FLORIDA HEALTH INSURANCE ADVISORY BOARD MEETING

Thursday, October 22, 2026, 9:00 AM
Conference Call
Call-In Number: 866-299-7949
Code: 1433866#

AGENDA

I. **Call to Order**

II. **Roll Call - Attachment**

III. **Antitrust Statement - Attachment**

IV. **Approval of Minutes, August 25, 2026 - Attachment**

V. **Executive Director's Report - Attachment**

VI. **Discussion of Legislative Proposals for 2027 – Attachments**

VII. **Other Business**

VIII. **Public Comment**

IX. **Adjourn**

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Attachment A

FLORIDA HEALTH INSURANCE ADVISORY BOARD

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Vacant
Carrier

Vacant
Carrier

Vacant
Individual Policyholder

Attachment B

FLORIDA HEALTH INSURANCE ADVISORY BOARD

BOARD MEETING

October 2026

Antitrust Statement

We are here to discuss and act on matters relating to the business of the Florida Health Insurance Advisory Board. We are not here to discuss or pursue the business interests of any individual companies. All of us should proceed with caution and awareness of the requirements and prohibitions of federal and state antitrust laws. We should not engage in discussions, either at this meeting or in private conversation, of our individual companies' plans or contemplated activities. We should concern ourselves only with the business of the Florida Health Insurance Advisory Board, as set forth in the agenda for this meeting and each company's business plans cannot be discussed. If you have questions, please contact the General Counsel.

Attachment C

DRAFT

Florida Health Insurance Advisory Board
Board of Directors Meeting Minutes
Tuesday, August 25, 2026, 9:00 AM
Via Teleconference
Tallahassee, FL

Board Members Present:

Alexis Bakofsky, Chair	Robert Muszynski	Bill Herrle
Eric Johnson	Karin Bailey	Vickie Whaley
Seth Phelps	Rick Wallace	
Christina Lake	Carol Taylor	

Others Present:

- Jack McDermott, FHIAB Executive Director
- Jeffrey Joseph, Assistant General Counsel at the Florida Office of Insurance Regulation

I. Call to Order

Alexis Bakofsky (Deputy Commissioner – Life & Health, Office of Insurance Regulation), as the Chair, called the meeting to order around 9:00 am, indicating the meeting was properly noticed to the public in accordance with Florida Law, and she mentioned the meeting was being recorded.

II. Roll Call

Jack McDermott conducted a roll call of members, noting the presence of a quorum.

III. Antitrust Statement

Jeffrey Joseph was recognized to review the antitrust statement.

IV. Approval of Minutes, December 19, 2025

The Chair presented the minutes from the Board's December 19, 2025, meeting and asked for questions or comments. The Chair accepted a motion from Seth Phelps to approve the minutes, seconded by Carol Taylor. The minutes were approved without changes.

V. Executive Director's Report

The Chair recognized the Executive Director for this report.

<u>Financial Update</u>

The Executive Director reviewed the financial statements as of July 31, 2026. As of this date, the Board had Total Assets of over $56,000 for the two programs on a cash accounting basis, and he reported the annual assessments of $59,986 had been deposited. The Board has enough money to sustain Board operations until collection of the assessments in 2027.

VI. 2025-2029 Financial Audits: Request for Services

The Chair recognized Seth Phelps (Audit Committee Chair). Seth stated the audit committee decided to have a request for proposal sent to local audit firms to audit the FHIAB for the years 2025-2029. The process produced three bids that were reviewed independently by the audit committee members for such factors as pricing of the services, and quality of services provided. The audit committee members each selected the incumbent, Purvis Gray, to be FHAIB's financial auditor for calendar years 2025-2029. The audit committee respectively requested the Board to approve this recommendation for audit services.

The Chair thanked the audit committee for their work and announced the audit committee's recommendation served as a motion so she requested a second. This motion was seconded by Carol Taylor and passed unanimously.

VII. Other Business

The Chair announced the next meeting will include a discussion of Legislative Proposals for 2027, and for Board members to please submit their recommendations to the Executive Director by Wednesday, September 30th, to be compiled. During the next Board meeting, the Board sponsor will present the proposed legislative proposal and answer any questions the Board may have.

The Chair asked if any Board members had other business. No Board member responded.

VIII. Public Comment

The Chair opened the meeting to public comment; no members of the public asked to speak.

IX. Adjournment

The Chair thanked everyone who participated. Having completed the agenda, the Chair adjourned the meeting.

_____ _____

Prepared by: Jack McDermott, Executive Director Approved by Board

DRAFT

Attachment D

Balance Sheet
September 30, 2026
FHIAB

	Small Employer Plan	Individual Plan	Combined Total
Assets			
Cash Operating	34,670.43	7,956.52	42,626.95
Cash Depository	3,498.66		3,498.66
Cash Special Purpose	-		-
Prepaid Expenses	-	-	-
Due Between Pools*	(3,006.80)	3,006.80	-
Total Assets	35,162.29	10,963.32	46,125.61

Income Statement
For the Period Ended September 30, 2026
FHIAB

	Small Employer Plan	Individual Plan	Combined Total
Revenues			
Interest Income	0.34	0.67	1.01
Expense Write-off	-	-	-
Assessments	49,992.00	9,994.00	59,986.00
Total Revenues	49,992.34	9,994.67	59,987.01
Expenses			
Contract Services	37,350.00	7,650.00	45,000.00
Professional Fees	-	-	-
Meetings (Phone)	69.70	14.28	83.98
Audit (2024)	7,500.00	3,875.00	11,375.00
Adobe Acrobat	149.31	30.60	179.91
Quickbooks*	852.41	174.59	1,027.00
PO Box	-	-	-
Postage	17.48	3.58	21.06
Income Taxes	-	-	-
Avalara (Tax Prep Fees)	5.15	1.05	6.20
Total Expenses	45,944.05	11,749.10	57,693.15

**Quickbooks September Payment was delayed - reimbursed in October; Line1Communications $103.72 bill paid in October*

Attachment E

Proposal # 1: Deductible and Out-of-Pocket Carryover for Mid-Year Carrier Plan Changes

Vickie Whaley, REBC – Independent Agent

Florida residents insured under individual health plans who move to a new zip code or service area may be required to switch plans during the plan year, even when coverage remains with the same insurer. When this occurs, consumers may lose amounts already accumulated toward their annual deductible and out-of-pocket maximum and be required to begin satisfying these amounts again under the new plan.

These resets create significant financial burdens for individuals and families and disproportionately affect:

- Members relocating for work or personal reasons
- Individuals with chronic health conditions or ongoing treatment
- Families experiencing medical events early in the plan year
- Members in areas where individual plan availability and service areas differ by zip code or county

Florida law already recognizes the importance of accumulator continuity in certain group health insurance transitions. Section 627.666, Florida Statutes, requires a succeeding group insurer, under specified circumstances, to provide credit for satisfaction or partial satisfaction of deductibles and out-of-pocket limitations under the prior plan.

Similar protection does not currently apply when an individual maintains continuous individual health coverage but is required to select a different plan because a residential move places the individual outside the service area of the existing plan.

