

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 Health Policy

BILL: SB 1842

INTRODUCER: Senator Burton

SUBJECT: Out-of-network Providers

DATE: March 24, 2025

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	Pre-meeting
2.			AHS	
3.			FP	

I. Summary:

SB 1842 amends s. 456.0575, F.S., to require a health care practitioner to notify a patient in writing upon referring the patient to a nonparticipating provider for nonemergency services, or to a provider that is not under contract with the patient's health maintenance organization (HMO), or risk disciplinary action.

The bill also amends s. 627.6471, F.S., to require, under certain circumstances, any insurer issuing a policy of health insurance in the state of Florida to apply the payment for a service provided to an insured by a nonpreferred provider toward the insured's deductible and out-of-pocket maximum as if the service had been provided by a preferred provider.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Insurer

Under s. 627.6471(1)(a), F.S., an "insurer" means:

- Every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity; or
- A multiple-employer welfare arrangement.¹

¹ The term "multiple-employer welfare arrangement" means an employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health insurance benefits or any other benefits described in s. 624.33, other than life insurance benefits, to the employees of two or more employers, or to their beneficiaries; see s. 624.437(1), F.S.

Health Insurance

Under s. 624.603, F.S., “health insurance” is insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Health insurance does not include workers’ compensation coverages, except as provided in s. 624.406(4), F.S.

Health Maintenance Organization

Under s. 641.19(12), F.S., a “health maintenance organization” (HMO) is any organization authorized under part I of ch. 641, F.S., which:

- Provides, through arrangements with other persons, emergency care; inpatient hospital services; physician care including care provided by physicians licensed under chs. 458, 459, 460, and 461, F.S.;² ambulatory diagnostic treatment; and preventive health care services.
- Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis.
- Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers³ are entitled to receive pursuant to a contract.
- Provides physician services, by physicians licensed under chs. 458, 459, 460, and 461, F.S.,⁴ directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians.
- If offering services through a managed care system, has a system in which a primary physician licensed under chs. 458, 459, 460, or 461, F.S.,⁵ is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the HMO’s provider network.

Participating vs. Nonparticipating Providers

Generally, medical health insurance plans and HMOs have a list of physicians, hospitals, and other practitioners or providers⁶ that have agreed to participate in the plan’s network. Providers participating in the network have a contract with the health plan to care for its members at a certain cost. A member of the plan will typically pay less for medical services when using

² Chapter 458, F.S., is the practice act for medical doctors, a.k.a. allopathic physicians. Chapter 459, F.S., is the practice act for osteopathic physicians. Chapter 460, F.S., is the practice act for chiropractic physicians. Chapter 461, F.S., is the practice act for podiatric physicians.

³ “Subscriber” means an entity or individual who has contracted, or on whose behalf a contract has been entered into, with an HMO for health care coverage or other persons who also receive health care coverage as a result of the contract; *see* s. 641.19(18), F.S.

⁴ *Supra* note 2.

⁵ *Id.*

⁶ “Provider” means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state; *see* s. 641.47(14), F.S.

participating providers. If a plan member sees a practitioner or uses a hospital or other facility that does not participate with the health plan, the member is going out-of-network and will usually have to pay more for services rendered by a nonparticipating provider. Some plans will not cover any amount of out-of-network care, while others cover a percentage of care.⁷

Participating providers⁸ have a contract with an insurer that limits the amount of money the provider may charge individuals who are covered under the contracted insurance company. The agreed-upon contract rate includes both the patient and insurer shares and may be based on certain assumptions regarding the volume of patients that will use that provider's services. The portion of the contracted rate a patient pays is determined by his or her insurance policy or HMO subscriber contract.⁹

Nonparticipating providers¹⁰ are those who have not agreed to accept a contracted rate with a patient's insurance company or HMO. If a patient chooses to seek treatment outside of his or her network, insurance companies and HMOs typically increase cost-sharing.¹¹

Health Insurance Cost-Sharing

The term "cost-sharing" refers to how health plan costs are shared between insurers and insureds, sometimes called "out-of-pocket" costs when referring to the insured's share of costs for services that a plan covers that the insured must pay out of their own pocket.¹²

Types of Cost-Sharing

Health insurance policies and HMO subscriber contracts may include the following types of cost-sharing:

- **Premium Contribution** – A health coverage premium is the total amount that must be paid in advance to obtain coverage for a particular level of services. Usually, premiums are billed and paid on a monthly basis.¹³ Employers typically require employees to share the cost of the

⁷ Medicare.gov, *Health Maintenance Organizations (HMOs)*, available at <https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/HMO> (last visited Mar. 21, 2025).

