CARLTON FIELDS

No More Surprises: Florida Ends Certain Medical Balance Billing

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"Surprise medical billing" occurs when a patient receives care at a facility and receives treatment from a provider, such as an anesthesiologist or radiologist, who is not contracted with the patient's health insurance plan. The provider bills the patient as if the patient has no insurance. Surprise! The patient gets billed the entire amount or the "balance" between what the insurer typically pays its contracted providers and what the provider actually billed. Health maintenance organization (HMO) members, who must typically use network providers in order for their insurance company to pay, were already protected against balance billing when receiving emergency care. But consumers in a preferred provider organization (PPO) insurance lacked that protection. Effective July 1, 2016, providers will not be allowed to balance bill PPO-covered patients for services provided at a hospital, ambulatory surgery center, or urgent care center for:

1. Emergency services covered by the patient's health insurance plan, and
2. Non-emergent services covered by the patient's health insurance plan provided at a facility under contract with the health plan to provide those services if the patient lacked the opportunity to choose an available participating provider.

Copays, coinsurance, and deductibles can be collected and bills may be rendered for any non-covered service. Insurers are required to pay the provider, regardless of whether the provider is under contract. If the provider and the insurer cannot agree on a fee, either a voluntary dispute resolution process or litigation will resolve the issue. The new law also requires Florida hospitals and insurers to provide public notice of their existing provider contracts. Consumer action groups and health plans welcomed the new law while some physicians objected, fearful it will lead to litigation over physician reimbursement rates. Ambulance services are not covered by this new law.

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