HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 639 Coverage of Out-of-network Ground Ambulance Emergency Services
SPONSOR(S): Select Committee on Health Innovation, Yeager
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 568

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	11 Y, 0 N, As CS	Lloyd	Calamas
2) Appropriations Committee		Helpling	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Congress adopted the federal *No Surprises Act* in 2021 to address balance billing in health care, except in the area of ground transportation, emergency and non-emergency. Emergency transportation companies do not get a choice in their patients and must answer every 911 call received for a medical emergency. Whether or not a patient has insurance, what insurance, or ability to pay is not a consideration at the time a ground ambulance responds to the emergency call. In the same manner, patients in need of an emergency transport are not able to shop around for services or to research which ambulance to call.

The vast majority of ground ambulance emergency services are owned or operated by a county or local municipality such as fire departments (37 percent) or other government entities (25 percent) with the remainder being held by private businesses (30 percent) and hospital owned ambulances. When there is a choice of ambulance providers in an area, the 911 operator typically picks the provider based on its proximity to the scene and the patient's injury severity.

Florida established its own balance billing law in 2016. The law prohibits nonparticipating providers, including hospitals, ambulatory surgical centers, and urgent care centers, from balance billing members of a preferred provider organization (PPO) or exclusive provider organization (EPO) for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider.

The bill addresses the gap left by the two laws through the establishment of a set of options for payment of out-of-network claims by group health plans and individual health plan policies to be the lesser of:

- The rate set or approved, whether it is established in a contract or local government ordinance, in the jurisdiction in which the covered services occurred.
- 350 percent of the current published rate by federal CMS for ambulance services under Title XVIII of the Social Security Act for the same geographic area; or the ambulance's billed charges, whichever is less.
- The contracted rate at which the health care provider would reimburse an in-network ambulance provider for providing the covered service.

The bill also establishes that payment from the insurer is considered payment in full. Cost sharing from the patient may not exceed the in-network amounts that would have been charged for the same service.

The bill may have an insignificant, negative fiscal impact on state government. *See* Fiscal Analysis and Economic Impact Statement.

The bill has an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Emergency Ground Transportation

Ground emergency medical transportation is a life-saving service that may affect anyone, including the uninsured, privately insured, and those covered by governmental health care programs. In 2020, 37 percent[1] of emergency ground ambulance rides were provided through local fire departments,[2] 25 percent through other government agencies, 30 percent through private companies, and 8 percent through hospitals.[3] Federal laws and current Florida laws do not provide balance billing protections for insured consumers that use a non-participating or out-of-network emergency ground ambulance service.

About 51 percent of all ground ambulance calls require Advanced Life Support (ALS)[4] services compared to Basic Life Support (BLS) services.[5,6] Emergency ambulance fees usually include two components: a base fee and a mileage fee. According to FAIR Health report, the average charge for ALS emergency ground ambulance services has increased from $1,042 in 2017 to $1,277 in 2020, which represents a 22.6 percent increase. In Medicare, the average increase for these same services was $441 to $463, a five percent increase.[7] The average charge for BLS emergency ground ambulance services increased 17.5 percent from $800 in 2017 to $940 in 2020. The average Medicare amount for these services increased 4.8 percent from $372 to $390.[8] The second component of the billing rate, mileage fees can vary greatly as well from $20 per mile to $90 per mile.[9] And, depending on where a patient lives in relation to the closest emergency facility, the cost per mile can quickly add up. In urban Florida, the hospital ride may be less than 10 miles, but in more rural areas of Florida, it could be 50 or more miles to the closest or most appropriate hospital for the patient. In 2019, Florida has one of the lowest averages for mileage for ground ambulance emergency transportation at 7.2 miles compared to the highest state of Wyoming at 29.2 miles.[10]

One study found that 71 percent of all ambulance rides had the potential to incur surprise medical bills.[11] While this study occurred in 2000, prior to the implementation of the federal legislation addressing most types of balance billing, it still speaks to the percentage of ambulance rides that end up as balance billing cases, whether ground or air, and the costs involved for such transportation. The

