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 Committee on Fiscal Policy

BILL:	CS/CS/CS/SB 1842
INTRODUCER:	Fiscal Policy Committee; Appropriations Committee on Health and Human Services; Health Policy Committee; and Senator Burton
SUBJECT:	Out-of-network Providers
DATE:	April 24, 2025
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/CS/SB 1842 amends s. 456.053, F.S., to require that before a health care provider refers a patient for non-emergency services to an entity in which the provider has an investment interest, and such entity does not participate in the patient's health insurance or health maintenance organization (HMO) provider network, the provider must disclose to the patient his or her status with the referral entity, in writing, and the disclosure must indicate that services will be provided by the referral entity on an out-of-network basis, which might result in additional cost-sharing responsibilities for the patient.

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 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.

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[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.*

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]

Types of Cost-Sharing

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

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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.*

- 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]

The Florida "Patient Self-Referral Act of 1992"

Section 456.053, F.S., contains the "Patient Self-Referral Act of 1992" (Act). The purpose of the Act is to prevent conflicts of interest relating to patient referrals by health care providers to a provider of certain health care services in which the referring provider has an investment or other financial interest. The Legislature recognized that it may be appropriate for providers to own entities providing health care services, and to refer patients to such entities, as long as certain

[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).

safeguards are present in the arrangement. This section of statute also provides guidance to health care providers regarding prohibited, and authorized, patient referrals under Florida law.

Specifically, the Act prohibits a health care provider from referring a patient for the provision of designated health services (DHS) or any other health care items or services to an entity in which the health care provider is an investor or has an investment interest. DHS are:[20]

- Clinical laboratory services;
- Physical therapy services;
- Comprehensive rehabilitative services;[21]
- Diagnostic-imaging services;[22] and
- Radiation therapy services.

For purposes of the Act:

- An "entity" means any individual, partnership, firm, corporation, or other business entity.[23]
- A "health care provider" is a Florida licensed medical doctor, osteopathic physician, chiropractor, podiatrist, advanced practice registered nurse who is registered to practice autonomously (autonomous APRN), optometrist, or dentist.[24]
- "Investment interest" means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity interests or debt instruments. The following investment interests shall be excepted from this definition:[25]
    - An investment interest in an entity that is the sole provider[26] of DHS in a rural area;[27]
    - An investment interest in notes, bonds, debentures, or other debt instruments issued by an entity which provides DHS, as an integral part of a plan by such entity to acquire such investor's[28] equity investment interest in the entity, provided that the interest rate is consistent with fair market value,[29] and that the maturity date of the notes, bonds,

[20] Section 456.053(3)(c), F.S.
[21] "Comprehensive rehabilitation services" means services that are provided by health care professionals licensed under part I or part III of ch. 468, F.S., or ch. 486, F.S., to provide speech, occupational, or physical therapy services on an outpatient or ambulatory basis. *See* s. 456.053(3)(b), F.S.
[22] "Diagnostic imaging services" means magnetic resonance imaging, nuclear medicine, angiography, arteriography, computed tomography, positron emission tomography, digital vascular imaging, bronchography, lymphangiography, splenography, ultrasound, EEG, EKG, nerve conduction studies, and evoked potentials. *See* s. 456.053(3)(d), F.S.
[23] Section 456.053(3)(e), F.S.
[24] Section 456.053(3)(h), F.S.
[25] Section 456.053(3)(j), F.S.
[26] "Sole provider" means one Florida licensed medical doctor, osteopathic physician, chiropractor, podiatrist, or autonomous APRN, who maintains a separate medical office and a medical practice separate from any other health care provider and who bills for his or her services separately from the services provided by any other health care provider. A sole provider shall not share overhead expenses or professional income with any other person or group practice. *See* s. 456.053(3)(p), F.S.
[27] "Rural area" means a county with a population density of no greater than 100 persons per square mile, as defined by the United States Census. *See* s. 456.053(3)(o), F.S.
[28] "Investor" means a person or entity owning a legal or beneficial ownership or investment interest, directly or indirectly, including, without limitation, through an immediate family member, trust, or another entity related to the investor within the meaning of 42 C.F.R. s. 413.17, in an entity. *See* s. 456.053(3)(k), F.S.
[29] "Fair market value" means value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use, and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to

debentures, or other debt instruments issued by the entity to the investor is not later than October 1, 1996.
    - An investment interest in real property resulting in a landlord-tenant relationship between the health care provider and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant or exceeds fair market value; or
    - An investment interest in an entity which owns or leases and operates a hospital licensed under ch. 395, F.S., or a nursing home facility licensed under ch. 400, F.S.
- "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:
    - The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies DHS or any other health care item or service; or
    - The request or establishment of a plan of care by a health care provider, which includes the provision of DHS or other health care item or service.
    - The following orders, recommendations, or plans of care shall not constitute a referral by a health care provider:
        - By a radiologist for diagnostic-imaging services.
        - By a physician specializing in the provision of radiation therapy services for such services.
        - By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.
        - By a cardiologist for cardiac catheterization services.
        - By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.
        - By a health care provider who is the sole provider or member of a group practice[30] for DHS or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the supervision of such referring health care provider or group practice if such supervision complies with all applicable Medicare payment and coverage rules for services; provided, however, a Florida licensed medical doctor, osteopathic physician, chiropractor, podiatrist, or autonomous APRN may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for

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the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee. *See* s. 456.053(3)(f), F.S.

