A bill to be entitled

An act relating to coverage for out-of-network ground ambulance emergency services; creating ss. 627.42398 and 641.31078, F.S.; defining terms; requiring health insurers and health maintenance organizations, respectively, to reimburse out-of-network ambulance service providers at specified rates for providing emergency services; specifying that such payment is payment in full; providing exceptions; prohibiting cost-sharing responsibilities paid for an out-of-network ambulance service provider from exceeding those of an in-network ambulance service provider for covered services; requiring health insurers and health maintenance organizations, respectively, to remit payment for covered services if such transportation was requested by a first responder or a health care professional; providing procedures for claims; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.42398, Florida Statutes, is created to read:

627.42398 Coverage for out-of-network ground ambulance emergency services.—

(1) As used in this section, the term:

(a) "Ambulance service provider" means a ground ambulance service licensed pursuant to s. 401.25.

(b) "Clean claim" means a claim that has no defect of impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment which prevent timely payment from being made on the claim.

(c) "Covered services" means those emergency ambulance services that an enrollee is entitled to receive under the terms of a health insurance policy. The term does not include air ambulance services.

(d) "Out-of-network" means a provider that does not contract with the health insurer of the enrollee receiving the covered health care services.

(2) A health insurance policy must require a health insurer to reimburse an out-of-network ambulance service provider for providing covered services at a rate that is the lesser of:

(a) 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;

(b) Three hundred and fifty percent of the current published rate for ambulance services as established by the federal 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 service provider's billed charges, whichever is less; or

(c) The contracted rate at which the health insurer would reimburse an in-network ambulance provider for providing such covered services.

(3) Payment made in compliance with this section is payment in full for the covered services provided, except for any copayment, coinsurance, deductible, or other cost-sharing responsibilities required to be paid by the enrollee. An ambulance service provider may not bill the enrollee any additional amount for such paid covered services.

(4) Copayment, coinsurance, deductible, and other cost-sharing responsibilities paid for an out-of-network ambulance service provider's covered service may not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing responsibilities for covered services received by the enrollee.

(5) A health insurer shall, within 30 days after receipt of a clean claim for covered services, promptly remit payment for covered services directly to the ambulance service provider and may not send payment to an enrollee. A health insurer must remit payment for the transportation of any patient by ambulance as a medically necessary service if the transportation was requested by a first responder or a health care practitioner as defined in s. 456.001.

(6) If the claim is not a clean claim, the health insurer must, within 30 days after receipt of the claim, send a written notice acknowledging the date of receipt of the claim and informing the ambulance service provider of one of the following:

(a) That the insurer is declining to pay all or part of the claim, and the specific reason or reasons for the denial.

(b) That additional information is necessary to determine if all or part of the claim is payable, and the specific additional information that is required.

Section 2. Section 641.31078, Florida Statutes, is created to read:

641.31078 Coverage for out-of-network ground ambulance emergency services.—

(1) As used in this section, the term:

(a) "Ambulance service provider" means a ground ambulance service licensed pursuant to s. 401.25.

(b) "Clean claim" means a claim that has no defect of impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment which prevent timely payment from being made on the claim.

(c) "Covered services" means those emergency ambulance services that a subscriber is entitled to receive under the terms of a health maintenance contract. The term does not

include air ambulance services.

(d) "Out-of-network" means a provider that is not a provider under contract with the health maintenance organization of the subscriber receiving the covered health care services.

(2) A health maintenance contract must require a health maintenance organization to reimburse an out-of-network ambulance service provider for providing covered services at a rate that is the greater of the following:

(a) The rates set or approved, whether in contract, in ordinance, or otherwise, by a local governmental entity in the jurisdiction in which the covered services originated.

(b) Three hundred and fifty percent of the current published rate for ambulance services as established by the federal 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 service provider's billed charges, whichever is less.

(c) The contracted rate at which the health maintenance organization would reimburse an in-network ambulance provider for providing such covered services.

(3) Payment made in compliance with this section is payment in full for the covered services provided, except for any copayment, coinsurance, deductible, or other cost-sharing responsibilities required to be paid by the subscriber. An ambulance service provider may not bill the subscriber any

additional amount for such paid covered services.

(4) Copayment, coinsurance, deductible, and other cost-sharing responsibilities paid for an out-of-network ambulance service provider's covered services may not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing responsibilities for covered services received by the subscriber.

(5) A health maintenance organization shall, within 30 days after receipt of a clean claim for covered services, promptly remit payment for covered services directly to the ambulance service provider and may not send payment to a subscriber. A health maintenance organization must remit payment for the transportation of any patient by ambulance as a medically necessary service if the transportation was requested by a first responder or a health care practitioner as defined in s. 456.001.

(6) If the claim is not a clean claim, the health maintenance organization must, within 30 days after receipt of the claim, send a written notice acknowledging the date of receipt of the claim and informing the ambulance service provider of one of the following:

(a) That the health maintenance organization is declining to pay all or part of the claim, and the specific reason or reasons for the denial.

(b) That additional information is necessary to determine

if all or part of the claim is payable, and the specific additional information that is required.

Section 3. This act shall take effect July 1, 2024.