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[1] *Ground ambulance rides and potential for surprise billing* - Peterson-KFF Health System Tracker (June 24, 2021), available at Ground ambulance rides and potential for surprise billing - Peterson-KFF Health System Tracker (last visited January 31, 2024).
[2] *What are the differences between public and private ambulance services?* (ems1.com) (Oct. 23, 2017), available at What are the differences between public and private ambulance services? (ems1.com) (last visited January 31, 2024).
[3] *Protecting Consumers from Surprise Ambulance Bills* | Commonwealth Fund (Nov. 15, 2021), available at https://www.commonwealthfund.org/blog/2021/protecting-consumers-surprise-ambulance-bills (last visited January 31, 2024).
[4] Advanced Life Support Services (ALS) includes basic life support but must have a paramedic on board. The technicians on an ALS ambulance have a higher level of training. Typically, to treat a patient during an ALS ambulance service, an invasive procedure is done, for example, with needles or other devices that make cuts in the skin. An ALS provider can give injections, do very limited surgical procedures (e.g., a tracheotomy) and administer medicine. ALS ambulances are typically outfitted with airway equipment, cardiac life support, cardiac monitors and glucose testing devices.
[5] Also called "first step treatment," these services can be provided by either a paramedic or an emergency medical technician (EMT). They typically include fractures or injuries, psychiatric patients or medical and surgical patients who do not need cardiac monitoring or respiratory interventions.
[6] Ground Ambulance Services in the United States (2022), FAIR HEALTH, available at: Ground Ambulance Services in the United States - A FAIR Health White Paper.pdf (last visited January 30, 2024).
[7] Id.
[8] Id.
[9] PBS News Hour, *The No Surprises Act left out ground ambulances. Here is what is happening now, (August 17, 2023), available at* The No Surprises Act left out ground ambulances. Here's what's happening now | PBS NewsHour (last visited January 29, 2024).
[10] *Supra, note 6.*
[11] Karan R. Chhabra, Keegan McGuire, et al., "Most Patients Undergoing Ground and Air Ambulance Transportation Receive Sizeable Out-Of-Network Bills, HEALTH AFFAIRS (April 15, 2020), available at :Most Patients Undergoing Ground And Air Ambulance Transportation Receive Sizable Out-Of-Network Bills | Health Affairs

study found the median range in 2020 for surprise ground emergency transportation bill to be $450.[12] In balance billing for emergency ground transportation, which was not included in either the state or national balance billing laws, the Florida ambulance providers are reimbursed, on average, for 56 percent of their billed charges.

An ambulance may also arrive to a call, treat the patient, and not transport the patient to a facility. Nationally, from 2017 to 2019, the percentage has dropped for the number of cases from one percent of all calls to 0.7 percent, and then bounced back to one percent of all calls for emergency ground transportation.[13] For the four-year period of 2017-2020, the top five reasons for emergency ground transportation calls, but no transport to a facility have remained the same, if out of order. For 2020, the number one reason for a call was for general, non-specific reasons, followed by circulatory and respiratory issues, injury to the body, endocrine and metabolic issues, and signs and symptoms related to cognition.[14]

Balance Billing

Balance billing occurs when an insured patient accesses out of network services at an emergency facility or while receiving non-emergency services at in-network hospital or facility for covered services.[15] With balance billing, a provider bills a patient for the difference between the amounts the provider charges and the amount that the patient's insurance company pays. This does not include cost-sharing requirements such as copayments that are typically paid by a patient. As a result, a consumer may incur an average balance billing or out of pocket cost of $450.[16] In some states, the average is more than $1,000.[17]

Statewide Provider and Health Plan Claim Dispute Resolution Program

The Statewide Provider and Health Plan Claim Dispute Resolution Program was established by the 2000 Florida Legislature to assist contracted and non-contracted providers and managed care organizations reach a resolution of claim disputes that were not resolved by the provider and the managed care organization without litigation. Statute requires the Agency for Health Care Administration (AHCA) to contract with a resolution organization to timely review and consider claim disputes and submit recommendations to AHCA.

As of June 30, 2023, no provider and health plan claim disputes are being reviewed as the contract with the resolution organization ended at the end of the fiscal year. The AHCA is soliciting a new third-party vendor, but until then, claims are not being resolved. According to figures from AHCA, 563 claims were received last year and 443 claims were reviewed. The difference between the claims accepted and those reviewed may be attributed to several factors, including lack of follow up for additional information, or failure to submit a complete application.

