HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 681 Health Insurance Coverage for Emergency Services
SPONSOR(S): Insurance & Banking Subcommittee; Trujillo
TIED BILLS: **IDEN./SIM. BILLS:** SB 516

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	10 Y, 3 N, As CS	Peterson	Cooper
2) Appropriations Committee	25 Y, 1 N	Delaney	Leznoff
3) Health & Human Services Committee		McElroy	Calamas

SUMMARY ANALYSIS

A Preferred Provider Organization (PPO) is a health plan that contracts with providers to create a network of providers who participate for an alternative or reduced rate of payment. Generally, the member is responsible only for required cost-sharing amounts if covered services are obtained from network (contract) providers. However, if a member chooses to obtain services from a non-network (noncontract) provider, the member can be billed for the difference between the provider's charges and the PPO's approved reimbursement. In an Exclusive Provider Organization (EPO) arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the contract hospitals or providers to receive covered benefits, subject to limited exceptions. A Health Maintenance Organization (HMO) provides health care services pursuant to contractual arrangements with preferred providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits.

Current law requires an HMO to provide coverage for emergency services and care without prior authorization and without regard for whether the provider has a contract with the HMO. The HMO must reimburse a noncontract provider the lesser of the provider's charges; the usual and customary rate for provider charges in the community; or the rate agreed to between the provider and the HMO. The noncontract provider may not collect additional reimbursement from the subscriber.

The bill establishes a payment methodology for emergency services and care provided by noncontract providers to members of a PPO or EPO and prohibits those providers from collecting or attempting to collect any additional amount. Plans must reimburse noncontract providers the greater of the amount negotiated with the provider; the usual and customary reimbursement for the same service in the community; or the Medicare rate. PPOs and EPOs are required to provide coverage for emergency care without prior authorization and regardless of whether the provider is in-network. Applicable cost-sharing must be the same for network or non-network providers.

In addition, the bill revises the methodology an HMO must use to reimburse noncontract providers for emergency services and care to conform to the new methodology applicable to PPOs and EPOs, and adds conforming language to ch. 409, F.S., related to Medicaid. The effect is to change the existing reimbursement standard from one that is based on provider charges to one that is based on provider reimbursement.

The bill has an insignificant negative fiscal impact on Medicaid managed care rates as a result of the change to the payment methodology for emergency services and care. The change to the Medicaid managed care rates can be absorbed within existing appropriation. The bill has an indeterminate minimal negative fiscal impact on the State Group Health Insurance Program.

The bill is effective October 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Managed Care Organizations

Types[1]

Preferred Provider Organization (PPO)[2]

A PPO is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. A PPO is an insurance product. PPO plan members generally see specialists without prior referral or authorization from the insurer. Generally, the member is only responsible for the policy co-payment, deductible, or co-insurance amounts if covered services are obtained from network (contract) providers. However, if a member chooses to obtain services from a non-network (noncontract) provider, those out-of-pocket costs likely will be higher. An insurer that offers a PPO plan must make its current list of preferred providers available to its members.

Exclusive Provider Organization (EPO)[3]

In an EPO arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the contract hospitals or providers to receive covered benefits, subject to limited exceptions.

Health Maintenance Organization (HMO)[4]

An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. The network is made up of providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for non-network services rendered to the member.[5]

Regulation

The Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations, and other risk-bearing entities.[6] To operate in Florida, an HMO must obtain a certificate of authority from OIR.[7] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA pursuant to part III of ch. 641, F.S.[8]

---

[1] *See generally* FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers, available at*: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/chmo.shtml (last visited March 8, 2015).
[2] *See generally* s. 627.6471, F.S.
[3] *See generally* s. 627.6472, F.S.
[4] *See generally* part I of chapter 641, F.S.
[5] Section 641.31(38), F.S., creates an exception to this general rule. It authorizes an HMO to offer a point-of-service benefit. The benefit, offered pursuant to a rider, enables a subscriber to select, at the time of service and without referral, a noncontract provider for a covered service. The HMO may require the subscriber to pay a reasonable co-payment for each visit for services provided by a noncontract provider.
[6] s. 20.121(3)(a)1., F.S.
[7] ss. 641.21(1) and. 641.49, F.S.
[8] ss. 641.21(1) and 641.48, F.S.

