1 A bill to be entitled
2 An act relating to out-of-network health insurance
3 coverage; amending s. 395.003, F.S.; requiring
4 hospitals, ambulatory surgical centers, specialty
5 hospitals, and urgent care centers to comply with
6 certain provisions as a condition of licensure;
7 amending s. 395.301, F.S.; requiring a hospital to
8 post on its website certain information regarding its
9 contracts with health insurers, health maintenance
10 organizations, and health care practitioners and
11 medical practice groups and specified notice to
12 patients and prospective patients; amending s.
13 408.7057, F.S.; providing requirements for settlement
14 offers between certain providers and health plans in a
15 specified dispute resolution program; requiring the
16 Agency for Health Care Administration to include in
17 its rules additional requirements relating to a
18 resolution organization's process in considering
19 certain claim disputes; requiring a final order to be
20 subject to judicial review; amending ss. 456.072,
21 458.331, and 459.015, F.S.; providing additional acts
22 that constitute grounds for denial of a license or
23 disciplinary action, to which penalties apply;
24 amending s. 626.9541, F.S.; specifying an additional
25 unfair method of competition and unfair or deceptive
26 act or practice; creating s. 627.64194, F.S.; defining

27 terms; providing that an insurer is solely liable for
28 payment of certain fees to a nonparticipating
29 provider; providing limitations and requirements for
30 reimbursements by an insurer to a nonparticipating
31 provider; providing that certain disputes relating to
32 reimbursement of a nonparticipating provider shall be
33 resolved in a court of competent jurisdiction or
34 through a specified voluntary dispute resolution
35 process; amending s. 627.6471, F.S.; requiring an
36 insurer that issues a policy including coverage for
37 the services of a preferred provider to post on its
38 website certain information about participating
39 providers and physicians; requiring that specified
40 notice be included in policies issued after a
41 specified date which provide coverage for the services
42 of a preferred provider; amending s. 627.662, F.S.;
43 providing applicability of provisions relating to
44 coverage for services and payment collection
45 limitations to group health insurance, blanket health
46 insurance, and franchise health insurance; providing
47 effective dates.
48
49 Be It Enacted by the Legislature of the State of Florida:
50
51 Section 1. Paragraph (d) is added to subsection (5) of
52 section 395.003, Florida Statutes, to read:

53 395.003 Licensure; denial, suspension, and revocation.—
54 (5)
55 (d) A hospital, an ambulatory surgical center, a specialty
56 hospital, or an urgent care center shall comply with ss.
57 627.64194 and 641.513 as a condition of licensure.
58 Section 2. Subsection (13) is added to section 395.301,
59 Florida Statutes, to read:
60 395.301 Itemized patient bill; form and content prescribed
61 by the agency; patient admission status notification.—
62 (13) A hospital shall post on its website:
63 (a) The names and hyperlinks for direct access to the
64 websites of all health insurers and health maintenance
65 organizations for which the hospital contracts as a network
66 provider or preferred provider.
67 (b) A statement that:
68 1. Services may be provided in the hospital by the
69 facility as well as by other health care practitioners who may
70 separately bill the patient;
71 2. Health care practitioners who provide services in the
72 hospital may or may not participate with the same health
73 insurers or health maintenance organizations as the hospital;
74 and
75 3. Prospective patients should contact the health care
76 practitioner who will provide services in the hospital to
77 determine the health insurers and health maintenance

78 organizations with which he or she participates as a network
79 provider or preferred provider.
80 (c) As applicable, the names, mailing addresses, and
81 telephone numbers of the health care practitioners and medical
82 practice groups with which it contracts to provide services in
83 the hospital and instructions on how to contact the
84 practitioners and groups to determine the health insurers and
85 health maintenance organizations with which they participate as
86 a network provider or preferred provider.
87 Section 3. Paragraph (h) is added to subsection (2) of
88 section 408.7057, Florida Statutes, and subsections (3) and (4)
89 of that section are amended, to read:
90 408.7057 Statewide provider and health plan claim dispute
91 resolution program.—
92 (2)
93 (h) Either the contracted or noncontracted provider or the
94 health plan may make an offer to settle the claim dispute when
95 it submits a request for a claim dispute and supporting
96 documentation. The offer to settle the claim dispute must state
97 its total amount, and the party to whom it is directed has 15
98 days to accept the offer once it is received. If the party
99 receiving the offer does not accept the offer and the final
100 order amount is greater than 90 percent or less than 110 percent
101 of the offer amount, the party receiving the offer must pay the
102 final order amount to the offering party and is deemed a
103 nonprevailing party for purposes of this section. The amount of