Recommendation: *Add section 627.6428, Florida Statutes, to require continuity of deductible and out-of-pocket accumulators when an individual covered under an individual health insurance policy is required to change plans during the same plan year because of a residential move or service-area limitation.*

The protection should apply when:

- *Coverage remains with the same insurer;*
- *There is no lapse in coverage; and*
- *The plan change occurs because the existing plan is not available in the individual's new residential location.*

The insurer would apply amounts already credited toward the individual's deductible and annual out-of-pocket maximum under the prior plan toward the corresponding accumulators under the new plan for the remainder of the same plan year.

The requirement would apply to individual health insurance coverage offered on or off the federal Marketplace, including applicable individual coverage offered by insurers and HMOs, and would not apply to employer-sponsored group health plans.

Proposal # 2: Group Health Insurance Renewal Rate Impact Transparency

Vickie Whaley, REBC – Independent Agent

Florida employers continue to face significant increases in the cost of providing health insurance to their employees. While carriers provide employers with their proposed renewal rates, employers often receive limited information explaining the factors contributing to the increase.

Current transparency requirements provide access to certain claims, cost, and coverage information, but generally do not provide employers with a standardized explanation of how major rating factors contributed to their specific renewal change.

This creates an information imbalance for employers trying to evaluate increasingly difficult benefit decisions. Without meaningful information regarding the drivers of a renewal increase, employers may have difficulty determining whether to absorb additional costs, modify benefits or employee contributions, evaluate alternative funding arrangements, or market coverage to competing carriers.

The goal should not be to require disclosure of proprietary underwriting formulas, algorithms, negotiated provider arrangements, individual claimant information, or trade secrets. Rather, employers should receive a clear explanation of the relative impact that major rating categories had on the overall change in their health insurance premium.

Recommendation: *Amend applicable provisions of Chapter 627 and Chapter 641, Florida Statutes, to require health insurers and HMOs offering fully insured group health coverage to provide a standardized Renewal Rate Impact Disclosure with each renewal.*

The disclosure would identify the percentage-point contribution, whether positive or negative, of applicable major rating categories to the employer's overall renewal change, including:

- *Medical claims experience*
- *Prescription drug claims experience*
- *Medical and prescription drug trend*
- *Demographic changes*
- *Geographic or network factors*
- *Risk pooling, credibility, or large-claim adjustments*
- *Administrative expenses, retention, or other carrier expenses*
- *Benefit or plan design changes*
- *Taxes, assessments, or regulatory fees*
- *Other material rating factors*

For example, if an employer receives a 20% renewal increase, the disclosure should allow the employer to understand how the applicable rating categories collectively resulted in the 20% change without requiring disclosure of the carrier's underlying formulas or proprietary methodology.

The disclosure would be provided with the renewal and would not require disclosure of protected health information, individual claimant information, proprietary underwriting formulas, negotiated reimbursement arrangements, or trade-secret information.

This approach would provide Florida employers with meaningful information to understand and respond to rising health insurance costs, while supporting their ability to fulfill applicable fiduciary responsibilities and preserving appropriate protections for proprietary carrier information.

Proposal # 3: Standardized Consumer Disclosure for Limited and Alternative Health Coverage

Vickie Whaley, REBC – Independent Agent

As health care and health insurance costs continue to rise, Florida consumers and employers are increasingly evaluating alternative approaches to traditional comprehensive major medical coverage. These may include limited-benefit health plans, minimum essential coverage arrangements, direct health care memberships, short-term coverage, or combinations of products intended to address portions of an individual's health care needs.

These alternatives may provide meaningful access to certain health care services or offer more affordable options for consumers. However, the terminology used to describe coverage and health care arrangements can make it difficult for consumers to understand when a product does not provide the protections or benefits typically associated with comprehensive major medical insurance.

The potential financial consequences can be significant when consumers do not understand that major categories of care, such as hospitalization, emergency services, specialty care, prescription drugs, or treatment of serious illnesses, may be excluded or substantially limited. These gaps may result in significant medical debt for consumers and may also contribute to uncompensated care when patients are unable to pay for services not covered by their health care arrangement.

Florida already recognizes the importance of clear consumer disclosure for certain limited coverage. Section 627.6426, Florida Statutes, requires short-term health insurance policies to provide prominent disclosures regarding limitations and essential health benefits that are not covered. Similar disclosure requirements exist for direct health care agreements under section 624.27 and discount medical plans under section 636.212.

Recommendation: *Amend Chapter 627, Florida Statutes, to establish a standardized consumer disclosure requirement for limited health insurance products marketed or presented as an alternative to comprehensive major medical coverage. The Legislature should also amend sections 624.27 and 636.212, Florida Statutes, as appropriate, to provide consistent consumer disclosure standards for direct health care agreements and discount medical plans when such arrangements are presented as an alternative to comprehensive major medical coverage.*

The standardized disclosure should clearly identify when a product or arrangement is not comprehensive major medical coverage and provide an easy-to-understand summary of whether coverage is provided, limited, or excluded for major categories of care, including:

- *Hospitalization*
- *Emergency services*
- *Primary and specialist physician services*
- *Prescription drugs*
- *Maternity care*
- *Mental health and substance use treatment*
- *Preventive services*
- *Treatment for cancer and other complex or high-cost conditions*
- *Preexisting conditions*
- *Annual or lifetime benefit limitations*

- *Consumer out-of-pocket exposure or maximums*

The disclosure should be provided before enrollment or purchase and should use standardized terminology and formatting so consumers can more easily understand and compare coverage options.

The requirement should not prohibit the sale or use of alternative health coverage arrangements or establish new benefit mandates. Rather, it would provide consumers with clear information regarding material coverage limitations before making an enrollment decision.

This approach would support consumer choice while reducing the risk that individuals unknowingly enroll in coverage that leaves significant gaps in protection and potential exposure to substantial medical debt.

Proposal # 4: Florida Facility Fee Notice Act

Carol Taylor, JM-Compliance, REBC – Independent Agent

When a hospital buys a physician practice, the office can be reclassified as a hospital outpatient department. The same doctor, in the same office, giving the same visit, can then produce two bills: the physician's professional fee and a separate hospital facility fee. Patients often find out about the ownership change only when the second bill arrives. Florida law requires signage at hospital-owned freestanding emergency departments and includes facility fees in good faith estimates, but only if the patient asks. No Florida statute requires a hospital-owned physician office to tell patients before a visit that it now bills as a hospital and may charge a facility fee.

Consolidation is speeding up. By January 2026, hospitals and corporate entities owned about 64% of U.S. physician practices (up from 29.8% in 2018) and employed 82% of physicians. Research links hospital ownership to higher prices, with physician prices rising about 14% after acquisition. On the Treasure Coast, patients have reported surprise facility fees of about $174–$200 per routine visit after a health system took over their doctors' offices. Voluntary notices have been inconsistent and have not always said that patients might pay more. Federal site-neutral and billing-identifier reforms mostly apply to Medicare and do not require any advance notice to patients. That leaves commercially insured Floridians unprotected. Seniors, rural residents, and people on fixed incomes carry the heaviest burden. Twenty-one states, including Texas, Colorado, and Connecticut, now have some form of facility-fee protection.