As part of the certification process used by 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.[9]

The Florida Insurance Code requires health insurers and HMOs to provide an outline of coverage or other information describing the benefits, coverages, and limitations of a policy or contract. This may include an outline of coverage describing the principal exclusions and limitations of the policy.[10]

Balance Billing[11]

Background

Balance billing describes the situation where a health care provider seeks to collect payment from a patient for the difference between the provider's billed charges for a covered service and the amount that the managed care organization paid on the claim. Before the rise of managed care, consumers with insurance typically expected some balance billing. Under traditional indemnity insurance, the insured paid the provider directly then sought reimbursement from the insurer. The insurer reimbursed, minus any cost sharing, up to the policy amount. If the reimbursement was below the billed charge, then the patient would not be fully reimbursed.

Today most people with private insurance are covered by a managed care organization. Members must utilize the services of network providers to minimize out-of-pocket expenses. Typically, contracts between network providers include a "hold harmless" provision that protects members from being balance billed by a network provider for covered services. In consenting to these provisions, participating providers generally agree not to seek reimbursement from a member beyond payment of applicable cost-sharing requirements, such as copayments, co-insurance, or deductibles.

A member may choose to seek care from a non-network provider, for example from a specialist regarded as an expert in the field. A member may utilize non-network providers unknowingly while receiving care at a network hospital. While radiologists, anesthesiologists, pathologists, and increasingly emergency room physicians are hospital-based physicians, generally they are not hospital employees and may or may not contract with the same MCOs as the hospital. Likewise, a member may receive—and be billed for—services from a non-network provider if the member's network physician consults with a non-network specialist. Finally, a member may receive non-network care from a non-network hospital as a result of an emergency transport.

An analysis conducted for the California HealthCare Foundation in 2006 of 1.2 million residents with employer-sponsored commercial (private) insurance found that almost 11 percent of those studied used non-network services at some point during the year. Most non-network utilization occurred as a result of a hospital admission, or an emergency department visit without admission. The average balance bill (across facilities, physicians, and other professional providers) was $1,289 in addition to the average patient cost-sharing amount of $433. The average balance bill for an inpatient admission averaged $6,812.[12]

Current Prohibitions on Balance Billing

Currently, balance billing is prohibited for services provided under Medicaid,[13] workers compensation insurance,[14] emergency services or by an exclusive provider who is part of an EPO.[15] In addition, the

[9] s. 641.495, F.S.
[10] s. 627.642, F.S.
[11] *See generally* CALIFORNIA HEALTHCARE FOUNDATION, *Unexpected Charges: What States Are Doing About Balance Billing* (April 2009), *available at* http://www.chcf.org/publications/2009/04/unexpected-charges-what-states-are-doing-about-balance-billing (last visited March 14, 2015).
[12] *Id.* at 4.
[13] s. 409.907(3)(j), F.S.; Medicaid managed care plans and their providers are required to comply with the Provider General Handbook, which expressly prohibits balance billing. In addition, the Statewide Medicaid Managed Care Contract (CORE contract) establishes minimum requirements for contracts between plans and providers. The CORE contract requires those contracts to prohibit balance billing, except for any applicable cost sharing. (E-mail from Josh Spagnola, Legislative Affairs Director, Florida Agency for Health Care Administration, excerpting relevant provisions from the Handbook and the CORE contract (March 16, 2015) (on file with the House Insurance & Banking Subcommittee).
[14] s. 440.13(13(a), F.S.

law provides that an HMO is liable to pay, and may not balance bill for, covered services provided to a subscriber whether or not a contract exists between the provider and the HMO.[16] However, the statute further qualifies the prohibition by saying that an HMO is liable for services rendered if the provider obtains authorization from the HMO prior to providing services. Thus, a provider can balance bill if authorization is denied or if the provider does not seek prior authorization. [17,18]

Effect of Changes Related to Balance Billing

The bill establishes a payment methodology for emergency services and care provided by noncontract providers to members of a PPO or EPO and prohibits those providers from collecting or attempting to collect any additional amount. In effect, the bill prohibits these providers from balance billing, thereby applying the same prohibition to members of PPOs and EPOs as currently applies to members of an HMO.