⁸ "Participating provider" means a preferred provider as defined in s. 627.6471 or an exclusive provider as defined in s. 627.6472; see s. 627.64194(1)(f), F.S.

⁹ Centers for Medicare & Medicaid Services, *No Surprises: Health insurance terms you should know*, available at <https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf> (last visited Mar. 21, 2025).

¹⁰ "Nonparticipating provider" means a provider who is not a preferred provider as defined in s. 627.6471 or a provider who is not an exclusive provider as defined in s. 627.6472. For purposes of covered emergency services under this section, a facility licensed under chapter 395 or an urgent care center defined in s. 395.002 is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate; see s. 627.64194(1)(e), F.S.

¹¹ *Supra* note 9.

¹² *Id.*

¹³ Centers for Medicare & Medicaid Services, *Course 2 Health Coverage Basics*, available at <https://www.cms.gov/marketplace/technical-assistance-resources/training-materials/health-coverage-basics-training.pdf> (last visited Mar. 21, 2025).

plan premium. Employers are free to require employees to cover some or all of the premium cost for dependents, such as a spouse or children.¹⁴

- Copayments – A copayment or copay is a flat fee paid by the patient at the time of service.¹⁵
- Coinsurance – Coinsurance is the insured’s share of costs of a covered health service, calculated as a percent of the allowed amount for the service. If the plan pays 70 percent of the cost, then the patient pays 30 percent of the cost. If the plan pays 90 percent, then the patient pays 10 percent, and so forth.¹⁶
- Deductible – The deductible is the amount the insured pays before the plan pays anything. Deductibles generally apply per person per calendar year.¹⁷ Typically, the higher the deductible, the lower the premium. Some plans with particularly high deductibles are known as “high deductible” plans. While these plans may have significantly lower premiums, the insured is usually exposed to higher out-of-pocket costs.¹⁸
- Out-of-Pocket Maximum – The most that the insured or subscriber could pay during a coverage period (usually one year) for their share of the costs of covered services. After meeting the limit, the plan will usually pay 100 percent of the allowed amount. This limit helps the insured or subscriber plan for health care costs. This limit never includes the premium, balance-billed charges, or health care the plan does not cover. Some plans do not count all copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.¹⁹

Regulation of Health Insurance and HMOs in Florida

The Florida 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 Florida Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority²² from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA. As part of the certification process used by the 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.²³

¹⁴ Kaiser Family Foundation, *Employer-Sponsored Health Insurance 101* (May 28, 2024), available at <https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-introduction> (last visited Mar. 21, 2025).

¹⁵ *Supra* note 9.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ South Carolina Department of Insurance, *Understanding Your Deductible*, available at <https://doi.sc.gov/1019/Understanding-Your-Deductible#:~:text=Policies%20with%20lower%20deductibles%20typically,need%20to%20file%20a%20claim>. (last visited Mar. 21, 2025).

¹⁹ *Supra* note 9.

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.