The Act would require hospital-owned practices to:

1. Tell patients at scheduling that the practice is hospital-owned and that a facility fee may apply.
2. Give written notice before non-emergency visits, including the owner's name, an estimated fee or fee range, and how to get a good faith estimate.
3. Use a one-page AHCA model notice written at an eighth-grade reading level, in English and Spanish.
4. Send notice to all patients seen in the past three years within 30 days after a change in ownership or billing status, and at least 30 days before the first facility fee is charged.
5. Post signage and website notices and list facility fees as separate line items on bills.

Patients who did not receive the required notice could not be charged the fee, and patients who cancel after receiving notice could not be charged a cancellation fee. AHCA would enforce the Act through fines and refunds and would publish annual facility-fee data. Emergency and inpatient care would be exempt.

Additional information is referenced in the long version of the proposal.

Recommendation*: The Florida Legislature should enact the Florida Facility Fee Notice Act by creating a new section in Chapter 395, Part I, Florida Statutes (suggested s. 395.3012), with the definitions, notice requirements, patient protections, enforcement, and reporting provisions described above, effective January 1, 2028. This approach does not ban or cap facility fees, so it keeps costs to the state and providers modest and has strong political feasibility. It also builds on Florida's existing price-transparency framework in s. 395.301, F.S. The Act would restore informed choice for patients before they receive care and create a public record of how often facility fees are charged. A three-year legislative review would then let lawmakers decide whether stronger measures are needed, such as limits on facility fees for routine office visits.*

Proposal # 5 Florida Accessible Check-In Act (FACIA)

Carol Taylor, JM-Compliance, REBC – Independent Agent

Florida should guarantee every patient the right to check in with a person. Any licensed hospital, ambulatory surgical center, clinic, clinical laboratory, imaging center, or practitioner office that uses a kiosk, tablet, app, text link, or QR code for check-in would also have to offer a staffed, non-digital alternative during all patient hours, at no extra cost and with no loss of place in line. Patients could choose it for any reason, without disclosing age, disability, or language status.

Self-service check-in shifts work onto patients who are least able to do it. Florida has about 5.09 million residents age 65 and older (21.8% of the state), 22% of U.S. adults 65+ do not own a smartphone, and 12.1% of Floridians speak English less than "very well." People with vision, dexterity, or cognitive limitations and those without devices or data face the same barrier. The result is reliance on family or strangers, disclosure of private health information in waiting rooms, being marked late or no-show, loss of dignity, and forgone care. Existing law leaves a gap: the federal Section 504 rule covers only disability and only federally funded providers; Section 1557 and the ADA do not address digital check-in directly; and Florida's Patient's Bill of Rights (s. 381.026, F.S.) is silent on self-service technology and does not reach standalone labs or imaging centers.

The Act is technology-neutral: providers keep their kiosks so long as a human path stays open. It (1) requires a staffed alternative with access, convenience, and confidentiality equal to the digital system, mirroring the Section 504 standard; (2) offers free qualified interpretation and bars reliance on minors or other patients to interpret; (3) requires signage in English, Spanish, and Haitian Creole stating that a staff member will check the patient in; (4) prohibits fees, delays, rescheduling, or mandatory app downloads or online accounts; and (5) lets practices with fewer than 10 employees comply by phone or intercom. AHCA and DOH would enforce it through existing licensure inspections using a warn-then-fine model (notice and 30-day cure, then fines up to $500 and $2,500 for repeat violations), with no private right of action. It takes effect July 1, 2027, for hospitals and entities with 50+ employees and January 1, 2028, for all others, with a joint AHCA/DOH evaluation report due December 1, 2029. Costs are modest because most sites already staff a front desk.

Additional information is referenced in the long version of this proposal.

Recommendation*: The Legislature should enact FACIA in the next legislative session by creating a new numbered section in Chapter 381, Florida Statutes, placed after and cross-referenced in the Patient's Bill of Rights and Responsibilities (s. 381.026, F.S.), with the final section number assigned by the Office of Bill Drafting Services. The new section should contain the short title, legislative findings, definitions, the right to a staffed check-in alternative, language assistance, notice, prohibited practices, the small-practice accommodation, AHCA/DOH enforcement, and the phased effective dates described above. This approach extends standard providers already known from federal law to all Florida patients, at low cost and with existing state enforcement tools.*

Proposal # 6: Consumer Recognition for Eligible Direct Insurance Transactions (CREDIT Act)

Carol Taylor, JM-Compliance, REBC – Independent Agent

The CREDIT Act would require state-regulated health insurers to count a member's verified out-of-pocket payment for medically necessary, covered care toward the member's deductible and annual out-of-pocket maximum, whenever the amount paid is at or below what the insurer would otherwise have paid. It covers in-network and out-of-network services, including prescription drugs. It creates no new mandated benefit, adds no new payment obligation for insurers, and leaves each plan's deductibles, coinsurance, and copayments unchanged.

Under current Florida law, a patient who finds a lower cash price for covered care often gets no credit toward the deductible for that payment. In effect, the patient pays twice: once for the care, and again later against a deductible that never reflected the payment. This matters because high deductibles are now common: 87% of covered workers with single coverage have a deductible, and 28% of adults report delaying or skipping care because of cost. Hospital price-transparency research also shows that cash prices are often lower than insurer-negotiated rates. Texas (H.B. 2002, 2023) and Tennessee (S.B. 1392, 2024) have already adopted this model.

- **Eligibility:** A payment is credited when the service is medically necessary and covered, the amount paid is at or below the insurer's benchmark (the allowed amount, or a documented negotiated cash price), and the member submits an itemized receipt or comparable proof within a set window.
- **Insurer response:** The insurer must approve or deny within 30 days and explain any denial in writing. Appeals use Florida's existing appeal and external-review process, so no new body is needed.
- **Safeguards:** The Act bars balance billing once a lower cash price has been agreed and paid, and it protects providers from penalties for offering legitimate direct-pay discounts.
- **Scope:** It applies only to fully insured, state-regulated plans. Self-funded ERISA plans are outside state authority, the same limit Texas and Tennessee face.

More information can be found in the long version of this proposal.

Recommendation*: The Florida Legislature should enact the CREDIT Act by creating a new numbered section in Part VI of Chapter 627, Florida Statutes, for individual health insurance (for example, s. 627.64195, placed after the existing balance-billing protection in s. 627.64194). Matching sections should be added in Part VII of Chapter 627 for group policies and in Chapter 641 for HMOs. Each section should set out the crediting requirement, the benchmark-price and documentation conditions, the 30-day decision deadline with written denials, the protections against balance billing and against penalizing providers, and rulemaking authority for the Financial Services Commission and the Office of Insurance Regulation. Final section numbers would be assigned by legislative bill drafting. This is a low-cost, fairness-focused reform that builds on Florida's existing price-transparency and patient-protection laws.*

Proposal # 7: Extending Florida's Balance-Billing Protections to Self-Funded and Level-Funded Employer Health Plans: A Voluntary Opt-In Framework

Carol Taylor, JM-Compliance, REBC – Independent Agent

This proposal asks the Florida Legislature to let self-funded and level-funded employer group health plans voluntarily elect coverage under Florida's 2016 balance-billing law (CS/CS/HB 221; §§ 627.64194, 641.513(5), and 395.1041, Fla. Stat.). Electing plans would resolve qualifying out-of-network payment disputes through Florida's existing dispute resolution program under § 408.7057, instead of the federal No Surprises Act (NSA) Independent Dispute Resolution (IDR) process.