Access to Emergency Services and Care

Hospital Care

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. EMTALA imposes specific obligations on hospitals participating in the Medicare program which offer emergency services. Any patient who comes to the emergency department must be provided with a medical screening examination to determine if the patient has an emergency medical condition. If an emergency condition exists, the hospital must provide treatment within its service capability to stabilize the patient. If a hospital is unable to stabilize a patient, or if the patient requests, the hospital must transfer the patient to another appropriate facility.[19] A hospital that violates EMTALA is subject to civil monetary penalty,[20] termination of its Medicare agreement,[21] or civil suit by a patient who suffers personal harm.[22] EMTALA does not provide for civil action against a hospital's physicians.

Florida law imposes a similar duty.[23] The law requires AHCA to maintain an inventory of the service capability of all licensed hospitals that provide emergency care in order to assist emergency medical services (EMS or ambulance) providers and the public in locating appropriate medical care. Hospitals must provide all listed services when requested, whether by a patient, an emergency medical services provider, or another hospital, regardless of the patient's ability to pay. If the hospital is at capacity or does not provide the requested emergency service, the hospital may transfer the patient to the nearest facility with appropriate available services. Each hospital must ensure the services listed can be provided at all times either directly or through another hospital. A hospital is expressly prohibited from basing treatment and care on a patient's insurance status, economic status, or ability to pay. A hospital that violates Florida's access to care statute is subject to administrative penalties; denial, revocation, or suspension of its license; or civil action by another hospital or physician suffering financial loss. In addition, hospital administrative or medical staff are subject to civil suit by a patient who suffers personal harm; and may be found guilty of a second degree misdemeanor for a knowing or intentional violation. Physicians who violate the act are also subject to disciplinary action against their license; or civil action by another hospital or physician suffering financial loss.

---

[15] s. 627.6472(4)(c), F.S.
[16] ss. 641.315(1) and 641.3154(1), F.S.
[17] *But see Joseph L. Riley Anesthesia Associates v. Stein*, 27 So. 3d 140, 145 (Fla. 5th DCA 2010). The Fifth DCA has held that an authorization issued to a contract provider for services (surgery) in a hospital is deemed an authorization for a hospital-based provider of medically necessary services (anesthesia) that are provided under an exclusive contract without regard for the existence of a contract with the HMO. In other words, if the main service is authorized, related services provided under an exclusive contract are deemed authorized and balance billing is prohibited.
[18] *See also* FLORIDA MEDICAL ASSOCIATION, *Balance Billing*, http://www.flmedical.org/LRC_Balance_billing.aspx (last visited March 15, 2015).
[19] Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. §1395dd.; *see also* CENTERS FOR MEDICARE & MEDICAID SERVICES, *Emergency Medical Treatment & Labor Act (EMTALA)*, http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/ (last visited March 13, 2015).
[20] 42 U.S.C. § 1395dd(d)(1).
[21] 42 C.F.R. § 489.24(f).
[22] 42 U.S.C. § 1395dd(d)(2).
[23] *See* s. 395.1041, F.S.