Emergency Medical Treatment and Active Labor Act (EMTALA)

In 1986, Congress enacted EMTALA[18] to ensure public access to emergency services regardless of ability to pay. The 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 within the hospital's capabilities to determine if the

[12] Id.
[13] Id.
[14] Id.
[15] *Supra,* note *1.*
[16] *Role of States in Exclusion of Ground Ambulances from NSA*, Medicalbillersandcoders.com, available at: Role of States in Exclusion of Ground Ambulances from NSA (medicalbillersandcoders.com) (July 22, 2022) (last visited January 29, 2024).
[17] *EMERGENCY: The high cost of ambulance surprise bills (pirg.org)* (Oct. 26, 2023), available at EMERGENCY: The high cost of ambulance surprise bills (pirg.org) (last visited January 29, 2024).
[18] 42 U.S.C. 1395dd; Section 1867 of the Social Security Act.

patient has an emergency medical condition. If an emergency medical condition exists, the hospital must provide treatment within its service capability to stabilize the patient. [19]

If a hospital is unable to stabilize a patient or, if the patient requests, the hospital must transfer the patient to another appropriate facility.[20] A hospital that violates EMTALA is subject to civil monetary penalty[21] or civil suit by a patient who suffers personal harm.[22]

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 prohibited from basing emergency treatment and care on a patient's insurance status, economic status, or ability to pay.

Florida No Surprises Act

In 2016, the Florida Legislature passed and Governor Scott signed CS\CS\CS\HB 221[24] which, among other provisions, prohibited out of network providers for preferred provider organizations (PPOs)[25] and exclusive provider organizations (EPOs)[26] from balance billing its enrollees for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider. Effective July 1, 2016, the legislation sets standards for determining reimbursement to the providers and authorized providers and insurers to settle disputed claims under the statewide provider and health plan claim dispute resolution program.[27]

A health maintenance organization (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 out-of-network services rendered to the member. Current statutes governing HMOs already prohibit balance billing for covered emergency services at an out of network provider.

CS\CS\CS\HB 221 also required PPOs to publish a list of their network providers on their websites, and to update the list monthly. All PPOs must give their subscribers notice regarding the potential for

[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), (last visited January 29, 2024).
[20] 42 U.S.C. 1395dd(b)(2).
[21] 42 U.S.C. 1395dd(d)(1).
[22] 42 U.S.C. 1395dd(d)(2).
[23] *See* s. 395.1041, F.S. 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 statute are also subject to disciplinary action against their license or civil action by another hospital or physician suffering financial loss.
[24] ch. 2016-222, L.O.F.
[25] 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 coinsurance amounts if covered services are obtained from network providers. However, if a member chooses to obtain services from an out-of-network provider, those out-of-pocket costs likely will be higher. *See generally s. 627.6471, F.S.*
[26] In an EPO arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the participating hospitals or providers to receive covered benefits, subject to limited exceptions. See generally s. 627.6472, F.S
[27] S. 627.64194, F.S.

balance billing when using out-of-network providers. Disciplinary action for violations may be assessed on certain facilities and licensed health care practitioners for violations on balance billing.

Florida's *No Surprises Act* further requires hospitals publish information on their websites regarding their contracts with plans and providers of hospital-based services to keep consumers informed proactively of which hospitals participate with which PPOs and EPOs.

Florida Health Insurance Advisory Board

Repeating from its 2022 and 2023 list of Legislative Recommendations, the Florida Health Insurance Advisory Board (FHIAB) lists a prohibition against balance billing for ground emergency medical transportation as Proposal five out of eight proposals.[28] When the proposal was discussed and added to the FHIAB's list of recommendations in 2022, the proposal was adopted by the board unanimously.[29] The proposal was re-adopted and placed on the 2023 Legislative Recommendations list without discussion during FHIAB's 2022 November meeting.[30]

Federal No Surprises Act

The federal *No Surprises Act of 2022*[31] (Act) eliminated the practice of health care practitioners balance billing for most provider types with the exception of ground ambulance services beginning in 2022. Because of the complications involved with how ground ambulance services, emergency and non-emergency, are currently delivered with most delivered by municipalities and other local governments, and concerned about how national actions may impact those existing relationships and contracts, Congress deferred action and created an advisory committee.