Balance Billing

A provider, regardless of contracted status with an HMO, may not collect or attempt to collect money from an HMO 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 the covered patient.²⁶

Florida Regulation of Health Care Practitioners

Health care practitioners²⁷ are regulated by the Florida Department of Health (DOH) under ch. 456, F.S., and individual practice acts for each profession. Many practitioners are regulated by profession-specific boards or councils of members of the profession appointed by the Governor and administered by the DOH; however, some health care practitioners are regulated directly by the DOH without a board or council.²⁸

Chapter 456, F.S., and individual practice acts delineate standards of licensure and practice, and the boards, or the DOH if there is no board, enforce violations under the Administrative Procedure Act. Boards and the DOH may issue a reprimand or letter of concern, assess fines, suspend or restrict licenses, or revoke licenses, among other penalties, based on the nature of the violation.²⁹

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility³⁰ must provide, within seven days of a written request, a good faith estimate (GFE) of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group³¹ or the average

²⁴ Sections 641.315(1), and 641.3154(1) and (4), F.S.

²⁵ *Id.*

²⁶ Section 627.64194, F.S.

²⁷ "Health care practitioner" means any person licensed under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 462 (naturopathy); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry, dental hygiene, and dental laboratories); chapter 467 (midwifery); part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468 (speech-language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, or orthotics, prosthetics, and pedorthics); chapter 478 (electrolysis); chapter 480 (massage therapy practice); part I, part II, or part III of chapter 483 (clinical laboratory personnel, medical physicists, or genetic counseling); chapter 484 (dispensing of optical devices and hearing aids); chapter 486 (physical therapy practice); chapter 490 (psychological services); or chapter 491 (clinical, counseling, and psychotherapy services); *see* s. 456.001(4), F.S.

²⁸ Florida Department of Health, *Licensing and Regulation*, available at <https://www.floridahealth.gov/licensing-and-regulation/index.html> (last visited Mar. 21, 2025).

²⁹ Section 456.072, F.S.

³⁰ The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of ch. 395, F.S.

³¹ Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention, and resource intensity.

charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined \$500 for each instance of the facility's failure to provide the requested information.

Also, pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within seven days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates and that actual charges will be based on the services actually provided.³²

Florida Health Finder

Under s. 408.05, F.S., the AHCA contracts with a vendor to collect and publish this facility cost information to consumers on an internet site.³³ Hospitals and other facilities post a link to this site – known as Florida Health Finder³⁴ – to comply with the price transparency requirements. The cost information is searchable, based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.³⁵

Florida law also establishes the right of a patient to request a personalized estimate on the costs of care from health care practitioners who provide services in a licensed hospital facility or ambulatory surgical center.³⁶

Centers for Medicare & Medicaid Services, *Design and development of the Diagnosis Related Group (DRG)* (Oct. 2020), available at [https://www.cms.gov/icd10m/version38-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_\(DRGs\).pdf](https://www.cms.gov/icd10m/version38-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf) (last visited Mar. 21, 2025).

³² Section 395.301, F.S.

³³ Section 408.05(3)(c), F.S.

³⁴ Florida Agency for Health Care Administration, Health Care Transparency, *FloridaHealthPriceFinder*, available at <https://price.healthfinder.fl.gov/#> (last visited Mar. 21, 2025).

³⁵ *Supra* note 33.

³⁶ Section 456.0575(2), F.S.

Federal Transparency Requirements

Federal Oversight and Enforcement Relating to Price Transparency Requirements for Hospitals

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations³⁷ changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, the federal CMS also established new requirements for hospitals to publish standard charges for a wide range of health care services offered by such facilities. Specifically, the regulations require hospitals to make public both a machine-readable file of standard charges, as well as a consumer-friendly presentation of prices for at least 300 “shoppable” health care services or an online price estimator tool. The regulations became effective on January 1, 2021.³⁸

The regulations define a “shoppable” service as one that can be scheduled in advance, effectively giving patients the opportunity to select the venue in which to receive the service. This is a more expansive designation of shoppable services than currently exists in Florida law. For each shoppable service, a hospital must disclose several pricing benchmarks to include:³⁹

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and
- The discounted cash price.