Because these plans are governed by ERISA, Florida's insurance law cannot reach them. Yet they cover 67 percent of covered workers nationally, including 27 percent of workers at firms with 10–199 employees (KFF, 2025). Their only backstop is federal IDR, which generated an estimated $22.4 billion in costs from 2022–2025, roughly four times early projections, with $16.6 billion in 2025 alone (Health Affairs Forefront, Aug. 2026). Providers win about 85–88 percent of disputes, with median awards of 445 percent of the in-network benchmark (QPA). Four large filers account for more than half of all disputes: Radiology Partners, TeamHealth, HaloMD, and SCP Health, most of them backed by private equity. These costs are reaching Florida employers through stop-loss renewals and claims experience. By contrast, Virginia's state process for opted-in plans handled 252 disputes in a year, with providers winning about 45 percent.

Six states already allow this: Georgia, Maine, Nevada, New Jersey, Virginia, and Washington. Because the plan sponsor makes the election, the state is not regulating the plan, which avoids ERISA preemption. Florida would follow Washington's model:

1. A plan or its TPA files a written election with the Office of Insurance Regulation (OIR) at least 15 days before the plan year.
2. The election runs a full plan year and renews automatically unless the plan gives 30 days' notice of withdrawal.
3. Electing plans notify enrollees, providers, and their TPA.
4. OIR reports to the Legislature every two years on uptake and outcomes.
5. OIR adopts rules within 180 days, with elections available the following January 1.

The fiscal impact is limited to OIR's administrative costs. No new agency, subsidy, or claims fund is required.

Additional information is referenced in the long version of the proposal.

Recommendation*: The Legislature should introduce enabling legislation in the 2027 Regular Session, or as a committee bill developed during the interim by the House Health & Human Services Committee and the Senate Banking and Insurance Committee. The bill would add a new numbered subsection to § 627.64194, Florida Statutes, titled "Voluntary election by self-funded and level-funded plans," with conforming cross-references in § 641.513. The new subsection should allow any Florida employer's self-funded or level-funded plan to elect, by filing with OIR, to be bound by Florida's balance-billing and reimbursement standards and the § 408.7057 dispute process. It should also direct OIR to adopt a Washington-style election and attestation process and require a biennial report to the Legislature. This gives Florida employers, especially small and mid-size businesses, a lower-cost, more predictable option, while preserving every plan sponsor's right to remain solely under federal law.*

Proposal # 8: Closing the Ground Ambulance Gap: Extending Florida's Balance-Billing Protections to Ground Ambulance Transport

Carol Taylor, JM-Compliance, REBC – Independent Agent

Florida law (§§ 627.64194 and 641.513, F.S., enacted 2016) bars balance billing for out-of-network emergency hospital, physician, and air ambulance care, but it expressly excludes ground ambulance transport. The federal No Surprises Act (2022) has the same gap. As a result, an insured Floridian protected from a surprise bill in the emergency room can still be balance-billed for the ambulance ride that brought them there.

Patients cannot choose, vet, or negotiate with an ambulance in an emergency. Nationally, 51% of emergency and 39% of non-emergency ground transports for privately insured patients produce an out-of-network charge, the highest rate of any provider type, with a median balance bill of about $450, with bills over $1,000 being common. The federal Ground Ambulance and Patient Billing Advisory Committee (2024) recommended that states act first; Congress has not. At least 22 states already have. Florida advanced nearly identical bills in 2024 (CS/HB 639, passing committees 11–0 and 27–0) and 2025 (HB 425), but both died from committee-calendar attrition, never from an unfavorable vote.

The proposal adopts a comprehensive model covering emergency and non-emergency transport by both public and private providers. It (1) prohibits nonparticipating ground ambulance providers from billing patients beyond in-network cost-sharing; (2) requires insurers to pay providers directly at the lesser of the local ordinance/contract rate, 350% of Medicare, or the billed charge, preserving local rate-setting and protecting rural and volunteer EMS; (3) credits patient payments toward in-network deductibles and out-of-pocket maximums; (4) routes payment disputes through the existing § 641.513(5) process rather than creating new machinery; and (5) requires a written notice of billing rights. Because it regulates private insurance contracts, the 2024 legislative analysis found no fiscal impact on Medicaid or the state group insurance program. State law cannot reach ERISA self-funded plans, but it would protect fully insured, individual-market, and public-employee plan members.

Additional information can be found in the long version of this proposal.

Recommendation*: The Legislature should create a new section 627.64196, Florida Statutes, "Reimbursement of nonparticipating ground ambulance service providers; limitations on balance billing," with a conforming amendment to § 641.513(5), F.S., to bring HMO contracts under the same rule, effective July 1, 2027. To avoid the calendar attrition that stopped the 2024 and 2025 bills, House and Senate companions should be filed early in the 2027 Regular Session with sponsors seated on the committees of reference (Senate Banking and Insurance; House Health Care Facilities & Systems and Insurance & Banking), backed by a pre-filing coalition of fire chiefs, counties, ambulance operators, and consumer advocates. The Office of Insurance Regulation and the Department of Financial Services should then adopt the disclosure form and payer guidance and report ground ambulance complaints annually so the 350% benchmark can be adjusted if access problems emerge.*

More Detail for Proposals # 4 - # 8

STATE OF FLORIDA

PUBLIC POLICY PROPOSAL

Florida Facility Fee Notice Act

A proposal requiring advance notice to patients before hospital-owned physician offices charge a facility fee

Proposed by Carol Taylor, JM-Compliance, REBC

September 2026

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References

I. Executive Summary

Recommendation: The Florida Legislature should enact a Facility Fee Notice Act requiring any hospital-owned or hospital-affiliated physician office to give patients clear, advance, written notice before charging a facility fee on top of the physician's professional fee.

The problem. When a hospital buys a physician practice, the office can be reclassified as a hospital outpatient department. The same doctor, in the same building, delivering the same visit, can then generate two bills: the physician's fee and a separate hospital facility fee. Patients often learn about the ownership change only when the second bill arrives.

Why now. Consolidation is accelerating. By January 2026, hospitals and corporate entities employed 82% of U.S. physicians and owned about 64% of physician practices (Medical Economics, 2026). Florida patients on the Treasure Coast have publicly reported surprise facility fees of roughly $174–$200 per routine visit after a health system absorbed their doctors' offices (CBS12, 2025).