Prehospital Care

The Emergency Medical Transportation Services Act[24] similarly regulates the services provided by emergency medical technicians, paramedics, and air and ground ambulances. The act establishes minimum standards for emergency medical services personnel, vehicles, services, and medical direction, and provides for monitoring of the quality of patient care. The standards are administered and enforced by the Department of Health (DOH). Ambulance services operate pursuant to a license issued by DOH and a certificate of public convenience and necessity issued from each county in which the provider operates.[25] A licensee may not deny a person needed prehospital treatment or transport for an emergency medical condition.[26] A violation may result in denial, suspension, or revocation of a license; reprimand; or fine.[27]

In general, the medical director of an ambulance provider is responsible for issuing standing orders and protocols to the ambulance service provider to ensure that the patient is transported to a facility that offers a type and level of care appropriate to the patient's medical condition,[28] with separate protocols required for stroke patients.[29] Trauma alerts patients are an exception to the general requirement and are required to be transported to an approved trauma center.[30]

State law establishes the provision of ambulance services as a core function of county government.[31] Counties may provide the service directly, under contract with one or more private or municipal providers, or both. Currently, 61 counties and 97 municipalities are licensed to provide emergency medical services.[32] This represents more than half of all licensed providers.

Payment for Emergency Care and Services

Florida Law

A PPO must charge a member the same copayments for emergency care whether the care is provided by a contract or noncontract provider.[33]

An EPO plan must ensure that emergency care is available 24 hours a day and 7 days a week. Insurers issuing exclusive provider contracts must pay for services provided by non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.[34]

An HMO must provide coverage without prior authorization for prehospital transport or treatment or for emergency services and care[35] that is rendered by either a contract or noncontract provider.[36] An HMO must charge a subscriber the same copayments for emergency care whether the care is provided by a contract or noncontract provider. [37]

The law requires HMOs to pay noncontract providers specified minimum reimbursement for emergency services. Specifically, HMOs must reimburse providers the lesser of:[38]

- The provider's charges;

[24] Part III of chapter 401, F.S. (ss. 401.2101 – 401.465, F.S.)
[25] s. 401.25(2)(d), F.S.
[26] s. 401.45, F.S.
[27] s. 401.411, F.S.
[28] Rule 64J-1.004()(a), F.A.C.
[29] s. 395.3041(3), F.S.
[30] s. 395.4045, F.S.
[31] *See* s. 125.01(1)(e), F.S.; *see also* s. 155.22, F.S.
[32] Florida Department of Health, *EMS Provider Type Reports* (March 16, 2015) (on file with the House Insurance & Banking Subcommittee).
[33] s. 627.6405(4), F.S.
[34] s. 627.6472, F.S.
[35] "Emergency services and care" include the medical screening, examination, and evaluation to determine whether an emergency medical condition exists and the care, treatment, or surgery necessary to relieve or eliminate the emergency medical condition. (s. 641.47(8), F.S.)
[36] ss. 641.31(12) and 641.513(1)(a), F.S.
[37] s. 641.31097(4), F.S.
[38] s. 641.513(5), F.S.

- The usual and customary provider charges for similar services provided in the community; or
- The charge mutually agreed to by the HMO and the provider.

Reimbursement is net of any applicable copayment.

Statewide Medicaid Managed Care

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program in Part IV of Chapter 409, F.S. Reaching full implementation in the fall of 2014, the SMMC program is an integrated managed care program for Medicaid enrollees to provide all mandatory and optional Medicaid benefits. Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services, including emergency care and services.

Managed care plans in the MMA program must reimburse non-contracted Medicaid providers of emergency care and services the lesser of:[39]

- The provider's charges;
- The usual and customary provider charges for similar services provided in the community;
- The charge mutually agreed to by the HMO and the provider; or.
- The Medicaid rate.

Patient Protection and Affordable Care Act (PPACA)

PPACA was signed into law on March 23, 2010.[40] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, coverage for adult dependents, and other requirements.[41]

PPACA requires that coverage for emergency services must be provided without prior authorization and regardless of whether the provider is a network provider. Services provided by non-network providers must be provided with cost-sharing that is no greater than that which would apply for a network provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. In addition, plans must reimburse non-network providers the greater of:

- The median in-network rate;
- The usual and customary reimbursement, calculated using the plan's formula; or
- The Medicare rate. [42]

