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 Appropriations

BILL:	CS/CS/SB 1442
INTRODUCER:	Banking and Insurance Committee; Health Policy Committee; and Senator Garcia
SUBJECT:	Out-of-network Health Insurance Coverage
DATE:	February 24, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.	Johnson	Knudson	BI	**Fav/CS**
3.	Brown	Kynoch	AP	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1442 prohibits an out-of-network provider from balance billing members of a preferred provider organization (PPO) or an exclusive provider organization (EPO) for covered emergency services or covered nonemergency services. The bill establishes a payment process for insurers to provide reimbursement for such out-of-network services.

The bill requires insurers to provide coverage for emergency services without a prior authorization determination and regardless of whether the provider is a participating provider. Applicable cost sharing must be the same for participating or nonparticipating providers for the same services.

The bill also provides that willful noncompliance by a provider (health care practitioners subject to regulation under ch. 456, 458, or 459, F.S.) with the balance billing provisions for covered emergency services and nonemergency services, are grounds for discipline by the Department of Health (DOH) if such noncompliance occurs with such frequency as to constitute a general business practice. Other specified providers (hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers) are required to comply with the balance billing provisions as a condition of licensure.

In order to put the public on notice, hospitals are required under the bill to maintain information on their websites about insurers and health maintenance organizations for which the hospital is a contracted provider, as well as contact information for practitioners and practice groups

contracting with the hospital. The bill adds compliance with these new provisions as a condition of licensure for hospitals, surgical centers, and urgent care centers.

The bill has an indeterminate fiscal impact on state government.

Except as otherwise expressly provided, the effective date of the bill is October 1, 2016.

II. Present Situation:

The Office of Insurance Regulation (OIR) is responsible for the licensure and regulation of insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[1]

Balance Billing – Preferred Provider Organizations and Exclusive Provider Organizations

Generally, individuals purchase insurance coverage for protecting themselves from future expenses, or in the case of health insurance, unexpected medical bills or large health care costs. Preferred provider organization (PPOs) and exclusive provider organization (EPOs) contract with health care providers at set reimbursement rates for covered medical services. A PPO is a group of licensed health care providers with which the insurer has contracted for alternative or reduced rates of payment.[2]

An exclusive provider is a provider of health care, or a group of providers of health care, that has entered into a written agreement with an insurer to provide benefits under a health insurance policy.[3] In an EPO, an insurer contracts with hospitals, physicians, and other medical facilities. Insureds of an EPO must use the contracted hospitals or providers to receive covered benefits from this type of plan. Providers within an EPO or PPO network are prohibited from billing or otherwise seeking reimbursement from or recourse against any policyholder. Insurers and HMOs may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments.[4]

Under these types of coverage, an insured individual is responsible for any applicable copayments, coinsurance, or deductibles if services are obtained from a contracted provider. If the insured receives services from a non-contracted provider and the provider does not reach a reimbursement agreement with the PPO or EPO insurer, the provider may balance bill the insured for the difference between the cost of the services and what the PPO or EPO paid for the services. However, balance billing is prohibited under current law for health care services under Medicaid[5] by an exclusive provider who is part of an EPO[6] or a by provider who is under

[1] Section 20.121(3)(a), F.S.
[2] Section 627.6471, F.S.
[3] Section 627.6472, F.S.
[4] Sections 627.6405 and 641.31(12), F.S.
[5] Section 409.907(3)(j), F.S.; Medicaid managed care plans and their providers are required to comply with Provider General Handbook, which prohibits balance billing. In addition, the Statewide Medicaid Managed Care Contract (Core Provisions of the MMA Contract (Nov. 1, 2015) version, pp. 104-105) establishes minimum requirements for contracts between the managed care plans and its contracted providers. Except for copayments, the contract prohibits the provider from seeking payment from the enrollee for any covered services, and to seek payment from the managed care plan.
[6] Section 627.6472(4)(e), F.S.

contract with a prepaid limited service organization.[7] If the insured did not knowingly use a non-contracted provider, especially in an emergency services situation, the invoice for balance billing is often not expected and is known as a "surprise bill."