The gap. Florida law requires signage at hospital-owned freestanding emergency departments and folds facility fees into good faith estimates, but patients must ask for an estimate. No Florida statute requires a hospital-owned *physician office* to tell patients, before the visit, that it now bills as a hospital and may charge a facility fee.

The ask. Require (1) notice at scheduling, (2) written notice with an estimated fee amount before non-emergency visits, (3) posted signage and website disclosure, (4) a one-time letter to existing patients when a practice changes ownership or billing status, and (5) a bar on collecting a facility fee from a patient who did not receive the required notice. Enforcement would sit with the Agency for Health Care Administration (AHCA).

II. Problem Definition and Background

Problem statement: Florida patients are being charged hospital facility fees for routine physician-office visits without being told in advance that their practice is now hospital-owned or that a second charge will apply.

A. What a Facility Fee Is

An independent physician office bills one fee under the Medicare Physician Fee Schedule, which already covers overhead. A hospital outpatient department (HOPD) bills two: a professional fee for the clinician and a separate facility fee for the hospital (Bipartisan Policy Center, 2025). Once a hospital acquires a practice and registers it as provider-based, a visit that looks unchanged to the patient can produce that second claim.

For Medicare beneficiaries, the facility claim can carry its own hospital copayment in addition to the 20% coinsurance on the physician fee (24/7 Wall St., 2026). Commercially insured patients face the same pattern, often with facility charges applied to their deductible.

B. Consolidation Is the Driver

Measure	2018	January 2026
Share of physician practices owned by hospitals or corporate entities	29.8%	63.9%
Share of physicians employed by hospitals or corporate entities	—	82%
Physicians added to hospital payrolls, 2024–2025	—	about 44,000

Source: Physicians Advocacy Institute and Avalere Health, as reported by Medical Economics and Radiology Business (2026).

Peer-reviewed research links this vertical integration to higher prices. Baker, Bundorf, and Kessler (*Health Affairs*, 2014) found hospital ownership of physician practices associated with higher prices and spending. Capps, Dranove, and Ody (*Journal of Health Economics*, 2018) found physician prices rose roughly 14% after hospital acquisition.

C. The Florida Experience

Florida is not insulated from this trend. After Cleveland Clinic expanded on the Treasure Coast, a Port St. Lucie patient who had seen the same specialist for years began receiving a $200 facility charge per visit, owing $174 after insurance (CBS12, 2025).

The health system told NBC News it had mailed more than 250,000 letters to Florida patients and posts HOPD signage. However, NBC reported that those letters mentioned a change in billing without explicitly saying patients might pay more (NBC News, 2025). This illustrates the core problem: voluntary notice is inconsistent in content and quality, and nothing in state law sets a floor.

D. Why This Is a Public Problem, Not a Private Billing Dispute

- **Information asymmetry:** The hospital knows the ownership and billing status; the patient cannot observe it.
- **Loss of choice:** Without advance notice, patients cannot compare costs, seek an independent practice, or budget for the charge.
- **Disproportionate burden:** Seniors, rural residents, and people on fixed incomes are least able to absorb unexpected bills and, where local practices are consolidated, least able to switch providers.
- **Erosion of trust:** A surprise second bill for an unchanged service undermines confidence in both physicians and hospitals.

IV. Current Law and the Policy Gap

Existing Florida and federal rules address pieces of the problem but none requires a hospital-owned physician office to warn patients before a routine visit.

Law or rule	What it does	Why it falls short
s. 395.301, F.S. (price transparency, itemized bills)	Requires shoppable-service pricing, itemized bills, and notice of separately billing hospital-based physicians	Operates after care or on request; does not require disclosure that a physician office is hospital-owned
Good faith estimates (ch. 2024-183)	Facility fees must be included in estimates	Patient must ask; the 2024 estimate changes are tied to a pending federal rule (Justia notes to s. 395.301)
Freestanding emergency department signage	Hospital-owned off-site EDs must post signs that facility fees apply (CBS12, 2025)	Covers emergency sites only, not physician offices
Medicare site-neutral policy (Bipartisan Budget Act of 2015; CY 2026 OPPS rule)	Pays physician-fee-schedule-equivalent rates at many off-campus HOPDs; extended to drug administration in 2026 (Congressional Research Service, 2026)	Medicare-only; grandfathered and on-campus sites still bill full facility fees; no patient notice
Unique off-campus billing identifiers (Consolidated Appropriations Act, 2026)	Requires off-campus HOPDs to bill Medicare with a unique identifier; a commercial-plan version passed a House committee in May 2026 (HFMA, 2026)	Improves claims data, but does not tell patients anything before a visit
Federal hospital price transparency	Machine-readable files and shoppable-service lists	Designed for comparison shopping, not for alerting a returning patient that billing has changed

The gap: A Florida patient returning to a long-time physician has no statutory right to be told, before the appointment, that the office now bills as a hospital. State action is also needed because federal Medicare reforms do not reach commercially insured Floridians, and federal disclosure bills remain uncertain.

V. Lessons from Other States

Florida would not be pioneering. U.S. PIRG counts 21 states with some protection against unjustified facility fees as of early 2026, up from 15 in 2024 (PIRG, Outpatient Outrage 2026).

State	Approach	Relevant features
Texas (89th Leg., 2025)	Notice + telehealth ban	H.B. 2556 analysis: written notice of facility fees for hospital-owned and off-campus provider-based sites no later than 10 days before scheduled service (Texas House bill analysis); S.B. 1232 adds place-of-service coding and a telehealth fee ban (Senate Research Center)
Colorado (HB23-1215)	Notice + limited ban	Signage and notice at scheduling; bans facility fees for preventive services; violations treated as deceptive trade practices (United States of Care)

State	Approach	Relevant features
Connecticut	Notice + bans + cost-sharing limits	Signage and notice at scheduling; bans fees on telehealth and certain on-campus E/M visits (United States of Care)
Alaska (SB 105)	Estimates + reporting	Facility fees in good faith estimates; annual hospital reporting
New Mexico (HB 306, 2026, as analyzed)	Notice + limited ban	Notice at scheduling and at service with dollar amount; bilingual signage; no cancellation penalty if patient declines after notice (NM agency analysis)
Minnesota (S.F. 1503, 2025)	Moving from notice to ban	Would replace an existing disclosure law with a ban at off-campus clinics plus annual reporting (MN Senate summary)

Three lessons carry over to Florida:

1. **Timing matters.** The strongest laws require notice at scheduling, when a patient can still choose, not just at check-in.
2. **Content matters.** New Mexico's approach, requiring a dollar amount and protecting patients who cancel after notice, answers the weakness seen in the Treasure Coast letters.
3. **Notice is often a first step.** Minnesota's move toward a ban shows disclosure also generates the data and public awareness needed to evaluate stronger measures later.

VI. Policy Alternatives and Evaluation

Following Bardach and Patashnik, four alternatives are assessed against five criteria. Option C scores best overall because it closes the information gap at modest cost and with the highest political feasibility in Florida.

A. Criteria

- **Effectiveness:** Does it prevent patients from being surprised by facility fees?
- **Consumer choice:** Does it give patients a real opportunity to act before care?
- **Administrative cost:** Burden on providers and on AHCA.
- **Equity:** Protection for seniors, rural, low-income, and limited-English patients.
- **Political feasibility:** Fit with Florida's transparency-focused, market-oriented policy record.

