The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	CS/CS/SB 1842
INTRODUCER:	Appropriations Committee on Health and Human Services; Health Policy Committee; and Senator Burton
SUBJECT:	Out-of-network Providers
DATE:	April 14, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Fav/CS**
2.	Gerbrandt	McKnight	AHS	**Fav/CS**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1842 requires certain health care practitioners, when referring a patient for nonemergency services, to confirm whether a referral provider participates in the provider network of the patient's health insurer or health maintenance organization (HMO).

The bill requires healthcare practitioners to notify patients in writing when referring them to out-of-network providers that the providers are out of network and that it may result in higher out-of-pocket costs for the patient.

The bill provides that a practitioner who fails to comply without good cause will face disciplinary action and authorizes the Florida Department of Health (DOH) to adopt rules.

The bill has no fiscal impact on state expenditures or revenues. **See Section V., Fiscal Impact Statement.**

The bill takes effect July 1, 2025.

II. Present Situation:

Insurer

Under s. 627.6471(1)(a), F.S., an "insurer" means:

- Every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity; or
- A multiple-employer welfare arrangement.[1]

Health Insurance

Under s. 624.603, F.S., "health insurance" is insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Health insurance does not include workers' compensation coverages, except as provided in s. 624.406(4), F.S.

Health Maintenance Organization

Under s. 641.19(12), F.S., a "health maintenance organization" (HMO) is any organization authorized under part I of ch. 641, F.S., which:

- Provides, through arrangements with other persons, emergency care; inpatient hospital services; physician care including care provided by physicians licensed under chs. 458, 459, 460, and 461, F.S.;[2] ambulatory diagnostic treatment; and preventive health care services.
- Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis.
- Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers[3] are entitled to receive pursuant to a contract.
- Provides physician services, by physicians licensed under chs. 458, 459, 460, and 461, F.S.,[4] directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians.
- If offering services through a managed care system, has a system in which a primary physician licensed under chs. 458, 459, 460, or 461, F.S.,[5] is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the requested

[1] The term "multiple-employer welfare arrangement" means an employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health insurance benefits or any other benefits described in s. 624.33, other than life insurance benefits, to the employees of two or more employers, or to their beneficiaries; *see* s. 624.437(1), F.S.

[2] Chapter 458, F.S., is the practice act for medical doctors, a.k.a. allopathic physicians. Chapter 459, F.S., is the practice act for osteopathic physicians. Chapter 460, F.S., is the practice act for chiropractic physicians. Chapter 461, F.S., is the practice act for podiatric physicians.

[3] "Subscriber" means an entity or individual who has contracted, or on whose behalf a contract has been entered into, with an HMO for health care coverage or other persons who also receive health care coverage as a result of the contract; *see* s. 641.19(18), F.S.

[4] *Supra* note 2.

[5] *Id.*

service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the HMO's provider network.

Participating vs. Nonparticipating Providers

Generally, medical health insurance plans and HMOs have a list of physicians, hospitals, and other practitioners or providers[6] that have agreed to participate in the plan's network. Providers participating in the network have a contract with the health plan to care for its members at a certain cost. A member of the plan will typically pay less for medical services when using participating providers. If a plan member sees a practitioner or uses a hospital or other facility that does not participate with the health plan, the member is going out-of-network and will usually have to pay more for services rendered by a nonparticipating provider. Some plans will not cover any amount of out-of-network care, while others cover a percentage of care.[7]

Participating providers[8] have a contract with an insurer that limits the amount of money the provider may charge individuals who are covered under the contracted insurance company. The agreed-upon contract rate includes both the patient and insurer shares and may be based on certain assumptions regarding the volume of patients that will use that provider's services. The portion of the contracted rate a patient pays is determined by his or her insurance policy or HMO subscriber contract.[9]

Nonparticipating providers[10] are those who have not agreed to accept a contracted rate with a patient's insurance company or HMO. If a patient chooses to seek treatment outside of his or her network, insurance companies and HMOs typically increase cost-sharing.[11]