104 an offer made by a contracted or noncontracted provider to
105 settle an alleged underpayment by the health plan must be
106 greater than 110 percent of the reimbursement amount the
107 provider received. The amount of an offer made by a health plan
108 to settle an alleged overpayment to the provider must be less
109 than 90 percent of the alleged overpayment amount by the health
110 plan. Both parties may agree to settle the disputed claim at any
111 time, for any amount, regardless of whether an offer to settle
112 was made or rejected.
113 (3) The agency shall adopt rules to establish a process to
114 be used by the resolution organization in considering claim
115 disputes submitted by a provider or health plan which must
116 include:
117 (a) That the resolution organization review and consider
118 all documentation submitted by both the health plan and the
119 provider;
120 (b) That the resolution organization's recommendation make
121 findings of fact;
122 (c) That either party may request that the resolution
123 organization conduct an evidentiary hearing in which both sides
124 can present evidence and examine witnesses, and for which the
125 cost of the hearing is equally shared by the parties;
126 (d) That the resolution organization may not communicate
127 ex parte with either the health plan or the provider during the
128 dispute resolution;
129 (e) That the resolution organization's written

130 recommendation, including findings of fact relating to the
131 calculation under s. 641.513(5) for the recommended amount due
132 for the disputed claim, include any evidence relied upon; and
133 (f) That ~~the issuance by~~ the resolution organization issue
134 ~~of~~ a written recommendation~~, supported by findings of fact,~~ to
135 the agency within 60 days after the requested information is
136 received by the resolution organization within the timeframes
137 specified by the resolution organization. In no event shall the
138 review time exceed 90 days following receipt of the initial
139 claim dispute submission by the resolution organization.
140 (4) Within 30 days after receipt of the recommendation of
141 the resolution organization, the agency shall adopt the
142 recommendation as a final order. The final order is subject to
143 judicial review pursuant to s. 120.68.
144 Section 4. Paragraph (oo) is added to subsection (1) of
145 section 456.072, Florida Statutes, to read:
146 456.072 Grounds for discipline; penalties; enforcement.—
147 (1) The following acts shall constitute grounds for which
148 the disciplinary actions specified in subsection (2) may be
149 taken:
150 (oo) Willfully failing to comply with s. 627.64194 or s.
151 641.513 with such frequency as to indicate a general business
152 practice.
153 Section 5. Paragraph (tt) is added to subsection (1) of
154 section 458.331, Florida Statutes, to read:
155 458.331 Grounds for disciplinary action; action by the

156 board and department.—
157 (1) The following acts constitute grounds for denial of a
158 license or disciplinary action, as specified in s. 456.072(2):
159 (tt) Willfully failing to comply with s. 627.64194 or s.
160 641.513 with such frequency as to indicate a general business
161 practice.
162 Section 6. Paragraph (vv) is added to subsection (1) of
163 section 459.015, Florida Statutes, to read:
164 459.015 Grounds for disciplinary action; action by the
165 board and department.—
166 (1) The following acts constitute grounds for denial of a
167 license or disciplinary action, as specified in s. 456.072(2):
168 (vv) Willfully failing to comply with s. 627.64194 or s.
169 641.513 with such frequency as to indicate a general business
170 practice.
171 Section 7. Paragraph (gg) is added to subsection (1) of
172 section 626.9541, Florida Statutes, to read:
173 626.9541 Unfair methods of competition and unfair or
174 deceptive acts or practices defined.—
175 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
176 ACTS.—The following are defined as unfair methods of competition
177 and unfair or deceptive acts or practices:
178 (gg) Out-of-network reimbursement.—Willfully failing to
179 comply with s. 627.64194 with such frequency as to indicate a
180 general business practice.
181 Section 8. Section 627.64194, Florida Statutes, is created

182 to read:
183 627.64194 Coverage requirements for services provided by
184 nonparticipating providers; payment collection limitations.—
185 (1) As used in this section, the term:
186 (a) "Emergency services" means emergency services and
187 care, as defined in s. 641.47(8), which are provided in a
188 facility.
189 (b) "Facility" means a licensed facility as defined in s.
190 395.002(16) and an urgent care center as defined in s.
191 395.002(30).
192 (c) "Insured" means a person who is covered under an
193 individual or group health insurance policy delivered or issued
194 for delivery in this state by an insurer authorized to transact
195 business in this state.
196 (d) "Nonemergency services" means the services and care
197 that are not emergency services.
198 (e) "Nonparticipating provider" means a provider who is
199 not a preferred provider as defined in s. 627.6471 or a provider
200 who is not an exclusive provider as defined in s. 627.6472. For
201 purposes of covered emergency services under this section, a
202 facility licensed under chapter 395 or an urgent care center
203 defined in s. 395.002(30) is a nonparticipating provider if the
204 facility or center has not contracted with an insurer to provide
205 emergency services to its insureds at a specified rate.
206 (f) "Participating provider" means a preferred provider as
207 defined in s. 627.6471 or an exclusive provider as defined in s.