B. Alternatives

A. Status quo. Rely on existing estimates, federal rules, and voluntary hospital letters.

B. Signage and website disclosure only. Require posted notices at hospital-owned practices.

C. Comprehensive advance notice (recommended). Notice at scheduling, written notice with a dollar estimate, signage, ownership-change letters, and no collection without compliant notice.

D. Prohibit facility fees for off-campus office visits and telehealth, as Minnesota and West Virginia bills propose.

Criterion	A. Status quo	B. Signage only	C. Advance notice	D. Fee ban
Effectiveness	Low	Low–moderate	High	Very high
Consumer choice	Low	Low (seen on arrival)	High	Not applicable
Administrative cost	None	Very low	Low–moderate	Moderate (enforcement, reporting)
Equity	Low	Low	Moderate–high	High
Political feasibility	High	High	High	Low–moderate (strong hospital opposition)

Trade-offs. Option D offers the most direct financial relief but touches hospital revenue and would face intense opposition, including arguments about rural access. Option C does not lower prices by itself, but it restores informed choice, builds a public record of how often facility fees are charged, and leaves stronger options open for future sessions.

VII. Recommendation: The Florida Facility Fee Notice Act

The Legislature should create a new section in Chapter 395, Part I, Florida Statutes (suggested s. 395.3012), containing the provisions below. The language is a drafting outline for bill-drafting staff, not final statutory text.

1. Definitions

- **Facility fee:** Any fee charged or billed by a hospital, health system, or affiliated entity for outpatient services that is separate from the professional fee and intended to cover facility or operational costs.
- **Hospital-owned practice:** A physician or clinician office that is owned, operated, or controlled by a licensed hospital or health system, or that bills as a provider-based department of a hospital, whether on or off campus.
- **Change in billing status:** Any acquisition, affiliation, or reclassification that causes a practice to begin billing facility fees.

2. Notice at scheduling

When a non-emergency appointment is scheduled, the practice must tell the patient, orally or in writing, that it is hospital-owned and that a facility fee may be charged in addition to the physician's fee.

3. Written advance notice

For non-emergency services scheduled at least 3 business days ahead, the practice must deliver written notice (paper, patient portal, or email, at the patient's choice) that includes:

1. The name of the hospital or health system that owns the practice.
2. A plain-language statement that the visit may result in two separate bills.
3. The estimated facility fee amount for the scheduled service, or a range if the service is not yet known.
4. A statement that the patient's out-of-pocket cost may be higher than at an independent physician office.
5. How to obtain a good faith estimate and contact a billing representative.

For same-day or urgent appointments, the notice must be provided before services are rendered.

4. Standardized format

AHCA must adopt a one-page model notice, written at no higher than an eighth-grade reading level and available in English and Spanish.

5. Change-of-ownership notice

Within 30 days after a change in billing status, and at least 30 days before the first facility fee is charged, the practice must mail or electronically deliver the notice to every patient seen in the previous 3 years.

6. Signage and website

Hospital-owned practices must post a clearly visible sign at registration areas and a notice on their website and patient portal stating that the practice is hospital-owned and may charge facility fees.

7. Itemized billing

Bills must list the facility fee as a separate, labeled line item and identify the location where services were provided.

8. Patient protections

- A facility fee may not be collected from a patient who did not receive the required notice, except for emergency services.

- A patient who cancels or reschedules after receiving notice may not be charged a cancellation or no-show fee.

9. Enforcement

AHCA may impose administrative fines (for example, up to $1,000 per violation, capped annually) and require refunds of facility fees collected in violation. A pattern of violations may be referred to the Department of Legal Affairs under the Florida Deceptive and Unfair Trade Practices Act.

10. Reporting

Hospitals must report annually to AHCA the number of locations charging facility fees, the number of facility fees billed, and total amounts billed and collected. AHCA must publish a summary on FloridaHealthPriceFinder or a successor site.

11. Exemptions and effective date

Emergency services and inpatient care are exempt. The act would take effect January 1, 2028, giving providers a compliance runway after AHCA adopts the model notice.

VIII. Stakeholders, Objections, and Implementation

A. Stakeholder Map

Stakeholder	Likely position	Key interest
Patients, AARP Florida, consumer groups such as Florida PIRG	Support	Avoiding surprise bills; informed choice
Employers and health plans	Support	Lower outpatient spending; clearer claims
Independent physicians (e.g., Florida Medical Association members)	Likely support	Transparent competition with hospital-owned practices
Florida Hospital Association and health systems	Oppose or seek amendments	Administrative burden; protecting facility revenue
AHCA	Neutral	Workload, rulemaking, and enforcement capacity

B. Anticipated Objections and Responses

- **"Facility fees fund real costs and higher standards."** The proposal does not ban or cap any fee. It asks only that patients be told in advance, which is consistent with the quality rationale hospitals themselves give (NBC News, 2025).
- **"Exact amounts are hard to predict."** The notice allows an estimate or range and builds on the good faith estimate process hospitals already use.

- **"This duplicates federal transparency rules."** Federal rules require price files and Medicare billing identifiers, but none requires advance notice to a returning patient of a physician office.
- **"Compliance is burdensome."** A single AHCA model form, electronic delivery, and a phased effective date keep costs low. Connecticut, Colorado, and Texas already require comparable notice.

C. Implementation

1. **Rulemaking (first 6 months):** AHCA adopts the model notice, signage standards, and reporting template, with a public comment period.
2. **Provider readiness (next 6–12 months):** Hospitals update scheduling scripts, portal messages, and billing systems.
3. **Enforcement (from effective date):** Complaint-driven review through AHCA, with fines and refunds for violations.

D. Fiscal Impact

State costs are expected to be modest and limited to AHCA staff time for rulemaking, complaint handling, and publishing annual data. These can likely be absorbed within existing resources or offset by administrative fines; a formal estimate should come from AHCA's bill analysis. Private-sector costs fall mainly on hospitals for notice delivery and reporting.

E. Measuring Success

- Number of facility-fee billing complaints filed with AHCA and the Department of Financial Services.
- Share of patients reporting advance notice, measured through a short survey.
- Annual counts of hospital-owned sites charging facility fees and total amounts billed.
- A three-year legislative review to decide whether stronger measures, such as limits on facility fees for routine office visits, are warranted.

IX. Conclusion

Florida patients should know before they walk into a familiar doctor's office that it now bills like a hospital. The Facility Fee Notice Act answers that need with a targeted, low-cost, market-friendly disclosure mandate that builds on the Legislature's existing commitment to price transparency. It protects informed choice today and gives lawmakers the data to judge whether further action is needed tomorrow.

References

Baker, L. C., Bundorf, M. K., & Kessler, D. P. (2014). Vertical integration: Hospital ownership of physician practices is associated with higher prices and spending. *Health Affairs, 33*(5), 756–763.