Health Insurance Cost-Sharing

The term "cost-sharing" refers to how health plan costs are shared between insurers and insureds, sometimes called "out-of-pocket" costs when referring to the insured's share of costs for services that a plan covers that the insured must pay out of their own pocket.[12]

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[6] "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state; *see* s. 641.47(14), F.S.
[7] Medicare.gov, *Health Maintenance Organizations (HMOs), available at* https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/HMO (last visited Mar. 21, 2025).
[8] "Participating provider" means a preferred provider as defined in s. 627.6471 or an exclusive provider as defined in s. 627.6472; *see* s. 627.64194(1)(f), F.S.
[9] Centers for Medicare & Medicaid Services, *No Surprises: Health insurance terms you should know, available at* https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf (last visited Mar. 21, 2025).
[10] "Nonparticipating provider" means a provider who is not a preferred provider as defined in s. 627.6471 or a provider who is not an exclusive provider as defined in s. 627.6472. For purposes of covered emergency services under this section, a facility licensed under chapter 395 or an urgent care center defined in s. 395.002 is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate; *see* s. 627.64194(1)(e), F.S.
[11] *Supra* note 9.
[12] *Id.*

Types of Cost-Sharing

Health insurance policies and HMO subscriber contracts may include the following types of cost-sharing:

- Premium Contribution – A health coverage premium is the total amount that must be paid in advance to obtain coverage for a particular level of services. Usually, premiums are billed and paid on a monthly basis.[13] Employers typically require employees to share the cost of the plan premium. Employers are free to require employees to cover some or all of the premium cost for dependents, such as a spouse or children.[14]
- Copayments – A copayment or copay is a flat fee paid by the patient at the time of service.[15]
- Coinsurance – Coinsurance is the insured's share of costs of a covered health service, calculated as a percent of the allowed amount for the service. If the plan pays 70 percent of the cost, then the patient pays 30 percent of the cost. If the plan pays 90 percent, then the patient pays 10 percent, and so forth.[16]
- Deductible – The deductible is the amount the insured pays before the plan pays anything. Deductibles generally apply per person per calendar year.[17] Typically, the higher the deductible, the lower the premium. Some plans with particularly high deductibles are known as "high deductible" plans. While these plans may have significantly lower premiums, the insured is usually exposed to higher out-of-pocket costs.[18]
- Out-of-Pocket Maximum – The most that the insured or subscriber could pay during a coverage period (usually one year) for their share of the costs of covered services. After meeting the limit, the plan will usually pay 100 percent of the allowed amount. This limit helps the insured or subscriber plan for health care costs. This limit never includes the premium, balance-billed charges, or health care the plan does not cover. Some plans do not count all copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.[19]

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[13] Centers for Medicare & Medicaid Services, *Course 2 Health Coverage Basics, available at* https://www.cms.gov/marketplace/technical-assistance-resources/training-materials/health-coverage-basics-training.pdf (last visited Mar. 21, 2025).
[14] Kaiser Family Foundation, *Employer-Sponsored Health Insurance 101* (May 28, 2024), *available at* https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-introduction (last visited Mar. 21, 2025).
[15] Centers for Medicare & Medicaid Services, *No Surprises: Health insurance terms you should know, available at* https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf (last visited Mar. 21, 2025).
[16] *Id*.
[17] *Id*.
[18] South Carolina Department of Insurance, *Understanding Your Deductible, available at* https://doi.sc.gov/1019/Understanding-Your-Deductible#:~:text=Policies%20with%20lower%20deductibles%20typically,need%20to%20file%20a%20claim. (last visited Mar. 21, 2025).
[19] Centers for Medicare & Medicaid Services, *No Surprises: Health insurance terms you should know, available at* https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf (last visited Mar. 21, 2025).