A recent survey by the Kaiser Family Foundation found that among insured, non-elderly adults, nearly seven in ten individuals with unaffordable out-of-network medical bills were unaware that the health care provider was not part of their plan's network at the time they received care.[8] In these situations, having insurance did not necessarily protect individuals from unaffordable medical bills. In the same survey, one in five working age, insured individuals reported trouble paying medical bills that caused serious financial challenges, and the number was higher within the uninsured (53 percent).[9] Among the insured, 26 percent said they received unexpected denials and 32 percent said they received care from an out-of-network provider their insurance would not cover.[10] Insured individuals with higher deductible health plans were more likely to report medical bill issues than those with lower deductible plans (26 percent compared to 15 percent).[11]

According to a 2014 OIR balance billing survey, insurers reported $97.9 million in potential balance billings associated with out-of-network emergency claims. Further, insurers reported $1.3 billion in potential balance billings associated with out-of-network nonemergency claims.[12]

Balanced Billing – Health Maintenance Organizations

Generally, an HMO member must use the HMO's network of health care providers in order for the HMO to provide payment of benefits, except in the case of an emergency. In an emergency, an HMO is liable for payment of fees for services rendered to a subscriber by a provider, contracted or non-contracted, and the subscriber is not liable for payment of fees to the provider.[13] A provider, regardless of whether contracted or not with the HMO, may not collect or attempt to collect money from a subscriber of an HMO for payment of services for which the HMO is liable, if the provider in good faith knows or should know that the HMO is liable.[14] However, a provider can balance bill a subscriber in a nonemergency situation if authorization is denied or if a non-contract provider does not seek prior authorization.[15]

Florida law requires HMOs to provide coverage without prior authorization for emergency care,

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[7] Section 636.035(3)-(4), F.S.
[8] Kaiser Family Foundation, *Surprise Medical Bills* (January 2016), *available at* http://kff.org/private-insurance/issue-brief/surprise-medical-bills/ (last visited Jan. 27, 2016).
[9] Kaiser Family Foundation, *New Kaiser/New York Times Survey Finds One in Five Working Age Americans With Health Insurance Report Problems Paying Medical Bills* (January 5, 2016) *available at* http://kff.org/health-costs/press-release/new-kaisernew-york-times-survey-finds-one-in-five-working-age-americans-with-health-insurance-report-problems-paying-medical-bills/ (last visited Feb. 11, 2016).
[10] Id.
[11] Id.
[12] Office of Insurance Regulation, *2014 Balance Billing Data* (Feb. 2015) (on file with Senate Committee on Banking and Insurance).
[13] Section 641.3154(1), F.S.
[14] Section 641.3154(4), F.S.
[15] *See also* FLORIDA MEDICAL ASSOCIATION, *Balance Billing*, http://www.flmedical.org/LRC_Balance_billing.aspx (last visited Feb. 11, 2016).

based on a determination by a hospital physician or other personnel.[16] Prehospital and hospital-based trauma services and emergency services must be provided to a subscriber of an HMO as required under ss. 395.1041, 395.4045, and 401.45, F.S. When such services are obtained from an out-of-network provider, the statute establishes the reimbursement rate for the provider as the lesser of the provider's charges, the usual and customary charges[17] for similar services in the community where the services were provided, or the charges mutually agreed to by the HMO and the provider within 60 days of the claim submittal.[18]

Required Description of Coverage

The Florida Insurance Code requires insurers and HMOs to provide a description of coverage, benefits, and limitations of a policy or contract. This document may include an outline of coverage explaining the principal exclusions and limitations of the policy.[19]

Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) licenses and regulates hospitals, ambulatory surgical centers, home health agencies, clinical laboratories, nursing homes, assisted living facilities, and all other types of health care providers under ch. 395, F.S. The AHCA is responsible for inspections and investigations as part of the licensure process, including inspections to investigate emergency access complaints.[20]

The AHCA also regulates quality of care provided by HMOs and EPOs. Before receiving a certificate of authority from the OIR, an HMO or EPO must receive a health care provider certificate (HCPC) from the AHCA pursuant to part III of ch. 641, F.S.[21] As part of the review process to receive an HCPC for any given area, the plans must demonstrate the ability to provide quality of care consistent with the prevailing standards of care.[22]

