The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

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

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

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

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

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

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

II. Present Situation:

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

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

Federal and State Laws Relating to Emergency Medical Treatment

Emergency Medical Treatment and Active Labor Act (EMTALA)

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

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

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

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

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

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

The Federal No Surprise Act[12]

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

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

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

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

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

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

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

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

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

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

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

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

State Regulation of Emergency Medical Transportation

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

State Regulation of Insurance

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

Balance Billing

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

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

Insurance Coverage for Air Ambulance Services

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

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

Prompt Payment of Health Insurance Claims

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

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

Division of State Group Insurance

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

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

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

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

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

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

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

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

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

Medicare Ambulance Fee Schedules (AFS)[40]

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

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

Ambulance providers and suppliers must:

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

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

Medicare Ground Ambulance Data Collection System

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

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

Washington

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

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

Colorado[46]

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

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

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

Louisiana

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

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

Texas

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

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

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

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

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

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

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

III. Effect of Proposed Changes:

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

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

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

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

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

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

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

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

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

C. Government Sector Impact:

Indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

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

VIII. Statutes Affected:

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

IX. Additional Information:

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

CS by Banking and Insurance on January 9, 2023:

The CS provides the following changes:

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

B. Amendments:

None.

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