This information should provide a patient with both a reasonable estimate of the charge for a shoppable service, and also a range in which the actual charge can be expected to fall. The penalty for facility noncompliance under the federal regulations is a maximum fine of \$300 per day.⁴⁰

A 2021 review of more than 3,500 hospitals found that 55 percent of hospitals were not compliant with the rule and had not posted price information for commercial plans or had not posted any prices at all.⁴¹ Nearly 84 percent of hospitals failed to post machine-readable files containing standard charges, and roughly 78 percent of hospitals did not provide a consumer-friendly shoppable services display.⁴² Another review of more than 6,400 hospitals in 2022 indicated widespread non-compliance with the federal transparency rule in that more than 63

³⁷ Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 F.R. 65524 (November 27, 2019) (codified at 45 C.F.R. § 180).

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ John Xuefeng Jiang, et al., *Factors associated with compliance to the hospital price transparency final rule: A national landscape study*, *Journal of General Internal Medicine* (2021), available at <https://link.springer.com/article/10.1007/s11606-021-07237-y> (last visited Mar. 21, 2025).

⁴² *Id.*

percent of hospitals were estimated to be non-compliant.⁴³ According to that review, only 38 percent of Florida hospitals were in compliance.⁴⁴

Federal Transparency in Coverage Requirements – Insurers and HMOs

On October 29, 2020, the federal departments of Health and Human Services (HHS), Labor, and Treasury finalized Transparency in Coverage regulations⁴⁵ imposing new transparency requirements on issuers of individual and group health insurance plans.

Central to the new regulations is a requirement for insurers and HMOs to provide an estimate of an insured's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurers and HMOs must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs before receiving health care services, to encourage shopping and price competition among providers.⁴⁶

Transparency in Coverage Final Rules

The Transparency in Coverage Final Rules (TiC Rules) require non-grandfathered group health insurers and HMOs offering non-grandfathered group and individual health insurance coverage to make cost-sharing information available to insureds and subscribers through an Internet-based self-service tool and in paper form, upon request.⁴⁷ This information must be made available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the departments⁴⁸ in Table 1 of the preamble to the TiC Rules,⁴⁹ and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.⁵⁰

The insurer or HMO must make available to an insured or subscriber upon request cost-sharing information for a discrete covered item or service by billing code or descriptive term, and

⁴³ Foundation for Government Accountability, *How America's Hospitals Are Hiding the Cost of Health Care* (Aug. 2022), available at <https://www.TheFGA.org/paper/americas-hospitals-are-hiding-the-cost-of-health-care>. (last visited Mar. 21, 2025).

⁴⁴ *Id.*

⁴⁵ Transparency in Coverage, 85 F.R. 73158 (Nov. 12, 2020) (codified at 29 C.F.R. § 54, 29 C.F.R. § 2590, 45 C.F.R. § 147, and 45 C.F.R. § 158).

⁴⁶ Health Affairs Blog, *Trump Administration Finalizes Transparency Rule for Health Insurers* (Nov. 1, 2020), available at <https://www.healthaffairs.org/doi/10.1377/hblog20201101.662872/full/> (last visited Mar. 21, 2025).

⁴⁷ 26 C.F.R. § 54.9815-2715A2(b); 29 C.F.R. § 2590.715-2715A2(b); and 45 C.F.R. § 147.211(b). The Consolidated Appropriations Act, 2021 imposed a largely duplicative requirement, and added a requirement that price comparison guidance also be provided by telephone, upon request. See also FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), Q3, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf>, and [FAQs about Affordable Care Act Implementation Part 61 \(cms.gov\)](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf) (Sep. 27, 2024) (last visited Mar. 21, 2025).

⁴⁸ Department of Treasury, Department of Labor, and Department of Health and Human Services.

⁴⁹ 85 F.R. 72158, 72182-90 (Nov. 12, 2020)

⁵⁰ 26 C.F.R. § 54.9815-2715A2(c)(1); 29 C.F.R. § 2590.715-2715A2(c)(1); and 45 C.F.R. § 147.211(c)(1).

generally must furnish it according to the insured's or subscriber's request.⁵¹ Further, the TiC Rules require an insurer or subscriber to provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider, according to the insured's or subscriber's request, permitting the individual to specify the information necessary for the insurer or HMO to provide meaningful cost-sharing liability information.⁵²