Access to Emergency Services and Care

The Federal Emergency Medical Treatment and Active Labor Act

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.[23] The EMTALA

[16] Section 641.513, F.S.
[17] The interpretation of "usual and customary charges" has been the subject of litigation between providers and insurers. In 2010, a court held that the determination of fair market value of a hospital's emergency services could include consideration of amounts billed and accepted by the hospital except for Medicare and Medicaid payments.[17] In determining the fair market value of the services, it is appropriate to consider the amounts billed and the amounts accepted by providers with one exception. The reimbursement rates for Medicare and Medicaid are set by government agencies and cannot be said to be "arms' length." Moreover, in the emergency room context, hospitals do not have the option that private providers have to refuse to provide services to Medicare or Medicaid patients. Thus, it is not appropriate to consider the amounts accepted by providers for patients covered by Medicare and Medicaid. *See: Baker County Medical Services, Inc. v. Aetna health Management LLC and Humana Medical Plan*, 31 So.3d 842 (Fla. 1st DCA 2010).
[18] Section 641.513(5), F.S.
[19] Section 627.642, F.S.
[20] Section 395.0161(1)(e), F.S.
[21] Sections 641.21(1) and 641.48, F.S.
[22] Section 641.495, F.S.
[23] 42 U.S. Code s. 1395dd.

imposes specific obligations on hospitals participating in the Medicare program and 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 upon the patient's request, the hospital must transfer the patient to another appropriate facility. A hospital that violates EMTALA is subject to civil penalty, termination of its Medicare agreement, or civil suit by a patient who suffers personal harm. The EMTALA does not provide for civil action against a hospital's physicians.

Requirements in Florida Law for Access to Emergency Services

Florida law imposes similar requirements on hospitals that in some ways are more stringent than EMTALA.[24] AHCA is required 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.

Under Florida law, every general hospital that has an emergency department must provide emergency services and care for any emergency medical condition when:

- Any person requests emergency services and care; or
- Emergency services and care are requested on behalf of a person by:
  - An EMS provider who is rendering care to or transporting the person; or
  - Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided.[25]

Arrangements for transfers of patients seeking or receiving emergency services must be made between hospital emergency services personnel for each hospital, unless other arrangements between the hospitals exist. A patient, whether stabilized or not, may be transferred to another hospital that has the service capability or is not at service capacity, only if:

- The patient, or a person who is legally responsible for the patient and acting on the patient's behalf, after being informed of the hospital's obligations and of the risk of transfer, requests that the transfer be effected;[26]
- A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risks to the individual's medical condition;[27] or
- In cases in which a physician is not physically present at the time of transfer, a qualified medical person, in consultation with a physician, signs a certification that the consulting physician has determined that the medical benefits reasonably expected from medical treatment at another facility outweigh the increased risks to the patient, provided that the consulting physician countersigns the certification.[28]

[24] *See* s. 395.1041, F.S.
[25] *See* s. 395.1041(3)(a), F.S.
[26] *See* s. 395.1041(3)(c)1., F.S.
[27] *See* s. 395.1041(3)(c)2., F.S.
[28] *See* s. 395.1041(3)(c)3., F.S.

However, the provisions above relating to patient transfers do not require facilities to accept a transfer that is not medically necessary.[29]

When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital, and the transferring hospital is required to receive the patient within its service capability.[30]

Each hospital must ensure emergency services can be provided at all times either directly or through an arrangement with another hospital. Hospitals are expressly prohibited from allowing the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient previously transferred, to be based upon, or affected by, the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.[31]

A hospital that violates Florida's access to emergency care statute is subject to administrative penalties; denial, revocation, or suspension of its license; and civil action by another hospital or physician suffering financial loss. In addition, hospital administrative or medical staff are subject to a 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 and civil action by another hospital or physician suffering financial loss.[32]

Pre-hospital Care

The Emergency Medical Transportation Services Act[33] (EMTSA) similarly regulates the services provided by emergency medical technicians, paramedics, and air and ground ambulances. The EMTSA establishes minimum standards for emergency medical services personnel, vehicles, services, and medical direction, and provides for monitoring of the quality of patient care. The Florida Department of Health (DOH) administers and enforces these standards. Ambulance services operate pursuant to a license issued by the DOH and a certificate of public convenience and necessity issued from each county in which the provider operates.[34] A licensee may not deny a person necessary prehospital treatment or transport for an emergency medical condition.[35] A violation may result in denial, suspension, or revocation of a license, or a reprimand or fine.[36]