Grandfathered health plans are exempt from these requirements.[43] PPACA does not prohibit balance billing. A guidance document from the U.S. Department of Labor has characterized the requirements as "set[ting] forth minimum payment standards…to ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply

[39] ss. 641.513(6) and 409.967(2)(b), F.S.
[40] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, H.R. 3590, 11th Cong. (March 23, 2010). On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.
[41] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act. (42 U.S.C. 300gg et seq.).
[42] 45 C.F.R. s. 147.138(b)
[43] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. Grandfathered health plan coverage is tied to the individual or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010. (PPACA § 1251; 42 U.S.C. § 18011; 45 C.F.R. § 147.140).

balance bill the patient." The guidance further states that the minimum payment requirements do not apply if state law prohibits balance billing or the plan is contractually responsible for payment.[44]

Hospital Emergency Department Utilization by Payer Type

The following reflects utilization of hospital emergency departments by payer type during the 12-month period ending July 1, 2014.[45]

	ED Visits - Inpatient Admission		ED Visits - No Admission		Totals	
Medicare	600,583	36.1%	852,375	11.0%	1,452,958	15.4%
Medicare HMO	293,605	17.7%	474,522	6.1%	768,127	8.2%
Medicaid	164,457	9.9%	1,327,002	17.1%	1,491,459	15.9%
Medicaid HMO	100,517	6.0%	1,222,919	15.8%	1,323,436	14.1%
Commercial	272,038	16.4%	1,749,662	22.6%	2,021,700	21.5%
Workers Compensation	4,382	0.3%	76,301	1.0%	80,683	0.9%
TRICARE	13,296	0.8%	117,074	1.5%	130,370	1.4%
VA	12,327	0.7%	25,683	0.3%	38,010	0.4%
Other Government	13,433	0.8%	55,819	0.7%	69,252	0.7%
Self-pay	136,086	8.2%	1,549,706	20.0%	1,685,792	17.9%
Other	4,519	0.3%	29,336	0.4%	33,855	0.4%
Charity	38,213	2.3%	157,580	2.0%	195,793	2.1%
KidCare	1,849	0.1%	40,330	0.5%	42,179	0.4%
Commercial Liability	6,408	0.4%	66,152	0.9%	72,560	0.8%
TOTALS	**1,661,713**		**7,744,461**		**9,406,174**	

Effect of Changes Related to Payment for Emergency Care and Treatment

The bill creates a new section of law that establishes requirements for PPOs and EPOs related to coverage for emergency care. Specifically, the bill:

- Prohibits prior authorization.
- Requires coverage whether service is provided by a participating (contract) or nonparticipating (noncontract) provider.
- Requires cost-sharing to be the same whether services are provided by a participating or nonparticipating provider.

The bill requires PPOs and EPOs to reimburse nonparticipating providers the greater of:

- The amount negotiated with the provider;
- The usual and customary reimbursement for the same service in the community; or
- The Medicare rate.

Reimbursement is net of any applicable copayment. Nonparticipating providers are prohibited from balance billing.

The effect of the changes is to impose a payment methodology applicable to EPO and PPO reimbursement of emergency services provided by nonparticipating providers that is similar to the standard imposed by PPACA. The bill differs from PPACA, however, in that PPACA does not prohibit

[44] U.S. Dept. of Labor, Employee Benefits Security Administration, *FAQs About the Affordable Care Act Implementation Part I,* http://www.dol.gov/ebsa/faqs/faq-aca.html (last visited March 16, 2015).

[45] Inpatient and emergency department discharge data are reported to the AHCA by hospitals pursuant to s. 408.061(1(a), F.S. and are publicly-available. *See* AGENCY FOR HEALTH CARE ADMINISTRATION, *FloridaHealthFinder.gov,* http://www.floridahealthfinder.gov/researchers/researchers.aspx (last visited March 15, 2015).

balance billing and, by interpretation of the U.S. Department of Labor, does not impose the PPACA payment methodology in states that prohibit balance billing.

