Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Trujillo offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraph (d) is added to subsection (5) of section 395.003, Florida Statutes, to read:

395.003 Licensure; denial, suspension, and revocation.—

(5)

(d) A hospital, ambulatory surgical center, specialty hospital, or urgent care center shall comply with the provisions of ss. 627.64194 and 641.513 as a condition of licensure.

Section 2. Subsection (13) is added to section 395.301, Florida Statutes, to read:

395.301 Itemized patient bill; form and content prescribed by the agency; patient admission status notification.—

(13) A hospital shall post on its website:

(a) The names and hyperlinks for direct access to the websites of all health insurers and health maintenance organizations for which the hospital contracts as a network provider or participating provider.

(b) A statement that:

1. Services provided in the hospital by health care practitioners may not be included in the hospital's charges;

2. Health care practitioners who provide services in the hospital may or may not participate with the same health insurance plans as the hospital;

3. 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.

(c) As applicable, the name, mailing address and telephone number of the health care practitioners and practice groups that the hospital has contracted with to provide services in the hospital and instruction on how to contact these health care practitioners and practice groups to determine the health insurers and health maintenance organizations for which the hospital contracts as a network provider or participating provider.

Section 3. Paragraph (oo) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(oo) Failing to comply with the provisions of s. 627.64194 or s. 641.513 with such frequency as to constitute a general business practice.

Section 4. Section 627.64194, Florida Statutes, is created to read:

627.64194 Coverage requirements for services provided by nonparticipating providers.—

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

(a) "Emergency services" means the services and care to treat an emergency medical condition, defined in s. 641.47. For purposes of this section, "emergency services" includes emergency transportation and ambulance services, to the extent permitted by applicable state and federal law.

(b) "Facility" means a licensed facility as defined in s. 395.002(16) and an urgent care center as defined in s. 395.002(30).

(c) "Nonemergency services" means the services and care to treat a condition other than an emergency medical condition, as defined in s. 395.002(8).

(d) "Nonparticipating provider" means a provider who is not a "preferred provider" as defined in s. 627.6471 or an "exclusive provider" as defined in s. 627.6472.

(e) "Participating provider" means a "preferred provider" as defined in s. 627.6471 or an "exclusive provider" as defined in s. 627.6472.

(2) An insurer is solely liable for payment of fees to a nonparticipating provider of emergency services and an insured is not liable for payment of fees to a nonparticipating provider of emergency services, other than applicable copayments and deductibles. An insurer must provide coverage for emergency services that:

(a) May not require prior authorization.

(b) Must be provided regardless of whether the service is furnished by a participating or nonparticipating provider.

(c) May impose a coinsurance amount, copayment, or limitation of benefits requirement for a nonparticipating provider only if the same requirement applies to a participating provider.

(3) An insurer is solely liable for payment of fees to a nonparticipating provider of nonemergency services and an insured is not liable for payment of fees to a nonparticipating provider, other than applicable copayments and deductibles, for nonemergency services that are:

(a) Provided in a facility which has a contract with the insurer; and

(b) Provided under circumstances where the insured has no ability and opportunity to choose a participating provider at the facility.

(4) An insurer must reimburse a nonparticipating provider of emergency services or nonemergency services within the applicable timeframe provided by s. 627.6131:

1. The billed amount;

2. An amount that is a reasonable reimbursement for the services and care rendered; or

3. A charge mutually agreed to by the insurer and the nonparticipating provider.

(5) A nonparticipating provider of emergency services or nonemergency services may not be reimbursed an amount greater than that provided under subsections (4) or (6) by the insurer and may not collect or attempt to collect from the patient, directly or indirectly, any excess amount.

(6)(a) If an insured has assigned his or her benefit of payment to the nonparticipating provider, the provider may, within 60 days after receipt of the reimbursement described in subsection (4), request additional reimbursement by making a final reimbursement offer to the insurer. Within 30 days after receipt of the provider's final reimbursement offer, the insurer shall notify the provider of its final reimbursement offer. The provider may initiate binding arbitration in response within 30 days after receipt of the insurer's final reimbursement offer by notifying the insurer and the department. The initiation notification shall include the final reimbursement offers from both the provider and the insurer. The parties may agree to resolve multiple claims for additional reimbursement.

