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After New York, Florida Curbs Surprise Bills for Emergency and Out-of-Network Services

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It is generally understood that if a managed care member utilizes the services of a non-participating provider, the member could incur significant out of pocket expenses. However, there are instances where a member may unknowingly receive services from an out-of-network provider, such as a radiologist or anesthesiologist, while receiving emergency or non-emergency care at an in-network hospital. The "surprise" or "balance bill" that results from these services – i.e., the invoice from the non-participating provider for the difference between his billed charges and the amount the insurer actually paid – can be devastating. It was recently reported that 23 states have or are working toward legislation that eliminates or curtails the effects of surprise billing. New York passed comprehensive legislation last year, and now Florida will have a similar law when HB 221 goes into effect on July 1, 2016.

Emergency Services

Currently, Florida law prohibits balance billing for emergency services but only for members of a health maintenance organization (HMO). HB 221 will extend this prohibition to members of preferred provider organizations (PPOs) and exclusive provider organizations (EPOs) by requiring the PPOs and EPOs to cover emergency services without prior authorization and without regard for whether the provider is in- or out-of-network. Like the HMO members, the PPO and EPO members will remain responsible only for their cost sharing obligation, such as copayments or deductibles.

Non-emergency Services

The new law will protect consumers from surprise bills for non-emergency covered services received in a network facility if the insured "does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the insured." The term "facility" means a hospital, ambulatory surgery center, mobile surgical center, and urgent care center. Thus, a patient who undergoes a procedure in an office-based setting and is then unknowingly treated by a non-participating provider would not be protected from a surprise bill.

Reimbursement

Reimbursement to non-participating providers who provide emergency services or non-emergency

services at a facility when the member could not choose an in-network provider will be set in accordance with the methodology currently applicable to HMOs, which is at the lesser of (i) the provider's charges; (ii) the usual and customary provider charges for similar services in the community where the services were provided; or (iii) the charge mutually agreed to by the insurer and the provider within 60 days after submitting the claim.

Dispute Resolution

Unlike New York, which implemented a mandatory dispute resolution process, the Florida law will permit providers and insurers to resolve out-of-network payment disputes in court or through the Statewide Provider and Health Plan Claim Dispute Resolution Program, which was created in 2000. If they choose the dispute resolution process, the following rules will apply:

- Either party may offer to settle the claim, and the party to whom an offer is directed will have 15 days to accept the offer once it is received.
- If an offer is not accepted and the Agency for Health Care Administration (AHCA) issues a final order that is greater than 90% or less than 110% of the offer, then the party that did not accept the offer will be considered the non-prevailing party and must pay the final order plus all accrued interest.
- The parties may agree to settle the disputed claim at any time, for any amount, regardless of whether an offer to settle was made or rejected.

Transparency

The bill includes transparency provisions for PPOs and hospitals.

- PPOs must publish on their website:
    - A list of their network providers, including names, addresses, and telephone numbers of all physicians and facilities and, in the case of physicians, their board certifications, languages spoken, and any affiliations with participating hospitals, all of which must be updated monthly.
    - A notice regarding the implications of using an out-of- network provider and the potential for balance billing.
- Hospitals must publish on their website:
    - The names of and hyperlinks to the plans with which they contract.
    - A statement that (i) services may be provided in the hospital as well as by other health care practitioners who may separately bill the patient; (ii) practitioners who provide services in the hospital may or may not participate with the same plans as the hospital; and (iii) prospective patients should contact the provider who will treat the patient in the hospital to determine which plans the practitioner participates in as a network provider or preferred provider.

- The names, addresses, and telephone numbers of providers with which it contracts to provide services in the hospital, and instructions on how to contact them in order to determine which plans they participate in as a network or preferred provider.

What's next?

Through improved disclosure obligations, new balanced billing prohibitions, and an expanded dispute resolution process, it is clear that Florida's legislature is aiming to protect consumers from the financial devastation of a surprise bill. At the same time, the law does not quite meet the standards set by New York, which, in addition to creating a mandatory dispute resolution process, defined a surprise bill to include (i) a bill received by an *uninsured* patient at a hospital or ASC for non-emergency services and who did not timely receive certain provider disclosures, and (ii) a bill from a non-participating provider to whom the insured was referred by a participating provider without the insured's explicit written consent and acknowledgment that the referral was to an out-of-network provider.

As steps are taken by the appropriate state agencies to implement regulations, it will be interesting to see how far or limited in scope they will be. For example, New York regulations clarified that an insured can receive a surprise bill if a participating physician sends the insured's specimen to a non-participating laboratory or pathologist without the insured's written consent. As it currently reads, the Florida legislation would not cover specimens to independent laboratories because it is limited to non-emergency services "provided at a facility," as opposed to "ordered at a facility."

Another provision that the regulatory agencies may explore is the insured's "ability and opportunity to choose a participating provider at the facility who is available to treat the insured." Will an insured have the "ability" to choose a network provider if he is awake during a procedure? Is it the facility's obligation to give the insured the "opportunity" to select the participating provider? When is a participating provider considered "available"? We will be closely monitoring these and other developments in the weeks and months to come.

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