Regulation of Health Insurance and HMOs in Florida

The Florida Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities.[20] To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.[21] The Florida Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority[22] from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA. As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[23]

Balance Billing

A provider, regardless of contracted status with an HMO, may not collect or attempt to collect money from an HMO subscriber.[24] The subscriber is not liable for payment of fees to the provider.[25] Balance billing is also prohibited in cases when emergency services are provided by a nonparticipating provider, and when nonemergency services are provided by a nonparticipating provider and the insured or subscriber does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the covered patient.[26]

Florida Regulation of Health Care Practitioners

Health care practitioners[27] are regulated by the Florida Department of Health (DOH) under ch. 456, F.S., and individual practice acts for each profession. Many practitioners are regulated by profession-specific boards or councils of members of the profession appointed by the Governor and administered by the DOH; however, some health care practitioners are regulated directly by the DOH without a board or council.[28]

Chapter 456, F.S., and individual practice acts delineate standards of licensure and practice, and the boards, or the DOH if there is no board, enforce violations under the Administrative Procedure Act. Boards and the DOH may issue a reprimand or letter of concern, assess fines,

[20] Section 20.121(3)(a)1., F.S.
[21] Section 641.21(1), F.S.
[22] Sections 624.401 and 641.49, F.S.
[23] Section 641.495, F.S.
[24] Sections 641.315(1), and 641.3154(1) and (4), F.S.
[25] *Id*.
[26] Section 627.64194, F.S.
[27] "Health care practitioner" means any person licensed under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 462 (naturopathy); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry, dental hygiene, and dental laboratories); chapter 467 (midwifery); part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468 (speech-language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, or orthotics, prosthetics, and pedorthics); chapter 478 (electrolysis); chapter 480 (massage therapy practice); part I, part II, or part III of chapter 483 (clinical laboratory personnel, medical physicists, or genetic counseling); chapter 484 (dispensing of optical devices and hearing aids); chapter 486 (physical therapy practice); chapter 490 (psychological services); or chapter 491 (clinical, counseling, and psychotherapy services); *see* s. 456.001(4), F.S.
[28] Florida Department of Health, *Licensing and Regulation, available at* https://www.floridahealth.gov/licensing-and-regulation/index.html (last visited Mar. 21, 2025).

suspend or restrict licenses, or revoke licenses, among other penalties, based on the nature of the violation.[29]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[30] must provide, within seven days of a written request, a good faith estimate (GFE) of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group[31] or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also, pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within seven days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates and that actual charges will be based on the services actually provided.[32]

Federal Transparency Requirements

Federal Transparency in Coverage Requirements – Insurers and HMOs

On October 29, 2020, the federal departments of Health and Human Services (HHS), Labor, and Treasury finalized Transparency in Coverage regulations[33] imposing new transparency requirements on issuers of individual and group health insurance plans.

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[29] Section 456.072, F.S.
[30] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of ch. 395, F.S.
[31] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention, and resource intensity.
Centers for Medicare & Medicaid Services, *Design and development of the Diagnosis Related Group (DRG)* (Oct. 2020), *available at* https://www.cms.gov/icd10m/version38-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf (last visited Mar. 21, 2025).
[32] Section 395.301, F.S.
[33] Transparency in Coverage, 85 F.R. 73158 (Nov. 12, 2020) (codified at 29 C.F.R. § 54, 29 C.F.R. § 2590, 45 C.F.R. § 147, and 45 C.F.R. § 158).

Central to the new regulations is a requirement for insurers and HMOs to provide an estimate of an insured's or subscriber's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurers and HMOs must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs before receiving health care services, to encourage shopping and price competition among providers.[34]

Transparency in Coverage Final Rules

The Transparency in Coverage Final Rules (TiC Rules) require non-grandfathered group health insurers and HMOs offering non-grandfathered group and individual health insurance coverage to make cost-sharing information available to insureds and subscribers through an Internet-based self-service tool and in paper form, upon request.[35] This information must be made available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the departments[36] in Table 1 of the preamble to the TiC Rules,[37] and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.[38]

The insurer or HMO must make available to an insured or subscriber upon request cost-sharing information for a discrete covered item or service by billing code or descriptive term, and generally must furnish it according to the insured's or subscriber's request.[39] Further, the TiC Rules require an insurer or subscriber to provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider, according to the insured's or subscriber's request, permitting the individual to specify the information necessary for the insurer or HMO to provide meaningful cost-sharing liability information.[40]

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[34] Health Affairs Blog, *Trump Administration Finalizes Transparency Rule for Health Insurers* (Nov. 1, 2020), *available at* https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last visited Mar. 21, 2025).

