By Senator Hooper

21-00606-24 2024568__

1 A bill to be entitled
2 An act relating to coverage for out-of-network ground
3 ambulance emergency services; creating ss. 627.42398
4 and 641.31078, F.S.; defining terms; requiring health
5 insurers and health maintenance organizations,
6 respectively, to reimburse out-of-network ambulance
7 service providers at specified rates for providing
8 emergency services; specifying that such payment is
9 payment in full; providing exceptions; prohibiting
10 cost-sharing responsibilities paid for an out-of-
11 network ambulance service provider from exceeding
12 those of an in-network ambulance service provider for
13 covered services; requiring health insurers and health
14 maintenance organizations, respectively, to remit
15 payment for covered services if such transportation
16 was requested by a first responder or a health care
17 professional; providing procedures for claims;
18 providing an effective date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21
22 Section 1. Section 627.42398, Florida Statutes, is created
23 to read:
24 627.42398 Coverage for out-of-network ground ambulance
25 emergency services.—
26 (1) As used in this section, the term:
27 (a) “Ambulance service provider” means a ground ambulance
28 service licensed pursuant to s. 401.25.
29 (b) “Clean claim” means a claim that has no defect of

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30 impropriety, including lack of required substantiating
31 documentation or particular circumstances requiring special
32 treatment which prevent timely payment from being made on the
33 claim.
34 (c) “Covered services” means those emergency ambulance
35 services that an enrollee is entitled to receive under the terms
36 of a health insurance policy. The term does not include air
37 ambulance services.
38 (d) “Out-of-network” means a provider that does not
39 contract with the health insurer of the enrollee receiving the
40 covered health care services.
41 (2) A health insurance policy must require a health insurer
42 to reimburse an out-of-network ambulance service provider for
43 providing covered services at a rate that is the greatest of any
44 of the following:
45 (a) The rate set or approved, whether in contract, in
46 ordinance, or otherwise, by a local governmental entity in the
47 jurisdiction in which the covered services originated.
48 (b) Three hundred and fifty percent of the current
49 published rate for ambulance services as established by the
50 federal Centers for Medicare and Medicaid Services under Title
51 XVIII of the Social Security Act for the same service provided
52 in the same geographic area; or the ambulance service provider’s
53 billed charges, whichever is less.
54 (c) The contracted rate at which the health insurer would
55 reimburse an in-network ambulance provider for providing such
56 covered services.
57 (3) Payment made in compliance with this section is payment
58 in full for the covered services provided, except for any

59 copayment, coinsurance, deductible, or other cost-sharing
60 responsibilities required to be paid by the enrollee. An
61 ambulance service provider may not bill the enrollee any
62 additional amount for such paid covered services.
63 (4) Copayment, coinsurance, deductible, and other cost-
64 sharing responsibilities paid for an out-of-network ambulance
65 service provider's covered service may not exceed the in-network
66 copayment, coinsurance, deductible, and other cost-sharing
67 responsibilities for covered services received by the enrollee.
68 (5) A health insurer shall, within 30 days after receipt of
69 a clean claim for covered services, promptly remit payment for
70 covered services directly to the ambulance service provider and
71 may not send payment to an enrollee. A health insurer must remit
72 payment for the transportation of any patient by ambulance as a
73 medically necessary service if the transportation was requested
74 by a first responder or a health care practitioner as defined in
75 s. 456.001.
76 (6) If the claim is not a clean claim, the health insurer
77 must, within 30 days after receipt of the claim, send a written
78 notice acknowledging the date of receipt of the claim and
79 informing the ambulance service provider of one of the
80 following:
81 (a) That the insurer is declining to pay all or part of the
82 claim, and the specific reason or reasons for the denial.
83 (b) That additional information is necessary to determine
84 if all or part of the claim is payable, and the specific
85 additional information that is required.
86 Section 2. Section 641.31078, Florida Statutes, is created
87 to read:

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88 641.31078 Coverage for out-of-network ground ambulance
89 emergency services.—
90 (1) As used in this section, the term:
91 (a) "Ambulance service provider" means a ground ambulance
92 service licensed pursuant to s. 401.25.
93 (b) "Clean claim" means a claim that has no defect of
94 impropriety, including lack of required substantiating
95 documentation or particular circumstances requiring special
96 treatment which prevent timely payment from being made on the
97 claim.
98 (c) "Covered services" means those emergency ambulance
99 services that a subscriber is entitled to receive under the
100 terms of a health maintenance contract. The term does not
101 include air ambulance services.
102 (d) "Out-of-network" means a provider that is not a
103 provider under contract with the health maintenance organization
104 of the subscriber receiving the covered health care services.
105 (2) A health maintenance contract must require a health
106 maintenance organization to reimburse an out-of-network
107 ambulance service provider for providing covered services at a
108 rate that is the greatest of the following:
109 (a) The rate set or approved, whether in contract, in
110 ordinance, or otherwise, by a local governmental entity in the
111 jurisdiction in which the covered services originated.
112 (b) Three hundred and fifty percent of the current
113 published rate for ambulance services as established by the
114 federal Centers for Medicare and Medicaid Services under Title
115 XVIII of the Social Security Act for the same service provided
116 in the same geographic area; or the ambulance service provider's

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117 billed charges, whichever is less.
118 (c) The contracted rate at which the health maintenance
119 organization would reimburse an in-network ambulance provider
120 for providing such covered services.
121 (3) Payment made in compliance with this section is payment
122 in full for the covered services provided, except for any
123 copayment, coinsurance, deductible, or other cost-sharing
124 responsibilities required to be paid by the subscriber. An
125 ambulance service provider may not bill the subscriber any
126 additional amount for such paid covered services.
127 (4) Copayment, coinsurance, deductible, and other cost-
128 sharing responsibilities paid for an out-of-network ambulance
129 service provider's covered services may not exceed the in-
130 network copayment, coinsurance, deductible, and other cost-
131 sharing responsibilities for covered services received by the
132 subscriber.
133 (5) A health maintenance organization shall, within 30 days
134 after receipt of a clean claim for covered services, promptly
135 remit payment for covered services directly to the ambulance
136 service provider and may not send payment to a subscriber. A
137 health maintenance organization must remit payment for the
138 transportation of any patient by ambulance as a medically
139 necessary service if the transportation was requested by a first
140 responder or a health care practitioner as defined in s.
141 456.001.
142 (6) If the claim is not a clean claim, the health
143 maintenance organization must, within 30 days after receipt of
144 the claim, send a written notice acknowledging the date of
145 receipt of the claim and informing the ambulance service

21-00606-24 2024568__

146 provider of one of the following:

147 (a) That the health maintenance organization is declining

148 to pay all or part of the claim, and the specific reason or

149 reasons for the denial.

150 (b) That additional information is necessary to determine

151 if all or part of the claim is payable, and the specific

152 additional information that is required.

153 Section 3. This act shall take effect July 1, 2024.

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