Capps, C., Dranove, D., & Ody, C. (2018). The effect of hospital acquisitions of physician practices on prices and spending. *Journal of Health Economics, 59*, 139–152.

Fung, A., Graham, M., & Weil, D. (2007). *Full disclosure: The perils and promise of transparency.* Cambridge University Press.

Bipartisan Policy Center. (2025). Site neutrality in Medicare payment.

CBS12. (2025, August 18). Facility fees on medical bills, the new normal.

Congressional Research Service. (2026). Medicare's site-neutral payment policy (IF13233).

Florida Statutes, s. 395.301 (2025).

HFMA. (2026). Off-campus outpatient billing rules could extend to commercial claims.

Medical Economics. (2026). Physician independence vanishes as corporate medicine swallows up U.S. health care.

Minnesota Senate Counsel. (2025). S.F. 1503 bill summary.

NBC News. (2025). After Cleveland Clinic expanded to Florida, patients say surprise fees followed.

New Mexico Legislature. (2026). HB 306 agency analysis.

Radiology Business. (2026). 82% of physicians now employed by corporate entities.

Texas House Research. (2025). Bill analysis, H.B. 2556.

Texas Senate Research Center. (2025). Bill analysis, C.S.S.B. 1232.

U.S. PIRG. (2026). Outpatient outrage 2026.

United States of Care. (2024). State laws to promote fair billing practices.

24/7 Wall St. (2026, August 4). Same doctor, same office, new owner.

STATE OF FLORIDA
PUBLIC POLICY PROPOSAL

Florida Accessible Check-In Act (FACIA)

A proposal for relief for Florida Consumers Allowing for Accessible Check-In

Proposed by Carol Taylor, JM-Compliance, REBC
September 2026

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I. Executive Summary

Florida should enact a **Florida Accessible Check-In Act** (FACIA)**,** requiring every licensed health care provider, clinical laboratory, and hospital that uses a kiosk, tablet, app, text link, or QR code for patient check-in to also offer a staffed, non-digital alternative at no extra cost and with no loss of place in line.

Self-service check-in saves staff time, but it quietly shifts work onto patients. Seniors unfamiliar with touchscreens, residents with limited English proficiency (LEP), people with vision, hearing, dexterity, or cognitive limitations, and people without smartphones or data plans must now ask strangers for help, share private health information in a waiting room, or leave without being seen. When a patient cannot get through the front door of the care system, every downstream investment in quality and access is wasted.

The proposed Act would do four things:

1. **Guarantee a human alternative.** A staffed desk, phone line, or trained staff member must be available to check patients in during all hours the site accepts patients.
2. **Require visible notice.** Plain-language signage in English and Spanish, at a minimum, stating that patients may check in with a staff member instead.
3. **Prohibit penalties.** No late fees, lost appointments, or longer waits for patients who choose the alternative.
4. **Protect privacy and language access.** The alternative must allow private disclosure of information and connect LEP patients to qualified interpretation, consistent with federal Section 1557 obligations.

The Agency for Health Care Administration (AHCA) and the Department of Health (DOH) would enforce the Act through existing licensure inspections, with a phased effective date and a small-practice safe harbor. Costs are modest because most sites already employ front-desk staff; the Act regulates how that capacity is made available, not whether it exists.

II. Problem Definition

Florida patients who cannot use a kiosk, tablet, app, or QR code are being asked to prove digital competence before they can receive care, and many of them are Florida's most frequent users of that care.

A problem stated as a private inconvenience invites no public action, while a problem stated as a barrier to a public good invites a remedy. This proposal defines the issue as a barrier to access at the point of entry to health care, not as a customer-service preference.

A. Who Is Affected

Group	Florida scale	Why digital-only check-in fails them
Residents 65 and older	About 5.09 million people, 21.8% of the state in 2024, versus 18% nationally (America's Health Rankings, 2025; USAFacts, n.d.)	22% of U.S. adults 65+ do not own a smartphone (Pew Research Center, 2026); ownership falls further among the oldest and lowest-income seniors (Pew Research Center, 2017)
Limited English proficiency (LEP) residents	12.1% of Floridians age 5+ spoke English less than "very well" in 2023 (Florida Health CHARTS, n.d.); Florida holds about 9% of the nation's LEP population (Haldar et al., 2023)	Kiosk screens often offer only English or English and Spanish; Haitian Creole, Portuguese, Vietnamese, and Russian speakers are common in Florida (National Immigrant Women's Advocacy Project [NIWAP], 2023)
People with disabilities	Overlaps heavily with the 65+ group	Touchscreens can be unusable with low vision, tremor, arthritis, or cognitive impairment
People without devices or data	Concentrated among low-income households	Text-link and QR-code check-in assumes a working smartphone and data plan

The overlap matters. An 80-year-old Haitian Creole speaker with arthritis faces three barriers at once, and no single existing law addresses the combination.

B. What the Research Shows

The digital divide in health care is persistent, not transitional. Recent analyses of patient portal data find that older adults and non-English speakers remain less likely to use digital health tools, even inside integrated health systems (Ali et al., 2026). Interviews with older adults found that many felt compelled to adopt portals during the pandemic and struggled with aging-related barriers and a lack of training (Jeong & Kim, 2023). A study of homebound Medicare beneficiaries found that nearly three-quarters did not use eHealth at all, and that in-person assistance, not self-directed tools, was what closed the gap (Park et al., 2025).

C. The Harm

When check-in is digital-only, affected patients face four outcomes, each of them bad:

- **Dependence on a family member or close friend.** They must coordinate their care for when family members are available to assist them. This may be difficult if the family member or friend must schedule time out of work, have reliable transportation and other barriers to providing assistance.
- **Dependence on strangers.** They ask other patients for help, disclosing names, birth dates, insurance numbers, and reasons for their visit in a public waiting room.

- **Delay.** They wait for an overstretched staff member, sometimes long enough to be marked late or no-show.
- **Loss of dignity.** Competent adults are made to feel incapable in a setting where trust matters.
- **Forgone care.** Some leave, reschedule, or stop coming. For a population managing chronic conditions, a missed lab draw or follow-up visit can mean a preventable hospitalization later.

Open question for the record: no Florida agency currently tracks how many patients abandon visits because of check-in barriers. The Act's evaluation component (below) would begin collecting that data.

III. Background and Current Legal Landscape

Existing law protects some patients some of the time, but no Florida or federal rule guarantees every patient a non-digital way to check in.