[35] 26 C.F.R. § 54.9815-2715A2(b); 29 C.F.R. § 2590.715-2715A2(b); and 45 C.F.R. § 147.211(b). The Consolidated Appropriations Act, 2021 imposed a largely duplicative requirement, and added a requirement that price comparison guidance also be provided by telephone, upon request. *See* also FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), Q3, *available at* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf, and FAQs about Affordable Care Act Implementation Part 61 (cms.gov) (Sep. 27, 2024) (last visited Mar. 21, 2025).

[36] Department of Treasury, Department of Labor, and Department of Health and Human Services.

[37] 85 F.R. 72158, 72182-90 (Nov. 12, 2020)

[38] 26 C.F.R. § 54.9815-2715A2(c)(1); 29 C.F.R. § 2590.715-2715A2(c)(1); and 45 C.F.R. § 147.211(c)(1).

[39] In responding to an insured's or subscriber's request, the group health plan or health insurer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. 26 C.F.R. § 54.9815-2715A2(b)(2)(ii); 29 C.F.R. § 2590.715-2715A2(b)(2)(ii); and 45 C.F.R. § 147.211(b)(2)(ii).

[40] 26 C.F.R. § 54.9815-2715A2(b)(1); 29 C.F.R. § 2590.715-2715A2(b)(1); and 45 C.F.R. § 147.211(b)(1).

The Federal "No Surprises" Act

On December 27, 2020, Congress enacted the No Surprises Act (Act) as part of the Consolidated Appropriations Act of 2021.[41] The Act includes a wide range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of health care. Most sections of the Act went into effect on January 1, 2022, and the federal departments of HHS, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.[42]

Federal "No Surprises" Act Requirements Relating to Estimates – Facilities

The Act requires a health insurer or HMO to generate an "advanced explanation of benefits" (AEOB) that combines information on charges provided by a hospital facility with patient-specific cost information provided by a policy or contract. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a GFE of the total expected charges for scheduled items or services, including any expected ancillary services, with a health insurer (if the patient is insured) or individual (if the patient is uninsured).[43]

Federal "No Surprises" Act Requirements of Health Insurers and HMOs

Under the Act, once the GFE has been shared with a patient's health insurer or HMO, then the insurer or HMO must then develop the AEOB. This personalized cost estimate must include the following:[44]

- An indication of whether the facility participates in the patient's insurer's or HMO's network. If the facility is non-participating, information must be included on how the patient can receive services from a participating provider;
- The GFE prepared by the hospital facility based on billing or diagnostic codes;
- A GFE of the amount to be covered by the health insurer or HMO;
- A GFE of the amount of the patient's out-of-pocket costs;
- A GFE of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's policy or contract;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (e.g., medical necessity determinations, prior authorization, step therapy, etc.); and
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.

Deferral of Federal Enforcement Related to the GFEs and the AEOBs for Insured Individuals

In October 2021, the decision to defer enforcement of certain requirements described above was made in response to stakeholder requests that standards first be established for the data transfer from providers and facilities to plans and issuers, and give plans, issuers, providers, and facilities enough time to build the infrastructure necessary to support the transfers.

[41] Public Law 116-260. The No Surprises Act is found in Division BB of the Act.
[42] Public Law 116-260. The No Surprises Act is found in Division BB of the Act.
[43] *Id*.
[44] *Id*.