The Federal “No Surprises” Act

On December 27, 2020, Congress enacted the No Surprises Act (Act) as part of the Consolidated Appropriations Act of 2021.⁵³ The Act includes a wide range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of health care. Most sections of the Act went into effect on January 1, 2022, and the federal departments of HHS, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.⁵⁴

Federal “No Surprises” Act Requirements Relating to Estimates – Facilities

The Act requires a health insurer or HMO to generate an “advanced explanation of benefits” (AEOB) that combines information on charges provided by a hospital facility with patient-specific cost information provided by a policy or contract. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a GFE of the total expected charges for scheduled items or services, including any expected ancillary services, with a health insurer (if the patient is insured) or individual (if the patient is uninsured).⁵⁵

Federal “No Surprises” Act Requirements of Health Insurers and HMOs

Under the Act, once the GFE has been shared with a patient's health insurer or HMO, then the insurer or HMO must then develop the AEOB. This personalized cost estimate must include the following:⁵⁶

- An indication of whether the facility participates in the patient's insurer's or HMO's network. If the facility is non-participating, information must be included on how the patient can receive services from a participating provider;
- The GFE prepared by the hospital facility based on billing or diagnostic codes;
- A GFE of the amount to be covered by the health insurer or HMO;
- A GFE of the amount of the patient's out-of-pocket costs;
- A GFE of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's policy or contract;

⁵¹ In responding to an insured's or subscriber's request, the group health plan or health insurer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. 26 C.F.R. § 54.9815-2715A2(b)(2)(ii); 29 C.F.R. § 2590.715-2715A2(b)(2)(ii); and 45 C.F.R. § 147.211(b)(2)(ii).

⁵² 26 C.F.R. § 54.9815-2715A2(b)(1); 29 C.F.R. § 2590.715-2715A2(b)(1); and 45 C.F.R. § 147.211(b)(1).

⁵³ Public Law 116-260. The No Surprises Act is found in Division BB of the Act.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

- A disclaimer indicating whether the services scheduled are subject to medical management techniques (e.g., medical necessity determinations, prior authorization, step therapy, etc.); and
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.

Deferral of Federal Enforcement Related to the GFEs and the AEOBs for Insured Individuals

In October 2021, the decision to defer enforcement of certain requirements described above was made in response to stakeholder requests that standards first be established for the data transfer from providers and facilities to plans and issuers, and give plans, issuers, providers, and facilities enough time to build the infrastructure necessary to support the transfers.

In September 2022, the federal government issued a Request for Information (RFI) relating to the AEOB and the GFE for covered individuals. In the RFI, as noticed in the Federal Register, it was stated that the HHS is deferring enforcement of the requirement that providers and facilities must provide a GFE to plans and issuers for covered individuals enrolled in a health plan or coverage and seeking to have a claim submitted for scheduled (or requested) items or services to their plan or coverage, as well as deferring enforcement of the requirement that plans and issuers must provide these covered individuals with an AEOB.⁵⁷

On April 23, 2024, the federal government provided an update⁵⁸ on progress towards AEOB rulemaking and implementation. The update included a summary of comments received in response to the September 2022 RFI. According to the update, various types of health care providers, payers, and third-party vendors were studied to understand technical needs and capabilities, existing claims processes, communications channels, and potential financial and operational constraints. Additionally, the federal government engaged digital service researchers, who recommended a single data exchange standard for the transmission of data between payers and providers and emphasized that current published technical standards may not be sufficient to meet the AEOB requirements. As a result, new standards may need to be developed to ensure successful implementation.⁵⁹

At this time, no further federal guidance has been issued to indicate how long enforcement will be deferred.⁶⁰

III. Effect of Proposed Changes:

Section 1 amends s. 456.0575, F.S., to require a health care practitioner to notify a patient in writing upon referring the patient to a nonparticipating provider for nonemergency services, as those terms are defined, for health insurance, in s. 627.64194(1), F.S., or to a provider, as

⁵⁷ 87 F.R. 56905.