208 627.6472.
209 (2) An insurer is solely liable for payment of fees to a
210 nonparticipating provider of covered emergency services provided
211 to an insured in accordance with the coverage terms of the
212 health insurance policy, and such insured is not liable for
213 payment of fees for covered services to a nonparticipating
214 provider of emergency services, other than applicable
215 copayments, coinsurance, and deductibles. An insurer must
216 provide coverage for emergency services that:
217 (a) May not require prior authorization.
218 (b) Must be provided regardless of whether the services
219 are furnished by a participating provider or a nonparticipating
220 provider.
221 (c) May impose a coinsurance amount, copayment, or
222 limitation of benefits requirement for a nonparticipating
223 provider only if the same requirement applies to a participating
224 provider.
225
226 The provisions of s. 627.638 apply to this subsection.
227 (3) An insurer is solely liable for payment of fees to a
228 nonparticipating provider of covered nonemergency services
229 provided to an insured in accordance with the coverage terms of
230 the health insurance policy, and such insured is not liable for
231 payment of fees to a nonparticipating provider, other than
232 applicable copayments, coinsurance, and deductibles, for covered
233 nonemergency services that are:

234 (a) Provided in a facility that has a contract for the
235 nonemergency services with the insurer which the facility would
236 be otherwise obligated to provide under contract with the
237 insurer; and
238 (b) Provided when the insured does not have the ability
239 and opportunity to choose a participating provider at the
240 facility who is available to treat the insured.
241
242 The provisions of s. 627.638 apply to this subsection.
243 (4) An insurer must reimburse a nonparticipating provider
244 of services under subsections (2) and (3) as specified in s.
245 641.513(5), reduced only by insured cost-share responsibilities
246 as specified in the health insurance policy, within the
247 applicable timeframe provided in s. 627.6131.
248 (5) A nonparticipating provider of emergency services as
249 provided in subsection (2) or a nonparticipating provider of
250 nonemergency services as provided in subsection (3) may not be
251 reimbursed an amount greater than the amount provided in
252 subsection (4) and may not collect or attempt to collect from
253 the insured, directly or indirectly, any excess amount, other
254 than copayments, coinsurance, and deductibles. This section does
255 not prohibit a nonparticipating provider from collecting or
256 attempting to collect from the insured an amount due for the
257 provision of noncovered services.
258 (6) Any dispute with regard to the reimbursement to the
259 nonparticipating provider of emergency or nonemergency services

260 as provided in subsection (4) shall be resolved in a court of
261 competent jurisdiction or through the voluntary dispute
262 resolution process in s. 408.7057.
263 Section 9. Subsection (2) of section 627.6471, Florida
264 Statutes, is amended to read:
265 627.6471 Contracts for reduced rates of payment;
266 limitations; coinsurance and deductibles.—
267 (2) Any insurer issuing a policy of health insurance in
268 this state, which insurance includes coverage for the services
269 of a preferred provider, must provide each policyholder and
270 certificateholder with a current list of preferred providers and
271 must make the list available on its website. The list must
272 include, when applicable and reported, a listing by specialty of
273 the names, addresses, and telephone numbers of all participating
274 providers, including facilities, and, in the case of physicians,
275 must also include board certifications, languages spoken, and
276 any affiliations with participating hospitals. Information
277 posted on the insurer's website must be updated on at least a
278 calendar-month basis with additions or terminations of providers
279 from the insurer's network or reported changes in physicians'
280 hospital affiliations ~~for public inspection during regular~~
281 ~~business hours at the principal office of the insurer within the~~
282 ~~state~~.
283 Section 10. Effective upon this act becoming a law,
284 subsection (7) is added to section 627.6471, Florida Statutes,
285 to read:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

286 627.6471 Contracts for reduced rates of payment;
287 limitations; coinsurance and deductibles.—
288 (7) Any policy issued under this section after January 1,
289 2017, must include the following disclosure: "WARNING: LIMITED
290 BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED.
291 You should be aware that when you elect to utilize the services
292 of a nonparticipating provider for a covered nonemergency
293 service, benefit payments to the provider are not based upon the
294 amount the provider charges. The basis of the payment will be
295 determined according to your policy's out-of-network
296 reimbursement benefit. Nonparticipating providers may bill
297 insureds for any difference in the amount. YOU MAY BE REQUIRED
298 TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT.
299 Participating providers have agreed to accept discounted
300 payments for services with no additional billing to you other
301 than coinsurance, copayment, and deductible amounts. You may
302 obtain further information about the providers who have
303 contracted with your insurance plan by consulting your insurer's
304 website or contacting your insurer or agent directly."
305 Section 11. Subsection (15) is added to section 627.662,
306 Florida Statutes, to read:
307 627.662 Other provisions applicable.—The following
308 provisions apply to group health insurance, blanket health
309 insurance, and franchise health insurance:
310 (15) Section 627.64194, relating to coverage requirements
311 for services provided by nonparticipating providers and payment

312 collection limitations.
313 Section 12. Except as otherwise expressly provided in this
314 act and except for this section, which shall take effect upon
315 this act becoming a law, this act shall take effect July 1,
316 2016.
317