In general, the medical director of an ambulance provider is responsible for issuing standing orders and protocols to ensure that the patient is transported to a facility that offers the type and

[29] *See* s. 395.1041(3)(c), F.S.
[30] *See* s. 395.1041(3)(e), F.S.
[31] *See* s. 395.1041(3)(f), F.S.
[32] *See* s. 395.1041(5), F.S.
[33] Part III of chapter 401, F.S. (ss. 401.2101-401.465, F.S.)
[34] Section 401.25(2)(d), F.S.
[35] Section 401.45, F.S.
[36] Section 401.411, F.S.

level of care appropriate to the patient's medical condition, with separate protocols required for stroke patients.[37] An exception to the general requirement is that trauma alert patients are required by statute to be transported to an approved trauma center.[38]

Federal Patient Protection and Affordable Care Act (PPACA)

On March 23, 2010, President Obama signed into law Pub. L. No. 111-148, the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, President Obama signed into law Public Law No. 111-152, the Health Care and Education Affordability Reconciliation Act of 2010, which amended the PPACA. The PPACA provides fundamental changes to the U.S. health insurance system by requiring 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. The PPACA imposes many insurance requirements, including required benefits, rating and underwriting standards, required review of rate increases, and other requirements. Emergency services is one of the required essential health benefits.[39]

PPACA Regulations on Charitable Hospitals

In February 2015, the U.S. Department of the Treasury released a regulation impacting charitable hospital organizations. The regulation is based on requirements in the PPACA for certain hospitals to conduct a community health needs assessment and adopt an implementation strategy once every three years to establish a written financial assistance policy (FAP) and a written policy related to care for emergency medical conditions.[40] Hospitals are also required to make reasonable efforts to determine whether an individual is eligible for assistance under a FAP before engaging in extraordinary collection activities.[41] In general, the final regulation requires charitable hospitals to:

- Limit charges to no more than the amounts generally billed to patients with insurance;
- Establish and disclose financial assistance policies;
- Abide by reasonable billing and collection requirements; and
- Perform a community health needs assessment at least every three years.

Federal Emergency Room Coverage Regulations

On June 28, 2010, the U.S. Department of Health and Human Services issued final regulations relating to coverage for emergency services.[42] Such coverage for emergency services is not subject to prior authorization, regardless of whether the provider is a participating 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,

[37] Section 395.3041(3), F.S.
[38] Section 395.4045, F.S.
[39] 42 U.S.C. s. 300gg-6.
[40] Internal Revenue Service, *Internal Revenue Bulletin: 2015-5, Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return,* (February 2, 2015) *available at* https://www.irs.gov/irb/2015-5_IRB/ar08.html (last visited Feb. 11, 2016).
[41] Id.
[42] 42 U.S.C. s. 300gg-19A.

and cost-sharing. Regulations specify minimum reimbursement that plans must pay a non-network provider for emergency services.[43] Plans are required to pay out-of-network providers a reasonable rate, which is defined to be the highest amount of the following:

- The amount negotiated with in-network providers for the emergency service furnished, with the stipulation that if the plan has more than one negotiated amount with providers for a particular service, the basis for payment would be the median amount;
- The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing; or
- The amount that would be paid under Medicare for the emergency services.

Subsequently, on September 20, 2010, the U.S. Centers for Medicare & Medicaid Services issued guidance relating to coverage for emergency services.[44] If a state law prohibits balance billing, plans and issuers are not required to satisfy the payment minimums set forth in the regulations described above. Similarly, if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, the plan or issuer is not required to satisfy the payment minimums. In both situations, however, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to such amounts, to prevent inadvertent payment by the patient. Nonetheless, even if state law prohibits balance billing, or if the plan or issuer is contractually responsible for amounts balance billed, the plan or issuer may not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.[45]

Statewide Provider and Health Plan Claim Dispute Resolution Program

The Statewide Provider and Health Plan Claim Dispute Resolution Program provides assistance to contracted and non-contracted providers and HMOs, insurers, prepaid health clinics, EPOs, and Medicaid prepaid health plans for resolution of claim disputes that are not resolved by the provider and the plan. Section 408.7057, F.S., requires the AHCA to contract with a third party resolution organization to timely review and consider claim disputes and to submit recommendations to the AHCA. The AHCA's responsibility is to issue a final order adopting the recommendation of the resolution organization.