⁵⁸ Centers for Medicare & Medicaid Services, *Progress Toward Advanced Explanation of Benefits (AEOB) Rulemaking and Implementation*, available at <https://www.cms.gov/files/document/progress-aeob-rulemaking-implementation.pdf> (last visited Mar. 22, 2025).

⁵⁹ NFP, An Aon Company, *FAQ: When must group health plans comply with the CAA 2021 Advanced Explanation of Benefits (AEOB) requirement*, available at <https://www.nfp.com/insights/faq-when-must-group-health-plans-comply-with-the-cao-2021-advanced-explanation-of-benefits-aeob-requirement/> (last visited Mar. 22, 2025).

⁶⁰ *Id.*

defined, for HMO coverage, in s. 641.47, F.S., that is not under contract with the patient's HMO. The written notice must be documented in the patient's medical record and state that the services will be provided on an out-of-network basis, which may result in additional cost-sharing responsibilities for the patient. Failure to comply, without good cause, will result in disciplinary action against the health care practitioner.

Section 2 amends s. 627.6471, F.S., to require that any insurer issuing a policy of health insurance in the state must apply an insured's payment for a service provided to a person covered under the policy by a nonpreferred provider toward the insured's deductible and out-of-pocket maximum as if the service had been provided by a preferred provider and if all of the following conditions apply:

- The insured requests that the insurer apply the payment for the service provided to the insured by the nonpreferred provider toward the insured's deductible and out-of-pocket maximum.
- The service provided to the insured by the nonpreferred provider is within the scope of services covered under the insured's policy.
- The amount that the nonpreferred provider charged the insured for the service is the same as or less than:
 - The average amount that the insured's preferred provider network charges for the service; or
 - The statewide average amount for the service based on data reported on the Florida Health Finder website.

Section 3 provides an effective date of July 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:

The bill requires health care practitioners to notify patients in writing upon referring the patient for nonemergency services to a provider not participating in the patient's health insurance network or to a provider that is not under contract with the patient's HMO. Provision of these notices, as well as looking-up insurer and HMO provider networks, may result in increased workload for health care practitioners.

The bill also requires, under certain circumstances, any insurer issuing a policy of health insurance in the state to apply the payment for a service provided to an insured by a nonpreferred provider toward the insured's deductible and out-of-pocket maximum as if the service had been provided by a preferred provider. This new requirement could result in additional administrative costs to the insurer due to the inclusion of out-of-network patient expenditures in deductible and out-of-pocket maximums. To the extent the bill results in greater patient utilization of nonpreferred providers, the insurer may experience:

- A negative fiscal impact, which could also result in future increases in cost-sharing for the insured.
- An erosion in the insurer's ability to attract providers into its network due to a loss of confidence by providers that policyholders are adequately incentivized to choose network providers, which could lead to a negative fiscal impact for insurers and insureds.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 1 of the bill excludes referrals for emergency services from the bill's requirement that practitioners must provide notification to patients about nonparticipating providers. However, the bill does not appear to exclude emergency service practitioners, such as physicians who provide care in a hospital emergency department, from having to provide such notification when referring patients in emergency care settings for follow-up care. It could be impractical for such emergency service practitioners to spend time checking whether a provider for a patient's follow-up care is an in-network provider as would be required under the bill.

The bill also requires that disciplinary action be taken against a health care practitioner who fails to comply, without good cause, with the bill's requirement for written patient notifications. However, it is unclear what constitutes "good cause" or a "disciplinary action."

Section 2 of the bill could result in greater patient utilization of nonpreferred providers who have not been credentialed⁶¹ by an insurer.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.0575 and 627.6471.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

⁶¹ Provider credentialing (also known as physician credentialing or medical credentialing) is a regulated process of assessing the qualifications of specific types of providers. This important safety check requires providers, such as doctors, dentists, and other allied health care professionals, to show they have the proper education, training and licenses to care for patients. Hospitals and health plans verify the information supplied by the provider before they are included as an in-network or preferred provider. See Council for Affordable Quality Healthcare, *Provider Credentialing: Explained*, available at <https://www.caqh.org/blog/provider-credentialing-explained> (last visited Mar. 21, 2025).