The Act established an advisory committee (Committee) to continue discussions on how to address surprise billings and balance billings with ground ambulance and emergency ground ambulance services.[32] The Charter for the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) was signed by the Health and Human Services Secretary on November 16, 2021. The Committee held three public meetings between May 2, and November 1, 2023.[33]

Recommendations by the Committee were released following the November 2023 meeting, including the renewal of the Committee's Charter. The Committee's 15 recommendations ranged from inclusion of standard definitions relating to ground ambulance services to reimbursement policies and fell into the general categories relating to:

- Adopt standard definitions relating to ground emergency services.
- Protect patients from patient billing.
- Limit copays for ground ambulance rides.
- Make ambulance bills more transparent and easier for patients to understand.
- Guarantee payment to the ambulance crews.
- Avoid the independent dispute resolution process.
- Recommend the incorporation of Ground Ambulance Emergency Medical Services in the definition of emergency services under the essential health benefits requirements.[34]

[28] Florida Health Insurance Advisory Board, *2024 Legislative Recommendations,* available at fhiablegrecommendations2024.pdf (floir.com) (last visited January 29, 2024).
[29] Florida Health Insurance Advisory Board, *2023 Legislative Recommendations,* available at board-minutes-(approved-9-28-23).pdf (floir.com) (last visited January 29, 2024).
[30] Florida Health Insurance Advisory Board, Board Meeting Minutes, November 17, 2023, available at board-minutes-(approved-9-28-23).pdf (floir.com) (last visited January 29, 2024).
[31] 42 U.S.C. 1395dd; Section 1867 of the Social Security Act.
[32] Advisory Committee on Ground Ambulance and Patient Billing Advisory Committee, Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriations Act, 2021 (CAA), Advisory Committee on Ground Ambulance and Patient Billing (GAPB) | CMS (last visited January 31, 2024).
[33] Centers for Medicare and Medicaid Services, *Advisory Committee on Ground Ambulance and Patient Billing*, available at: https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory-committee-ground-ambulance-and-patient-billing-gapb (last visited January 31, 2024).
[34] Centers for Medicare and Medicaid Services, *Advisory Committee on Ground Ambulance and Patient Billing,* Meeting Materials for October 31, and November 1, 2023 meeting, available at https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory-committee-ground-ambulance-and-patient-billing-gapb (last visited January 30, 2024).

All of the Committee's recommendations will be forwarded to Congress with a report which will notate which recommendations received a majority vote of the Committee.[35] The Secretary of the Department of Health and Human Services has acted on one of the recommendations and renewed the Committee's charter on November 16, 2023.[36]

Regulation of Insurers and Health Maintenance Organizations

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk bearing entities in Florida.[37] AHCA regulates the quality of care by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from AHCA.[38]

All persons who transact insurance in this state must comply with the ch. 624, F.S.[39] OIR has the authority to collect, propose, publish, and disseminate any information relating to the subject matter of ch. 624, F.S.,[40] and may investigate any matter relating to insurance.[41]

Patient Protection and Affordable Care Act

Under the Patient Protection and Affordable Care Act (PPACA),[42] all non-grandfathered health plans in the non-group and small group private health insurance markets must offer a core package of health care services known as the essential health benefits (EHBs). While not specifying the benefits within PPACA, 10 general categories of benefits and services are identified that must be covered. The details of those benefits were left to the Secretary of the Department of Health and Human Services to define through regulatory guidance.[43]

The 10 EHB categories are:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitation and habilitation services.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

PPACA requires each state to select its own reference benchmark plan as its EHB benchmark plan which all other health plans in the state use as a model. Florida selected its EHB plan before 2012 and has not modified that selection.[44]