[30] "Group practice" means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:

1. In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;
2. For which substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and
3. In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group. *See* s. 456.053(3)(g), F.S.

which the sole provider or group practice billed both the technical and the professional fee for or on behalf of the patient, if the referring physician or autonomous APRN has no investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider.[31] The group practice or sole provider may accept no more than 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.[32] However, the 15 percent limitation and certain requirements for accepting outside referrals for diagnostic imaging[33] do not apply to a group practice entity that owns an accountable care organization or an entity operating under an advanced alternative payment model according to federal regulations if such entity provides diagnostic imaging services and has more than 30,000 patients enrolled per year.

- By a health care provider for services provided by an ambulatory surgical center licensed under ch. 395, F.S.
- By a urologist for lithotripsy services.
- By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.
- By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.
- By a nephrologist for renal dialysis services and supplies, except laboratory services.
- By a health care provider whose principal professional practice consists of treating patients in their private residences[34] for services to be rendered in such private residences, except for services rendered by a home health agency licensed under ch. 400, F.S.
- By a health care provider for sleep-related testing.

The focus of the bill is s. 456.053(5)(j), F.S., which requires health care providers that are authorized to refer a patient to an entity in which the provider is an investor,[35] or to certain offices of radiation therapy centers,[36] to disclose his or her investment interest to his or her patients.

[31] "Patient of a group practice" or "patient of a sole provider" means a patient who receives a physical examination, evaluation, diagnosis, and development of a treatment plan if medically necessary by a physician who is a member of the group practice or the sole provider's practice. *See* s. 456.053(3)(m), F.S.
[32] "Outside referral for diagnostic imaging services" means a referral of a patient to a group practice or sole provider for diagnostic imaging services by a physician who is not a member of the group practice or of the sole provider's practice and who does not have an investment interest in the group practice or sole provider's practice, for which the group practice or sole provider billed for both the technical and the professional fee for the patient, and the patient did not become a patient of the group practice or sole provider's practice. *See* s. 456.053(3)(l), F.S.
[33] *See* s. 456.053(4)(a)2., F.S.
[34] The term "private residences" includes patients' private homes, independent living centers, and assisted living facilities, but does not include skilled nursing facilities. *See* s. 456.053(3)(n)l., F.S.
[35] *See* s. 456.053(5)(b), F.S.
[36] *See* s. 456.053(5)(i), F.S.

Currently, a health care provider cannot refer a patient to an entity in which such provider is an investor unless, prior to the referral, the provider furnishes the patient with a written disclosure form, informing the patient of:

- The existence of the investment interest.
- The name and address of each applicable entity in which the referring health care provider is an investor.
- The patient's right to obtain the items or services for which the patient has been referred at the location or from the provider or supplier of the patient's choice, including the entity in which the referring provider is an investor.
- The names and addresses of at least two alternative sources of such items or services available to the patient.

The physician or health care provider must also post a copy of the disclosure forms in a conspicuous public place in his or her office. A violation of these requirements constitutes a misdemeanor of the first degree, punishable as provided in s. 775.082, F.S.,[37] or s. 775.083, F.S.[38] In addition to any other penalties or remedies provided,[39] a violation will be grounds for disciplinary action by the respective board.[40,41]

The Federal Stark Law

A similar law exists at the federal level, commonly referred to as the Stark Law.[42] The Stark Law prohibits a physician from making referrals for certain DHS to an entity with which the physician, or an immediate family member, has a financial relationship (ownership, investment, compensation arrangement) and billing Medicare (or other payers), unless an exception applies. The following items or services are DHS:[43]

- Clinical laboratory services;

[37] A person who has been convicted of a designated misdemeanor of the first degree may be sentenced to a definite term of imprisonment not exceeding one year. *See* s. 775.082(4)(a), F.S.

