the list of network providers, including specified demographic information, on their websites, and to update the list with reported changes monthly.
- Required all PPO contracts to include a notice regarding the implications of using an out-of-network provider and the potential for balance billing.
- Subjected certain facilities and providers subject to disciplinary action for violations of the prohibition on balance billing.
- Required hospitals to publish information on their websites regarding the plans with which the hospital contracts; and providers of hospital-based services with which the hospital has contracted and how those providers may be contacted.

On February 9, 2016, the Appropriations Committee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all:

- Exempted hospitals from the prohibition on balance billing.
- Removed the arbitration provisions and substituted an offer of settlement and judgment process under the statewide provider and health plan dispute resolution program; disputed claims may also be resolved directly through court proceedings.
- Applied s. 627.64194, F.S., to group health insurance, blanket health insurance, and franchise health insurance; this includes the state group insurance program administered by the Department of Management Services.
- Expanded the bases for violations of the balance billing and payment requirements to specifically include physicians and health insurance plans, but required such conduct to be willful.
- Removed emergency transportation and ambulance services from the definition of "emergency services" and created a definition of "insured."

On February 17, 2016, the Health and Human Services Committee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all:

- Prohibited out-of-network hospitals and ambulatory surgical centers from balance billing members of a PPO or EPO in certain circumstances.
- Revised the requirements for dispute resolution and offers of settlement.
- Revised the definitions for "nonparticipating provider" and "participating provider".
- Eliminated the requirement that insurers make a list of preferred providers available for public inspection during regular business hours at the principal office of the insurer within the state.
- Required hospitals to publish information on their websites regarding the plans with which the hospital contracts; and providers of hospital-based services with which the hospital has contracted and how those providers may be contacted.

This analysis is drafted to the committee substitute.