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[35] Laura Santhanam, PBS News Hour, *New recommendations outline how Congress could lower ground ambulance costs,* available at: https://www.pbs.org/newshour/health/new-recommendations-outline-how-congress-could-lower-ground-ambulance-costs (last visited January 30, 2024).
[36] Centers for Medicare and Medicaid Services, Advisory Committee on Ground Ambulance and Patient Billing Advisory Committee, *Charter Renewal (November 16, 2023),* available at: https://www.cms.gov/files/document/gapb-charter-renewal-november-16-2023.pdf (last visited January 31, 2024).
[37] S. 20.121(3)(a), F.S.
[38] S. 641.21(1)(1), F.S.
[39] S. 624.11, F.S.
[40] S. 624.307(4), F.S.
[41] S. 624.307(3), F.S.
[42] Affordable Care Act (March 23, 2010), P.L. 111-141, as amended.
[43] 45 CFR 156.100 et. seq.
[44] Centers for Medicare and Medicaid Services, State Essential Health Benchmark Plans – Florida, https://www.cms.gov/cciio/resources/data-resources/downloads/updated-florida-benchmark-summary.pdf (last visited January 31, 2024).

State Health Insurance Mandates

A health insurance mandate is a legal requirement that an insurance company or health plan cover specific benefits, or services by particular health care providers, or specific patient groups. A contingent coverage mandate requires coverage of a service, condition, or provider's care *only if* coverage is provided for a certain other service, condition, or provider's care. In general, coverage mandates increase the cost of health coverage in varying amounts depending on the cost of the mandated care and the amount of patient utilization of that care.

Current Florida law requires every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurer, to submit to AHCA and the legislative committees having jurisdiction, a report that assesses the social and financial impacts of the proposed coverage.[45] To the extent information is available, the report should address:

- The extent to which the treatment or service is generally used by a significant portion of the population.
- The extent to which insurance coverage is generally available; or, if not generally available, results in persons avoiding necessary health care treatment.
- The extent to which lack of coverage results in unreasonable financial hardship.
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- The extent to which coverage will increase or decrease the cost of the treatment or service.
- The extent to which coverage will increase the appropriate uses of the treatment or service.
- The extent to which the treatment or service will be a substitute for a more expensive treatment or service.
- The extent to which the coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.
- The impact of this coverage on the total cost of health care.

The House Select Committee on Health Innovation has not received a report for this bill.

Effect of Proposed Changes:

The bill creates two new section of law to require health insurers and health maintenance organizations under chs. 627 and 641, F.S., respectively, to reimburse for claims incurred for out-of-network ambulance services using a specific formula. Currently, Florida law does not specify how claims for out of network ground ambulance services are to be reimbursed. Coverage issues and coverage benefits decisions are usually left up to the two parties involved in contracting for health care services, the employer, for example, and the insurer or insurer's representative, as part of the contract negotiation process, made determinations about what is or is not covered, and at what cost.

If there is not an agreement between the provider and the out of network of emergency ground ambulance provider, then a reimbursement rate established by the bill would apply. Under the bill, the rate would be the lesser amount of the following:

- The rate set or approved, whether it is established in a contract or local government ordinance, in the jurisdiction in which the covered services occurred; or
- 350 percent of the current published rate by federal CMS for ambulance services under Title XVIII of the Social Security Act for the same geographic area; or the ambulance's billed charges whichever is less; or
- The contracted rate at which the health care provider would reimburse an in-network ambulance provider for providing the covered service.

[45] S. 624.215, F.S.

Definitions are created for the new section for "ambulance services provider," "clean claim," "covered services," and "out of network" to ensure terms used in these newly created sections of law are understood uniformly and have the specific meaning intended when referencing these provisions.

Under both new sections, the payments would be considered payment in full for the services rendered, except for any copayment, coinsurance, deductible, or other cost sharing responsibilities of the insured. The ambulance service is prohibited from balance billing the patient for any unpaid amounts. Out of network ambulance providers would not be allowed to seek out any additional payments from patients through balance billing for any differences between what may have been the provider's initial billed charged compared to final payments under this provision. The out of network ambulance provider may accept the insurer's payment for the services as payment in full

Payments from the insurers are due within 30 days after receipt of a clean claim to the ground ambulance service. Insurers are prohibited from sending any payment to the insured. If the ground transportation was requested by a first responder[46] or a health care practitioner as defined in s. 456.001,[47] a health insurer is required to pay for the transportation of those patients.

If the claim is considered to not be a clean claim, within 30 days of receipt of the claim the health insurer must send a written notice that acknowledges the date of claim receipt and informs the ambulance services provider one of the following:

- Insurer is declining to pay all or part of this claim and the specific reason for the denial.
- Additional information is necessary to determine if all or part of the claim is payable, and the specific information that is required.