(b) The department shall publish a list of arbitrators or entities it has approved to provide binding arbitration. The arbitrators shall be American Arbitration Association or American Health Lawyers Association trained arbitrators. Both parties must agree and notify the department of their choice of an arbitrator from the list of arbitrators within ten business days after issuance of the arbitration initiation notification. If the parties cannot reach agreement, the provider shall, within fifteen business days after the arbitration initiation notification, request from the department the names of five arbitrators. The insurer and the provider can each veto two arbitrators. The provider shall be the first party to veto two of the arbitrators and shall within five business days of receiving the names of the five arbitrators notify the insurer and the department of the vetoed names. Upon the receipt of the notice of veto, the insurer shall have five business days to provide notice to the provider and the department of the names of the two arbitrators it has vetoed. The arbitrator remaining after both parties have submitted their vetoes shall be the chosen arbitrator.

(c) In making a determination of whether a provider should receive additional reimbursement pursuant to this subsection, the parties may provide, and the arbitrator shall consider, documentation of the following:

1. Individual patient characteristics.

2. The level of training, education, and experience of the nonparticipating provider.

3. The nonparticipating provider's usual charge for comparable services provided out-of-network with respect to any health care plans.

4. The contracted rate of payment for comparable services by a participating provider for the same or similar services in the same geographic area.

5. The aggregate provider charge, as defined by a public independent database of charges, for the same or similar services in the same geographic area.

6. A percentage of the Medicare allowable rate for comparable or similar services in the same geographic area.

7. The usual and customary provider reimbursement by the insurer for similar services in the community where the services were provided.

8. The nonparticipating provider's billed charges for the services provided;

9. The circumstances and complexity of the particular case, including the time and place of the service;

10. Discounts or rebates applied to charges billed to persons who are uninsured, indigent, or experiencing a financial hardship by the non-participating provider for comparable or similar services.

11. Previous arbitration decisions under this section for comparable services under similar circumstances and characteristics.

(d) The arbitration shall consist only of a review of the final reimbursement offer submitted by each party pursuant to paragraph (a) and any documentation submitted pursuant to paragraph (c). The arbitrator's decision shall be one of the two amounts that were submitted as final reimbursement offers.

(e) The arbitrator shall render a written decision within 60 days after being named the chosen arbitrator and file it with the department. Both parties shall be bound by the arbitrator's decision. The cost of arbitration shall be reasonable and both parties to the arbitration shall equally share the cost of the arbitration. Each party shall be responsible for their own attorney's fees and additional costs.

Section 5. Subsection (2) of section 627.6471, Florida Statutes, is amended and new subsection (7) is added to that section to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(2)(a) Any insurer issuing a policy of health insurance in this state, which insurance includes coverage for the services of a preferred provider, must provide each policyholder and certificateholder with a current list of preferred providers and must make the list available on its website. The list must include where applicable and reported, a listing by specialty of

the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. Information posted to the insurer's website must be updated on at least a calendar month basis with additions or terminations of providers from the insurer's network or reported changes in physician's hospital affiliations ~~must make the list available for public inspection during regular business hours at the principal office of the insurer within the state~~.

(7) Any policy issued under this section must include the following disclosure: " 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's 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 6. This act shall take effect October 1, 2016.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:
and insert: An act relating to out-of-network health insurance coverage; amending s. 395.003, F.S.; requiring hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers to comply with certain provisions as a condition of licensure; amending s. 395.301, F.S.; requiring a hospital to post certain information regarding its contracts with health insurers, health maintenance organizations, and health care practitioners and practice groups and specified notice to patients and prospective patients; amending s. 456.072, F.S.; adding a ground for discipline of referring health care providers by the Department of Health; creating s. 627.64194, F.S.; defining terms; specifying requirements for coverage provided by an insurer for emergency services; providing that an insurer is solely liable for payment of certain fees to a provider; providing limitations and requirements for reimbursements by an insurer to a nonparticipating provider; authorizing a nonparticipating provider or insurer to initiate arbitration to determine additional reimbursement; requiring the Department of Financial Services to maintain and, under certain circumstances, provide a list of qualified arbitrators; specifying timeframes; providing certain documentation that may

be submitted for consideration by the arbitrator; providing responsibility for fees and costs; amending s. 627.6471, F.S.; requiring an insurer that issues a policy including coverage for the services of a preferred provider to post certain information about participating providers; requiring specified notice to be included in policies providing coverage for the services of a preferred provider; providing an effective date.