Since May 2001, MAXIMUS has been under contract with the AHCA to review claim disputes. The cost of the program is borne by the users of the program. The non-prevailing entity in AHCA's final order must pay the review costs. In cases where both parties prevail in part, the review cost must be shared. The review costs are determined by MAXIMUS and depend largely on the complexity of the cases submitted.

[43] 45 C.F.R. s. 147.138(b).
[44] *See* Centers for Medicare and Medicaid Services, The Center for Consumer and Insurance Oversight, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html#Out-Of-Network Emergency Services (last visited Feb. 11, 2016).
[45] *Id.*

Eligible Claims

Claim disputes may be submitted by physicians, hospitals, institutions, other licensed health care providers, HMOs, EPOs, PHPs, major medical expense health insurance policies offered by a group or an individual health insurer, and PPOs. Hospital and physicians are required to aggregate claims (for one or more patients for same insurer) by type of service to meet certain thresholds:[46]

• Hospital Inpatient Claims (contracted providers)	$25,000
• Hospital Inpatient Claims (non-contracted providers)	$10,000
• Hospital Outpatient Claims (contracted providers)	$10,000
• Hospital Outpatient Claims (non-contracted providers)	$ 3,000
• Physicians	$ 500
• Rural Hospitals	None
• Other Providers	None

The following types of claims are not eligible for the program:

- Claims for less than minimum amounts listed above for each type of service;
- Claim disputes that are the basis for an action pending in state or federal court;
- Claims disputes that are subject to an internal binding managed care organization's resolution process for contracts entered into prior to October 1, 2000;
- Claims solely related to late payment and/or late processing;
- Interest payment disputes;
- Medicare claim disputes that are part of Medicare managed care internal grievance or that qualify for Medicare reconsideration appeal;
- Claims related to health plans not regulated by the state of Florida; and
- Claims filed more than 12 months after final determination by the health plan or provider.

During 2014, only 25 claim disputes were filed for consideration. Nine of the 25 claim disputes were accepted as eligible claims for review. At year-end, one case was settled; four cases were under review; and the plans opted-out of the remaining four cases. [47] In 2015, nine claim disputes were filed for consideration. Of those nine, only one was accepted as an eligible claim for review and settled, and three are still under review for acceptance. The remaining five were ineligible.[48]

III. Effect of Proposed Changes:

Section 1 amends s. 395.003, F.S., to require hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers to comply with the provisions of ss. 627.64194, and 641.513, F.S., as a condition of licensure.

[46] Claim thresholds are established by Rule 59A-12.030, F.A.C.

[47] Section 408.7057, F.S., requires the AHCA to submit an annual report to the Governor and the Legislature on the status of the program. *See* Agency for Health Care Administration. *Statewide Provider and Health Plan Claim Dispute Resolution Program Annual Report* (Feb. 2015) available at: https://ahca.myflorida.com/mchq/Health_Facility_Regulation/Commercial_Managed_Care/docs/SPHPClaimDRP/AnnualReportFeb-2015.pdf.

[48] *See* Agency for Health Care Administration. *Statewide Provider and Health Plan Claim Dispute Resolution Program Annual Report* (Feb. 2016) (on file with Senate Committee on Banking and Insurance).

Section 2 amends s. 395.301, F.S., to add website-posting requirements for hospitals. A hospital must post the following information:

- The names and hyperlinks for direct access to the websites of all health insurers and HMOs for which the hospitals contracts as a network provider or a participating provider;
- As applicable, the names, mailing addresses, and telephone numbers of the health care practitioners and practice groups under contract with the hospital to provide services in the hospital, and how to contact them to determine in which health insurers and HMOs they are participating providers; and
- A statement that:
  - Services provided in the hospital by health care practitioners may not be included in the hospital's charges;
  - Health care practitioners who provide services in the hospital may or may not participate in the same health insurance plans as the hospital; and
  - Prospective patients should contact the health care practitioner arranging for the services to determine the health care plans in which the health care practitioner participates.

