1 A bill to be entitled
2 An act relating to coverage for out-of-network ground
3 ambulance emergency services; creating ss. 627.42398
4 and 641.31078, F.S.; defining terms; requiring health
5 insurers and health maintenance organizations,
6 respectively, to reimburse out-of-network ambulance
7 service providers at specified rates for providing
8 emergency services; specifying that such payment is
9 payment in full; providing exceptions; prohibiting
10 cost-sharing responsibilities paid for an out-of-
11 network ambulance service provider from exceeding
12 those of an in-network ambulance service provider for
13 covered services; requiring health insurers and health
14 maintenance organizations, respectively, to remit
15 payment for covered services if such transportation
16 was requested by a first responder or a health care
17 professional; providing procedures for claims;
18 providing an effective date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21
22 Section 1. Section 627.42398, Florida Statutes, is created
23 to read:
24 627.42398 Coverage for out-of-network ground ambulance
25 emergency services.—

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

26 (1) As used in this section, the term:
27 (a) "Ambulance service provider" means a ground ambulance
28 service licensed pursuant to s. 401.25.
29 (b) "Clean claim" means a claim that has no defect of
30 impropriety, including lack of required substantiating
31 documentation or particular circumstances requiring special
32 treatment which prevent timely payment from being made on the
33 claim.
34 (c) "Covered services" means those emergency ambulance
35 services that an enrollee is entitled to receive under the terms
36 of a health insurance policy. The term does not include air
37 ambulance services.
38 (d) "Out-of-network" means a provider that does not
39 contract with the health insurer of the enrollee receiving the
40 covered health care services.
41 (2) A health insurance policy must require a health
42 insurer to reimburse an out-of-network ambulance service
43 provider for providing covered services at a rate that is the
44 greater of any of the following:
45 (a) The rate set or approved, whether in contract, in
46 ordinance, or otherwise, by a local governmental entity in the
47 jurisdiction in which the covered services originated.
48 (b) Three hundred and fifty percent of the current
49 published rate for ambulance services as established by the
50 federal Centers for Medicare and Medicaid Services under Title

51 XVIII of the Social Security Act for the same service provided
52 in the same geographic area; or the ambulance service provider's
53 billed charges, whichever is less.
54 (c) The contracted rate at which the health insurer would
55 reimburse an in-network ambulance provider for providing such
56 covered services.
57 (3) Payment made in compliance with this section is
58 payment in full for the covered services provided, except for
59 any copayment, coinsurance, deductible, or other cost-sharing
60 responsibilities required to be paid by the enrollee. An
61 ambulance service provider may not bill the enrollee any
62 additional amount for such paid covered services.
63 (4) Copayment, coinsurance, deductible, and other cost-
64 sharing responsibilities paid for an out-of-network ambulance
65 service provider's covered service may not exceed the in-network
66 copayment, coinsurance, deductible, and other cost-sharing
67 responsibilities for covered services received by the enrollee.
68 (5) A health insurer shall, within 30 days after receipt
69 of a clean claim for covered services, promptly remit payment
70 for covered services directly to the ambulance service provider
71 and may not send payment to an enrollee. A health insurer must
72 remit payment for the transportation of any patient by ambulance
73 as a medically necessary service if the transportation was
74 requested by a first responder or a health care practitioner as
75 defined in s. 456.001.

76 (6) If the claim is not a clean claim, the health insurer
77 must, within 30 days after receipt of the claim, send a written
78 notice acknowledging the date of receipt of the claim and
79 informing the ambulance service provider of one of the
80 following:
81 (a) That the insurer is declining to pay all or part of
82 the claim, and the specific reason or reasons for the denial.
83 (b) That additional information is necessary to determine
84 if all or part of the claim is payable, and the specific
85 additional information that is required.
86 Section 2. Section 641.31078, Florida Statutes, is created
87 to read:
88 641.31078 Coverage for out-of-network ground ambulance
89 emergency services.—
90 (1) As used in this section, the term:
91 (a) "Ambulance service provider" means a ground ambulance
92 service licensed pursuant to s. 401.25.
93 (b) "Clean claim" means a claim that has no defect of
94 impropriety, including lack of required substantiating
95 documentation or particular circumstances requiring special
96 treatment which prevent timely payment from being made on the
97 claim.
98 (c) "Covered services" means those emergency ambulance
99 services that a subscriber is entitled to receive under the
100 terms of a health maintenance contract. The term does not

101 include air ambulance services.
102 (d) "Out-of-network" means a provider that is not a
103 provider under contract with the health maintenance organization
104 of the subscriber receiving the covered health care services.
105 (2) A health maintenance contract must require a health
106 maintenance organization to reimburse an out-of-network
107 ambulance service provider for providing covered services at a
108 rate that is the greater of the following:
109 (a) The rates set or approved, whether in contract, in
110 ordinance, or otherwise, by a local governmental entity in the
111 jurisdiction in which the covered services originated.
112 (b) Three hundred and fifty percent of the current
113 published rate for ambulance services as established by the
114 federal Centers for Medicare and Medicaid Services under Title
115 XVIII of the Social Security Act for the same service provided
116 in the same geographic area; or the ambulance service provider's
117 billed charges, whichever is less.
118 (c) The contracted rate at which the health maintenance
119 organization would reimburse an in-network ambulance provider
120 for providing such covered services.
121 (3) Payment made in compliance with this section is
122 payment in full for the covered services provided, except for
123 any copayment, coinsurance, deductible, or other cost-sharing
124 responsibilities required to be paid by the subscriber. An
125 ambulance service provider may not bill the subscriber any

126 additional amount for such paid covered services.
127 (4) Copayment, coinsurance, deductible, and other cost-
128 sharing responsibilities paid for an out-of-network ambulance
129 service provider's covered services may not exceed the in-
130 network copayment, coinsurance, deductible, and other cost-
131 sharing responsibilities for covered services received by the
132 subscriber.
133 (5) A health maintenance organization shall, within 30
134 days after receipt of a clean claim for covered services,
135 promptly remit payment for covered services directly to the
136 ambulance service provider and may not send payment to a
137 subscriber. A health maintenance organization must remit payment
138 for the transportation of any patient by ambulance as a
139 medically necessary service if the transportation was requested
140 by a first responder or a health care practitioner as defined in
141 s. 456.001.
142 (6) If the claim is not a clean claim, the health
143 maintenance organization must, within 30 days after receipt of
144 the claim, send a written notice acknowledging the date of
145 receipt of the claim and informing the ambulance service
146 provider of one of the following:
147 (a) That the health maintenance organization is declining
148 to pay all or part of the claim, and the specific reason or
149 reasons for the denial.
150 (b) That additional information is necessary to determine

151 if all or part of the claim is payable, and the specific
152 additional information that is required.
153 Section 3. This act shall take effect July 1, 2024.