The bill does not mandate a new coverage, as emergency services and emergency ground transportation are already covered benefits as essential health benefits when provided by a covered provider; however, the bill does establish a requirement on health plans and individual health insurance policies, to reimburse a specific group of providers who do not contract with a patient's provider by a statutorily established formula. Currently, ground ambulance emergency rates are set mainly by local municipalities which run the vast majority of the emergency ambulance services in the state. The provisions of the bill would still allow for local governments to establish rates within certain guardrails which may or may not be lower than the rates currently charged. Additionally, the bill would end the ability of the emergency ground transportation services to seek additional payments from the patient after receipt of the payment from the insurer. Any out of pocket costs owed by the patient could not exceed the amounts the patient would have paid for an in-network service provider.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.42398, F.S., relating to coverage for out-of-network ground ambulance emergency services.
Section 2: Creates s. 641.31078, F.S.; relating to coverage for out-of-network ground ambulance emergency services.
Section 3: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[46] The term "first responder" is defined at s. 112.1815, F.S., and refers to law enforcement officer as defined in s. 943.10, a firefighter as defined in s. 633.102, or an emergency medical technician or paramedic as defined in s. 401.23 employed by state or local government. A volunteer law enforcement officer, firefighter, or emergency medical technician or paramedic engaged by the state or a local government is also considered a first responder of the state or local government for purposes of this section.
[47] A health care practitioner under s. 456.001(4), F.S. includes practitioners licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part I, part II, or part III of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

1. Revenues:

   None.

2. Expenditures:

   If it is determined that mandating payment options for the coverage of non-network ground ambulance emergency services is considered an expansion of benefits that generates an increase in premiums, then the state would be required to pay for the impact on all affected health insurance premiums for that benefit changes. The amount, if any, of that impact is indeterminate; however, the amount is not expected to be significant as both the Medicaid program and the State Group Health Insurance program have indicated no fiscal impact.

   The Agency for Health Care Administration reports no impact on the Florida Medicaid program.[48]

   The Department of Management Services for the Division of State Group Insurance reported no fiscal impact to the State Group Insurance Program.[49]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The total impact on local government revenue cannot be determined as it may vary from municipality to municipality, however it is likely an insignificant impact.

2. Expenditures:

   The total impact on local government expenditures cannot be determined as it may vary from municipality to municipality, however it is likely an insignificant impact.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The county/municipality mandates provision of Art. VII, section 18, of the Florida Constitution may apply because this bill requires those local governments which operate their own emergency ground ambulance services to provide such services in amount based on the rate options established by the bill. These rate options may or may not be less than the amount being charged by local municipalities for these services. The bill still permits the counties and local governments to negotiate for rates with insurers, but establishes guardrails should the two parties fail to reach an agreement to ensure that patients are not caught with a surprise emergency ground transportation bill. Because the bill provides rate options, including the continued negotiations between the parties to reach a mutually agreeable amount, the bill may not trigger the mandate provision.

[48] Agency for Health Care Administration, Letter from P. Steele, Legislative Affairs Director (January 11, 2024)(on file with Select Committee on Health Innovation).
[49] Department of Management Services, email from J. Holmgreen, Deputy Legislative Affairs Director (January 30, 2024)(on file with Select Committee on Health Innovation).

Based on responses from the DMS and Medicaid indicating that the changes proposed would have no fiscal impact on their program, any premium impact to health insurance coverage provided by local governments to their employees is likely to be insignificant. In addition, counties and municipalities can expect to be made whole by the state for any increased expenditures under the bill, based on application of current federal law requiring states to defray the costs of additional health insurance coverage mandates should other information suggest this interpretation is incorrect.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The OIR and AHCA have sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Most health insurer contracts and policies begin on January 1 and the bill provides an effective date of July 1, 2024. To align this change in contract terms with providers and with policyholders, consideration should be given to including language making any provisions requiring changes in health insurance contract terms or policies to be effective for policies issued or renewed on or after January 1, 2025.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 2, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment makes the makes the payment rate required by the bill the lesser of several options, rather than the greater of those options.

The analysis is drafted to the committee substitute as passed by the Select Committee on Health Innovation.