Section 3 amends s. 408.7057, F.S., to revise the statewide provider and health plan claim dispute resolution program. The bill authorizes the provider or a health plan to make an offer to settle a claim dispute by providing financial incentives for resolution. The party making the offer to settle must state its total amount offered and provide the other party 15 days to respond. If the party receiving the offer does not accept the offer and the final order is more than 90 percent or less than 110 percent of the offer amount, the party receiving the offer must pay the final order amount to the offering party and is deemed the non-prevailing party. The amount of an offer made by a provider to settle an alleged underpayment by a health plan must be greater than 110 percent of the reimbursement amount the provider received. The offer made by a health plan to settle an alleged overpayment to the provider must be less than 90 percent of the alleged overpayment by the health plan. 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.

Sections 4, 5, and 6 amends ss. 456.072, 458.331, and 459.015, F.S., respectively, to add as grounds for discipline of a licensee of the Department of Health (DOH) for the willful failure to comply with the provision s. 627.64191, F.S., or s. 641.513, F.S., with such frequency as to constitute a general business practice.

Section 7 amends s. 626.9541, F.S., to provide that a willful violation of s. 627.64194, F.S., by an insurer with such frequency as to indicate a general business practice would constitute an unfair insurance trade practice under s. 626.9541(1), F.S.

Section 8 creates s. 627.64194, F.S., to expand protection for out-of-network coverage of emergency services and covered nonemergency services for insureds of preferred provider organization (PPO) and exclusive provider organization (EPO) networks. Under this section, the following terms are defined:

- *Emergency services* means the services and care to treat an emergency medical condition, as defined in s. 641.47(8), F.S.;[49]

[49] "Emergency services and care" means medical screening, examination, and evaluation by a physician, or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an

- *Facility* means a licensed facility as defined in s. 395.002(16), F.S.,[50] or an urgent care center as defined in s. 395.002(30), F.S.;[51]
- *Nonemergency services* means the services and care to treat a condition other than an emergency medical condition;[52]
- *Nonparticipating provider* means a provider who is not a "preferred provider" as defined in s. 627.6471, F.S.,[53] or an "exclusive provider" as defined in s. 627.6472, F.S.;[54]
- *Participating provider* means a "preferred provider" as defined in s. 627.6471, F.S., and an "exclusive provider" as defined in s. 627.6472, F.S., but not a facility licensed under ch. 395, F.S.; and
- *Insured* means a person who is covered under an individual or group health insurance policy delivered or issued for delivery in this state by an insurer authorized to transact business in this state.

For purposes of covered emergency services, a facility licensed under ch. 395, F.S., or an urgent care center is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate.

The bill requires the insurer to be solely responsible for payment to a nonparticipating provider for emergency services in accordance with the coverage terms of the health insurance policy. The insured's liability for payment of fees to a nonparticipating provider of emergency services is limited to applicable coinsurance, copayments, and deductibles. The insurer must provide coverage for emergency services that:

- Does not require a prior authorization;

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emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency condition within the service capability of a hospital.

[50] "Licensed facility" means a hospital, ambulatory surgical center, or mobile surgical center licensed in accordance with this chapter.

[51] "Urgent care center" means a facility or clinic that provides immediate but not emergent ambulatory medical care to patients. The term includes an offsite emergency department of a hospital that is presented to the general public in any manner as a department where immediate and not only emergent care is provided. The term also includes: (a) An offsite facility of a facility licensed under this chapter, or a joint venture between a facility licensed under this chapter and a provider licensed under chapter 458 or chapter 459, that does not require a patient to make an appointment and is presented to the general public in any manner as a facility where immediate but not emergent care is provided. (b) A clinic organization that is licensed under part X of ch. 400, F.S., maintains three or more locations using the same or similar name, does not require a patient to make an appointment, and holds itself out to the public in any manner as a facility or clinic where immediate but not emergent medical care is provided.

[52] "Emergency medical condition" means (a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1. Serious jeopardy to patient health, including a pregnant woman or fetus. 2. Serious impairment to bodily functions. 3. Serious dysfunction of any bodily organ or part. (b) With respect to pregnant women: 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery. 2. That a transfer may pose a threat to the health and safety of the patient or fetus; or 3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

[53] "Preferred provider" means any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment, which shall include any health care provider listed in s. 627.419(3) and (4), F.S., and shall provide reasonable access to such health care providers.