[38] A person who has been convicted of an offense other than a capital felony may be sentenced to pay a fine in addition to any punishment described in s. 775.082, F.S.; when specifically authorized by statute, he or she may be sentenced to pay a fine in lieu of any punishment described in s. 775.082, F.S. A person who has been convicted of a noncriminal violation may be sentenced to pay a fine. Fines for designated crimes and for noncriminal violations shall not exceed $1,000, when the conviction is of a misdemeanor of the first degree. In addition to a fine, court costs will be assessed and collected in each instance a defendant pleads nolo contendere to, or is convicted of, or adjudicated delinquent for, a felony, a misdemeanor, or a criminal traffic offense under state law, or a violation of any municipal or county ordinance if the violation constitutes a misdemeanor under state law. The court costs imposed will be $50 for a felony and $20 for any other offense and will be deposited by the clerk of the court into an appropriate county account for disbursement. *See* ss. 775.083(1)(d) and 775.083(2), F.S.

[39] Any health care provider or other entity that enters into an arrangement or scheme, such as a cross-referral arrangement, which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of s. 456.053, F.S., will be subject to a civil penalty up to $100,000 for each circumvention arrangement or scheme to be imposed and collected by the appropriate board. *See* s. 456.053(5)(f), F.S.

[40] Section 456.052, F.S.

[41] Section 456.053(5)(g), F.S.

[42] 42 U.S.C. s. 1395nn (1989).

[43] Centers for Medicare & Medicaid Services, *Physician Self-Referral, available at* https://www.cms.gov/medicare/regulations-guidance/physician-self-referral?redirect=/physicianselfreferral/ (last visited Apr. 23, 2025).

- Physical therapy services;
- Occupational therapy services;
- Outpatient speech-language pathology services;
- Radiology and certain other imaging services;
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

The federal regulations implementing the Stark Law were updated to coordinate the care among physicians and other health care providers to improve the care of the patients they serve.[44] This rule provides exceptions to the referral prohibitions for, among other things, physician services and in-office ancillary services if the services are furnished personally; by another physician in the referring physician's group practice; or by another individual who is supervised by the referring physician or another physician in the group practice, provided that the supervision complies with all other applicable Medicare payment and coverage rules for the services.[45]

More recently, in the 2023 federal Consolidated Appropriations Act,[46] the U.S. Congress established a new exception to the physician self-referral law for physician wellness programs. Provided that all the requirements of the Stark Law are satisfied, provider facilities such as hospitals, ambulatory surgical centers, community health centers, rural emergency hospitals, rural health clinics, or skilled nursing facilities are allowed to offer a bona fide mental health or behavioral health improvement or maintenance program to physicians that practice in the specific geographic area served by such entity. Only physician wellness programs offered on or after December 29, 2022, can utilize this exception.[47]

III. Effect of Proposed Changes:

Section 1 amends s. 456.053, F.S., to require a health care provider who meets the requirements of ss. 456.053(b) and 456.053(i), F.S., to disclose to the patient his or her status with the entity in which the health care provider has an investment interest as a nonparticipating provider for nonemergency services, as those terms are defined in s. 627.64194, F.S., or to a provider, as defined in s. 641.47, F.S., not under contract with the patient's HMO before making a referral to his or her patient.

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[44] Centers for Medicare & Medicaid Services, *Modernizing and Clarifying the Physician Self-Referral Regulations Final Rule (CMS-1720-F)* (Nov. 20, 2020), *available at* https://www.cms.gov/newsroom/fact-sheets/modernizing-and-clarifying-physician-self-referral-regulations-final-rule-cms-1720-f (last visited Apr. 23, 2025).
[45] *See* 85 Federal Register 77492, 77667; 42 C.F.R. s. 411.355 (published December 2, 2020, effective January 19, 2021), *available at* https://www.govinfo.gov/content/pkg/FR-2020-12-02/pdf/2020-26140.pdf (last visited Apr. 23, 2025).
[46] Congress.gov, *H.R.2617 - Consolidated Appropriations Act, 2023, available at* https://www.congress.gov/bill/117th-congress/house-bill/2617/text (last visited Apr. 23, 2025).
[47] LUGPA: Integrated Practices Comprehensive Care, *Stark Law Update, available at* https://www.lugpa.org/stark-law-update-april-2023#:~:text=The%20new%20rule%20aligned%20the,context%20of%20value%2Dbased%20arrangements. (last visited Apr. 23, 2025).

The bill requires the disclosure to be in writing and to state that the services will be provided on an out-of-network basis, which may result in additional cost-sharing responsibilities for the patient.

Section 2 provides an effective date of 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:

None.

C. Government Sector Impact:

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

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 456.053 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/CS by Fiscal Policy on April 22, 2025:
The committee substitute:

- Removes the underlying bill's amendments to s. 456.0575, F.S.
- Amends s. 456.053, F.S., to require that before a health care provider refers a patient for non-emergency services to an entity in which the provider has an investment interest, and such entity does not participate in the patient's health insurance or HMO provider network, the provider must disclose to the patient his or her status with the referral entity, in writing, and the disclosure must indicate that services will be provided by the referral entity on an out-of-network basis, which might result in additional cost-sharing responsibilities for the patient.

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.