The bill revises two sections of law dealing with reimbursement of non-contracted providers of emergency care and services by managed care plans in the MMA program. The bill maintains current law in s. 409.967(2)(b), F.S., to require reimbursement of such providers in the **lesser** amount of certain benchmarks, but removes the provider's charge as one of the benchmarks. The bill also maintains the Medicaid rate as one of the benchmarks. The other two benchmarks are:

- The amount negotiated by the managed care plan with a non-contracted provider of the care or service to be reimbursed; or
- The usual and customary reimbursement received by a provider for the same service in the same area where the service was provided.

The revisions shift the basis of payment from a charges-based factor to a reimbursement-based factor, which reflect the actual payments being made for such services.

The bill also revises s. 641.513(6), F.S., to conform to the changes to s. 409.967(2)(b), F.S. However, the bill changes the basis for reimbursement from the **lesser** amount of the three benchmarks to the **greater** amount of the three benchmarks. The bill creates an internal conflict in Medicaid reimbursement policy for emergency care and services provided by a non-contracted provider.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.967, F.S., relating to managed care plan accountability.
Section 2: Creates s. 627.64194, F.S., relating to coverage for emergency services.
Section 3: Amends s. 641.513, F.S., relating to requirements for providing emergency services and care.
Section 4: Provides an effective date of October 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   There is anticipated to be an insignificant negative fiscal impact on Medicaid managed care rates as a result of the change to the payment methodology for emergency services and care; however, the impact is expected to be insignificant as emergency services and care encompasses a very small portion of the overall reimbursement rate.

   The Department of Management Services indicated that the bill will have a low, negative indeterminate fiscal impact on the State Group Health Insurance Program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Local governments participate in the Medicaid program through required cost sharing set forth in s. 409.915, F.S. The revisions to the payment methodology for emergency services and care provided

by a noncontract provider to an HMO's member could affect the total dollar value of a county's contribution if it were significant enough to increase or decrease overall program costs.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private providers of emergency services and care may experience a negative fiscal impact from the provisions that prohibit balance billing to the extent that those providers currently rely on that practice. In addition, private providers may see a fiscal impact as a result of the methodology for reimbursement.

The bill will have a positive fiscal impact on consumers due to the prohibition on balance billing, but may have a negative fiscal impact on noncontract providers of emergency services and care for this same reason.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

3. RULE-MAKING AUTHORITY:

   None.

4. DRAFTING ISSUES OR OTHER COMMENTS:

   CS/HB 681 creates a conflict between two sections of law applicable to Medicaid managed care plans. The bill includes proposed changes to s. 409.967(2)(b), F.S., and s. 641.513(6), F.S., which both concern reimbursement of emergency services and care provided to Medicaid recipients by providers who do not have a contract with the Medicaid managed care plan. The bill leaves intact the reimbursement policy in s. 409.967(2)(b), F.S., which permits reimbursement in the *lesser* amount of four charges: the provider's charges; the usual and customary reimbursement for the service in the area where it was provided; the negotiated rate with a non-contracted provider; or the Medicaid rate.

   However, the bill changes the reimbursement policy in s. 641.513(6), F.S., to permit reimbursement in the *greater* amount of the same four charges, which carries with it a potential significant impact to the SMMC program. The internal inconsistency in the bill can be resolved by reverting to current reimbursement policy in s. 641.513(6), F.S., and permitting reimbursement in the *lesser* amount of the four charges listed in statute. Also, s. 641.513(6), F.S., may be repealed as the policy predates the reimbursement policy for emergency services and care provided by a non-contracted provider in the SMMC program contained in s. 409.967(2)(b), F.S.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 18, 2015, the Insurance & Banking Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment revised the bill to: remove prehospital transportation service providers; remove references to participating provider from the

negotiated rate and cost-sharing provisions; to specify usual and customary reimbursement based on a community standard in lieu of the more general language used in the bill; and added conforming language to ch. 409, F.S., related to Medicaid.

The staff analysis is drafted to reflect the committee substitute as passed by the Insurance & Banking Subcommittee.