[54] "Exclusive provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the insurer to provide benefits under his section, which agreement shall include any health care provider listed in s. 627.419(3) and (4), F.S., and shall provide reasonable access to such health care providers.

- Pays for emergency services regardless of whether the service is furnished by a participating or nonparticipating provider; and
- Imposes coinsurance, copayment, or limitation of benefits for a nonparticipating provider only if the same applies to a participating provider.

Under the bill, the insurer, not the insured, is liable for payment of fees to a nonparticipating provider other than applicable coinsurance, copayments and deductibles, for covered nonemergency services provided to an insured pursuant with coverage terms of the health insurance policy, and such insured is not liable for payment of fees to a nonparticipating provider for covered nonemergency services that are:

- Provided in a facility licensed under ch. 395, F.S., which has a contract with the insurer for nonemergency services that the facility would be otherwise obligated to provide under contract with the insurer; and
- Provided when the insured has no ability and opportunity to choose a participating provider at the facility who is available to treat the insured.

An insurer must reimburse the nonparticipating provider for services provided to an insured in the manner specified under s. 641.513(5), F.S.,[55] reduced only by an insured's cost sharing responsibilities provided in the policy, and within the specified timeframes of s. 627.6131, F.S.[56] A nonparticipating provider of covered emergency services or nonemergency services may not collect or attempt to collect from the insured any amount in excess of applicable coinsurance, copayments, or deductibles. A provider may collect or attempt to collect from an insured an amount due for the provision of uncovered services.

If there is a dispute as to the amount of the reimbursement to the nonparticipating provider of either emergency or nonemergency services, the dispute must be resolved in either a court of competent jurisdiction or by the voluntary dispute resolution process in s. 408.7057, F.S.

Section 9 amends s. 627.6471, F.S., to require that an insurer must make a current list of preferred providers available on its website. The bill requires that the preferred provider list be ordered by specialty, where applicable, and include the names, addresses, and telephone numbers of all participating providers, including facilities, and in the case of physicians, their board specialties, languages spoken, and affiliations with local hospitals. The website must be updated on at least a calendar month basis with additions and terminations of providers from the network and any changes in physician hospital affiliations.

Section 10 amends s. 627.6471, F.S., relating to insurance contracts and policies for preferred provider networks, effective upon the bill becoming law. While current law requires any insurer issuing a policy under s. 627.6471, F.S., to provide each policyholder and certificate holder with a current list of preferred providers, the bill requires any such health insurance policy issued after January 1, 2017, to also include the following specific disclosure to policyholders:

[55] Under this statute, the nonparticipating provider may be reimbursed for emergency services in an amount which is the lesser of: the provider's charges; the usual and customary provider charges for similar services in the community where the services were provided; or the charge mutually agreed to by the health maintenance organization and the provider within 60 days of submittal of the claim.

[56] Typically, with an electronically submitted claim, an insurer shall pay the claim within 20 days after receipt or notify the provider or designee if the claim is to be denied or contested.

> WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly.

Section 11 amends s. 627.662, F.S., to apply the provisions of s. 627.64194, F.S., relating to coverage requirements for services provided by out-of-network providers and payment collection limitations, to group health insurance, blanket health insurance, and franchise health insurance.

Section 12 provides that, except as otherwise expressly provided, the bill is effective October 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact"

Under CS/CS/SB 1442, patients covered by an exclusive provider organization (EPO) or preferred provider organization (PPO) will not be subject to balance billing for emergency services provided by nonparticipating providers. An insurer is liable for the payment of covered nonemergency services provided by nonparticipating providers if the services are provided in a facility that has a contract with the insurer for the

nonemergency services, which the facility would be otherwise obligated to provide under the contract, and if the insured does not have the ability and opportunity to select a participating provider.

Hospitals will be required to post and maintain information on their websites about which insurers, health maintenance organizations (HMOs), practitioners, and group practices with which they contract, to put the public on notice. The hospitals may incur an indeterminate amount of costs to comply with this notice requirement.