In September 2022, the federal government issued a Request for Information (RFI) relating to the AEOB and the GFE for covered individuals. In the RFI, as noticed in the Federal Register, it was stated that the HHS is deferring enforcement of the requirement that providers and facilities must provide a GFE to plans and issuers for covered individuals enrolled in a health plan or coverage and seeking to have a claim submitted for scheduled (or requested) items or services to their plan or coverage, as well as deferring enforcement of the requirement that plans and issuers must provide these covered individuals with an AEOB.[45]

On April 23, 2024, the federal government provided an update[46] on progress towards AEOB rulemaking and implementation. The update included a summary of comments received in response to the September 2022 RFI. According to the update, various types of health care providers, payers, and third-party vendors were studied to understand technical needs and capabilities, existing claims processes, communications channels, and potential financial and operational constraints. Additionally, the federal government engaged digital service researchers, who recommended a single data exchange standard for the transmission of data between payers and providers and emphasized that current published technical standards may not be sufficient to meet the AEOB requirements. As a result, new standards may need to be developed to ensure successful implementation.[47]

At this time, no further federal guidance has been issued to indicate how long enforcement will be deferred.[48]

III. Effect of Proposed Changes:

Section 1 amends s. 456.0575, F.S., to require a health care practitioner providing nonemergency services, as defined in s. 627.64194, F.S., to a patient and referring the patient to a provider for nonemergency services, to confirm whether the referral provider participates in the provider network of the patient's health insurer or Health Maintenance Organization (HMO) at the point of service. The practitioner, or his or her employee, may confirm the referral provider's participation by contacting the referral provider or the patient's health insurer or HMO, as necessary, or may rely on the online provider directory of the health insurer or HMO.

The bill provides that such requirement does not apply if the patient declines in writing the offer to confirm whether other providers participate in the patient's health insurer or HMO provider network.

The bill requires that when making a referral, a practitioner must notify a patient in writing that services provided by an out-of-network provider or that are not covered services under the

[45] 87 F.R. 56905.
[46] Centers for Medicare & Medicaid Services, *Progress Toward Advanced Explanation of Benefits (AEOB) Rulemaking and Implementation, available at* https://www.cms.gov/files/document/progress-aeob-rulemaking-implementation.pdf (last visited Mar. 22, 2025).
[47] NFP, An Aon Company, *FAQ: When must group health plans comply with the CAA 2021 Advanced Explanation of Benefits (AEOB) requirement, available at* https://www.nfp.com/insights/faq-when-must-group-health-plans-comply-with-the-caa-2021-advanced-explanation-of-benefits-aeob-requirement/ (last visited Mar. 22, 2025).
[48] *Id*.

patient's health coverage may result in additional cost-sharing responsibilities for the patient, and such notice must be documented in the patient's medical record. Failure to comply, without good cause, will result in disciplinary action against the health care practitioner.

The bill authorizes the Department of Health (DOH) to adopt rules to implement its provisions.

The bill takes effect July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may result in an indeterminate negative fiscal impact on healthcare practitioners who may see an increased workload due to the provisions in the bill.

C. Government Sector Impact:

The bill has no fiscal impact on state expenditures or revenues.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 1 requires that disciplinary action be taken against a health care practitioner who fails to comply, without good cause, with the bill's requirement for written patient notifications. However, it is unclear what constitutes "good cause" or a "disciplinary action."

VIII. Statutes Affected:

This bill substantially amends section 456.0575 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS/CS by Appropriations Committee on Health and Human Services on April 10, 2025:

The committee substitute:

- Requires a patient to notify a practitioner *in writing* if they do not wish for confirmation that a referral provider participates in the provider network of the patient's health insurer or health maintenance organization (HMO).
- Allows practitioners to confirm whether the referral provider participates in the provider network of the patient's health insurer or HMO by relying on the online provider directory of the health insurer or HMO.

CS by Health Policy on March 25, 2025:

The committee substitute:

- Removes the underlying bill's amendments to the Insurance Code relating to health insurance deductibles.
- Clarifies that a health care practitioner providing nonemergency services to a patient and making a referral to another provider for nonemergency services, must confirm the referral provider's participation in the provider network of the patient's health insurer or Health Maintenance Organization (HMO) at the point of service unless the patient declines the practitioner's offer to make the network confirmation or declines to share identifying information with the referral provider. The CS allows the referring practitioner to delegate this duty to an employee.
- Requires a practitioner to notify a patient in writing when additional cost-sharing responsibilities are possible when making a referral for services provided by an out-of-network provider or that are not covered services under the patient's health coverage.
- Authorizes the Department of Health (DOH) to adopt rules.

B. Amendments:

None.