A bill to be entitled

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 on its website 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 nonparticipating 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 publish a list of approved arbitrators; specifying timeframes and the process for choosing an arbitrator;

providing requirements for the arbitration process, including responsibility for attorney fees and additional costs; amending s. 627.6471, F.S.; requiring an insurer that issues a health insurance policy including coverage for preferred provider services to post certain information about preferred providers, preferred provider facilities, and health care providers in the preferred provider network on its website; requiring a specified notice to be included in such policies; providing an effective date.

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

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 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) Each 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 with 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 insurers and health maintenance organizations with which the hospital contracts.

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 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 instructions on how to contact such practitioners and practice groups to determine the health insurers and health maintenance organizations with 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 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, as defined in s. 395.002. The term "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, or an urgent care center, as defined in s. 395.002.

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

(d) "Nonparticipating provider" means a provider that 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, other than applicable copayments and deductibles, to a nonparticipating provider of emergency services. 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, other than applicable copayments and deductibles, to a nonparticipating provider of nonemergency services that are:

(a) Provided in a facility that has a contract with the insurer.

(b) Provided under circumstances in which the insured does not have the 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 in s. 627.6131:

(a) The billed amount;

(b) An amount that is a reasonable reimbursement for the services and care rendered; or

(c) 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 in subsection (4) or subsection (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 nonparticipating provider may, within 60 days after receipt of the reimbursement provided in subsection (4), request additional reimbursement by making a final reimbursement offer to the insurer. Within 30 days after receipt of the nonparticipating provider's final reimbursement offer, the insurer shall notify the nonparticipating provider of its final reimbursement offer. The nonparticipating provider may initiate binding arbitration within 30 days after receipt of the insurer's final reimbursement offer by notifying the insurer and the department. The notice of initiation of binding arbitration shall include the final reimbursement offers from the nonparticipating

provider and the insurer. The parties may agree to resolve multiple claims for additional reimbursement.

(b) The department shall publish a list of arbitrators that it has approved to provide binding arbitration. Approved arbitrators shall be trained by the American Arbitration Association or the American Health Lawyers Association. The parties must agree and notify the department of their choice of an arbitrator from the list of approved arbitrators within 10 business days after issuance of the notice of initiation of binding arbitration. If the parties cannot reach an agreement, the nonparticipating provider shall, within 15 business days after receiving the notice of initiation of binding arbitration, request from the department the names of five approved arbitrators. The insurer and the nonparticipating provider may each veto two of the arbitrators. The nonparticipating provider shall be the first party to veto two of the arbitrators and, within 5 business days after receiving the names of the five arbitrators, shall notify the insurer and the department of the names of the two arbitrators it has vetoed. After receiving the notice of veto, the insurer shall have 5 business days to notify the nonparticipating 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) When making a determination of whether a nonparticipating provider shall receive additional reimbursement

pursuant to this subsection, the parties may provide and the arbitrator shall consider documentation of:

1. Individual patient characteristics.

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

3. The nonparticipating provider's usual and customary charge for similar or comparable services provided out-of-network with respect to any health care plan.

4. A participating provider's contracted rate of payment for similar or comparable services in the same geographic area.

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

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

7. The usual and customary reimbursement by an insurer for similar or comparable services in the same geographic area.

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

9. The circumstances and complexity of the particular case, including the time and location of the service provided.

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

11. Previous arbitration decisions made under this subsection for similar or comparable services provided under similar or comparable 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 pursuant to paragraph (a).

(e) The arbitrator shall render a written decision within 60 days after being named the chosen arbitrator and file the decision with the department. The parties shall be bound by the arbitrator's decision. The cost of arbitration shall be reasonable and shall be equally shared by the parties. Each party is responsible for his or her own attorney fees and additional costs.

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

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

(2) 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, when applicable and reported, organized by specialty: the names, addresses, and telephone numbers of all preferred providers and, for physicians, their board certifications, languages spoken, and facility affiliations; and the names, addresses, and telephone numbers of all preferred provider facilities. Information posted on the insurer's website must be updated each calendar month and include additions or terminations of preferred providers, preferred provider facilities, and health care providers in the preferred provider network or changes in a health care provider's facility affiliations ~~must make the list available for public inspection during regular business hours at the principal office of the insurer within the state~~.

(7) Each 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 use the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based on 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 6. This act shall take effect October 1, 2016.