To the extent that the options provided for determining reimbursement of an out-of-network emergency services claim are different from how an insurer or health care provider currently is reimbursed, the formula for reimbursement may have a fiscal impact on the affected parties.

C. Government Sector Impact:

The bill adds a new licensing condition for the Agency for Health Care Administration (AHCA) to consider when inspecting hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers, which may involve an indeterminate amount of additional time and resources for the completion of an inspection.

The Department of Health (DOH) may experience an indeterminate amount of additional workload relating to the bill's new disciplinary grounds.

There is a potential negative fiscal impact of the bill on the Division of State Group Insurance.[57] The impact does not require an appropriation; rather, it indicates a potential impact to the State Employees' Group Health Self-Insurance Trust Fund to be considered through future Self-Insurance Estimating Conferences. The future impact on employer and employee contributions is unknown.

[57] February 23, 2016, email from Department of Management Services (DMS) staff on file with the Committee on Appropriations. An analysis done by the DMS, in consultation with actuarial consultants Foster & Foster, indicated a potential negative fiscal impact of $7 to $14 million annually on the State Employees' Group Health Self-Insurance Trust Fund. 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.

The analysis performed by Foster & Foster assumes participation in the Statewide Provider and Health Plan Claim Dispute Resolution Program process; however, the current definition of "health plan" in s. 408.7057(1)(b), F.S., does not reference the State Group Insurance Program as defined in s. 110.123(2)(j), F.S. The Department of Management Services and Foster & Foster are conducting a more in-depth analysis to fully evaluate the cost impact to the State Group Health Insurance Program regarding the Statewide Provider and Health Plan Claim Dispute Resolution Program not being applicable to the State Group Health Insurance Program.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The effective date of this bill is October 1, 2016, which is in the middle or towards end of the plan year for individual health insurance plans and many group plans. It may be more appropriate for the provisions of sections 8 and 11 of this bill to apply to new plans and plan renewals starting after the effective date.

The bill provides that an insured is not liable for payment of fees to a nonparticipating provider for nonemergency services only if the services are provided in a facility contracted for nonemergency services and only if the insured "has no ability and opportunity to choose a participating provider at the facility." The manner in which that ability and opportunity is to be determined is not specified. It may be appropriate to place responsibility on the insurer and the contracted facility, rather than the consumer, for determining and ensuring that the providers treating the consumer at the contracted facility will be participating providers unless the consumer expressly selects a specific nonparticipating provider.[58]

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.003, 395.301, 408.7057, 456.072, 458.331, 459.015, 626.9541, 627.6471, and 627.662.

This bill creates section 627.64194 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/CS by Banking and Insurance on February 16, 2016:
The CS/CS:

- Excludes emergency transportation and ambulance services from the definition of "emergency services."
- Provides that a facility licensed under ch. 395, F.S., or an urgent care center is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate.
- Revises the statewide provider and health claim dispute resolution program by creating an offer to settle as mechanism to resolve disputes.
- Expands the bases for violations of the balance billing prohibitions and payment requirements to include physicians licensed under ch. 458 or 459, F.S., and health insurers, but requires the conduct to be willful.

[58] Office of Insurance Regulation, *2016 Agency Legislative Bill Analysis* (Feb. 3, 2016) (on file with Senate Committee on Banking and Insurance).

- Applies provisions of the bill to group health insurance as well as individual health insurance.
- Provides technical, conforming changes.

CS by Health Policy on February 1, 2016:
The CS requires:

- Hospitals to post on its website a listing of its contractual relationships with insurers and health maintenance organizations (HMOs), practitioners and practice groups along with contact information and hyperlinks;
- Application of the current HMO reimbursement statute for out of network emergency services for preferred provider organization (PPO) and exclusive provider organization (EPO) patients;
- The parties to seek resolution through a court of competent jurisdiction or through the voluntary resolution dispute process for disputes over the reimbursement amount for emergency or nonemergency fees;
- Any issuer of health insurance products in this state for reduced rates of payment to make a list of preferred providers available on its website, with monthly updates; and
- Any issuer of health insurance products in this state for reduced rates of payment to provide additional warning and disclosure language regarding limited benefits and payment when nonparticipating providers are used beginning January 1, 2017.

The CS includes emergency transportation and ambulance services in the definition of emergency services.

B. Amendments:

None.

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