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A bill to be entitled  
 An act relating to coverage for out-of-network ground  
 ambulance emergency services; creating ss. 627.42398  
 and 641.31078, F.S.; defining terms; requiring health  
 insurers and health maintenance organizations,  
 respectively, to reimburse out-of-network ambulance  
 service providers at specified rates for providing  
 emergency services; specifying that such payment is  
 payment in full; providing exceptions; prohibiting  
 cost-sharing responsibilities paid for an out-of-  
 network ambulance service provider from exceeding  
 those of an in-network ambulance service provider for  
 covered services; requiring health insurers and health  
 maintenance organizations, respectively, to remit  
 payment for covered services if such transportation  
 was requested by a first responder or a health care  
 professional; providing procedures for claims;  
 providing an effective date.

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

Section 1. Section 627.42398, Florida Statutes, is created  
 to read:

627.42398 Coverage for out-of-network ground ambulance  
 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  
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  
42 insurer to reimburse an out-of-network ambulance service  
43 provider for providing covered services at a rate that is the  
44 lesser of:

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; or

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  
 58 payment in full for the covered services provided, except for  
 59 any 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  
 69 of a clean claim for covered services, promptly remit payment  
 70 for covered services directly to the ambulance service provider  
 71 and may not send payment to an enrollee. A health insurer must  
 72 remit payment for the transportation of any patient by ambulance  
 73 as a medically necessary service if the transportation was  
 74 requested by a first responder or a health care practitioner as  
 75 defined in 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  
 82 the 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:

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 greater of the following:

109 (a) The rates 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  
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  
122 payment in full for the covered services provided, except for  
123 any 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  
134 days after receipt of a clean claim for covered services,  
135 promptly remit payment for covered services directly to the  
136 ambulance service provider and may not send payment to a  
137 subscriber. A health maintenance organization must remit payment  
138 for the transportation of any patient by ambulance as a  
139 medically necessary service if the transportation was requested  
140 by a first responder or a health care practitioner as defined in  
141 s. 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  
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

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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.