Authority	What it covers	Gap this proposal fills
HHS Section 504 final rule (45 C.F.R. Part 84, effective July 8, 2024)	Recipients of HHS funds, including Medicare and Medicaid providers, must make kiosks usable by people with disabilities; where a kiosk is not accessible, a work-around must give equal access, convenience, and confidentiality (Reed Smith, 2024)	Protects **disability** only. A senior who is simply unfamiliar with technology, or a patient with limited English, is not covered. Practices with no federal funding are outside it. HHS extended the web and app deadlines by one year in May 2026 (RegLantern, 2026), a sign federal timelines can shift
Section 1557 of the Affordable Care Act	Prohibits discrimination, including national-origin discrimination that reaches language access, by federally funded health programs	Its implementing rules have been repeatedly revised and litigated across administrations; enforcement depends on federal priorities and complaints, and it does not address digital check-in specifically
Americans with Disabilities Act, Title III	Public accommodations, including private doctors' offices, must provide effective communication and reasonable modifications	Disability-based; enforcement mainly through private lawsuits
Florida Patient's Bill of Rights, s. 381.026, F.S.	Patients have a right to know what support services exist, including whether an interpreter is available; a patient in a facility who does not speak English has a	Silent on check-in and self-service technology; the interpreter right is conditional; it applies only to physicians, osteopaths, podiatrists, APRNs, and ch. 395

Authority	What it covers	Gap this proposal fills
	right to an interpreter if one is readily available	facilities, not to standalone labs or imaging centers
HIPAA Privacy Rule	Limits disclosure of health information by covered entities	Does not stop a patient from being forced to disclose information to a stranger who is helping them at a kiosk

Two conclusions follow. First, Florida's most characteristic vulnerable groups, older adults without a disability diagnosis and LEP residents, fall between existing protections. Second, the one relevant federal rule (Section 504) already accepts the core idea of this proposal: when a kiosk does not work for a patient, a staffed alternative providing equal access, convenience, and confidentiality is the remedy. Florida would extend that proven standard to all patients rather than inventing a new one.

IV. Policy Goals and Evaluation Criteria

The goal is simple: no Florida patient should miss or delay care because they cannot operate a check-in device.

This proposal measures options against six standards:

Criterion	Question asked
Effectiveness	Does it reliably let affected patients check in independently and on time?
Equity	Does it serve seniors, LEP residents, people with disabilities, and people without devices, without requiring them to self-identify?
Dignity and privacy	Can the patient check in without disclosing health information to strangers?
Cost and burden	What does it cost providers, especially small practices, and the state?
Administrative feasibility	Can existing agencies enforce it with existing tools?
Political feasibility	Can it attract bipartisan support in the Florida Legislature?

The equity criterion is deliberately worded. A remedy that requires patients to prove age, disability, or language status before receiving help adds a new barrier. The best option works for anyone who asks.

V. Policy Alternatives

Alternative D, a statutory right to a staffed check-in alternative, best meets the criteria at acceptable cost.

Criterion	A. Status quo	B. Voluntary guidance and education	C. Kiosk design standards only	D. Statutory right to a staffed alternative (recommended)
Effectiveness	Low	Low to moderate	Moderate: better screens still fail patients who cannot or will not use them	High
Equity	Low	Low	Moderate: helps disability and language users, not the digitally unfamiliar	High: available to anyone on request
Dignity and privacy	Low	Low	Moderate	High
Cost to providers	None	Minimal	High: hardware and software replacement	Low to moderate: uses existing front-desk staff or other personnel
Administrative feasibility	N/A	High	Low: the state lacks kiosk technical expertise	High: fits AHCA and DOH inspections
Political feasibility	N/A	High	Moderate: vendor and industry resistance	High: narrow, consumer-protective, senior-focused

A. Status quo. Relies on federal rules that exclude most affected Floridians and on the kindness of other patients. The problem grows as more practices adopt self-service tools.

B. Voluntary guidance. AHCA or the Department of Elder Affairs could publish best practices and fund digital-literacy classes at senior centers. Worthwhile as a complement, but voluntary guidance does not change behavior at a busy practice facing staffing pressure, and literacy training cannot reach patients with cognitive decline.

C. Kiosk design standards. Florida could mandate large text, audio output, and multilingual interfaces. This is expensive, technically demanding to enforce, and still leaves out patients who simply cannot use a screen. Section 504 already addresses kiosk accessibility for federally funded providers.

D. Statutory right to a staffed alternative. Technology-neutral: providers keep any system they like, as long as a human path remains open. It mirrors the equal-access, equal-convenience, and confidentiality work-around standard HHS already applies under Section 504, so compliance for most providers is an extension of an existing obligation.

VI. Recommended Policy: Model Statutory Provisions

The Legislature should create a new section of Chapter 381, Florida Statutes, cross-referenced in the Patient's Bill of Rights (s. 381.026), with the following provisions. Section numbering would be assigned by the Office of Bill Drafting Services.

Section 1. Short title. This act may be cited as the "Florida Accessible Check-In Act (FACIA)."

Section 2. Legislative findings. The Legislature finds that self-service check-in technology can improve efficiency but must not become a barrier to care; that Florida has one of the nation's largest populations of older adults and residents with limited English proficiency; and that every patient is entitled to begin a health care visit with dignity, privacy, and without reliance on strangers.

Section 3. Definitions.

1. "Covered entity" means a hospital or ambulatory surgical center licensed under chapter 395; a health care clinic licensed under part X of chapter 400; a clinical laboratory, imaging center, or patient service center operating in this state; and the office of a health care practitioner licensed under chapters 458, 459, 460, 461, 463, 464 (APRN), or 466 that conducts patient check-in.
2. "Digital check-in system" means any kiosk, tablet, touchscreen, mobile application, text-message link, QR code, website, or other self-service electronic method used to register arrival, verify identity or insurance, complete intake forms, or join a waiting queue.
3. "Staffed check-in alternative" means check-in completed with the direct assistance of a trained employee or agent of the covered entity, in person or by telephone from the premises.

Section 4. Right to a staffed check-in alternative.

1. A covered entity that uses a digital check-in system shall make a staffed check-in alternative available during all hours in which it accepts patients.
2. A patient may choose the staffed alternative for any reason and shall not be required to state a reason, disclose age or disability, or demonstrate inability to use the digital system.
3. The staffed alternative shall provide access, convenience, and confidentiality equivalent to the digital system, including a place or manner of communication that prevents other patients from overhearing protected health information.
4. A patient who begins waiting for assistance shall be treated as arrived at the time they first sought assistance for purposes of lateness, no-show, or cancellation policies.

Section 5. Language assistance. Staff providing the staffed alternative shall offer, at no cost to the patient, access to a qualified interpreter, in person or by telephone or video, for any patient who

requests one. A patient shall not be required to rely on a minor child or another patient to interpret. Nothing in this section limits obligations under federal law.

Section 6. Notice. A covered entity shall post, at each kiosk and at the entrance to each check-in area, a sign in English, Spanish, and Haitian Creole, in no smaller than 28-point type, stating in substance: *"You do not have to use this machine or your phone. A staff member will check you in. Ask for help at any time."* The Department of Health shall publish model signage, including a pictogram, and may require additional languages for regions where a language is spoken by 5 percent or more of residents.

Section 7. Prohibited practices. A covered entity shall not:

1. charge a fee for using the staffed alternative;
2. deprioritize, delay, or reschedule a patient because the patient chose the staffed alternative;
3. require a patient to download an application, create an online account, or provide an email address as a condition of receiving care; or
4. remove the staffed alternative during staffing shortages without providing a telephone line answered on the premises.

Section 8. Small-practice accommodation. A covered entity with fewer than 10 employees may satisfy Section 4 by any means, including a telephone or intercom answered by clinical staff, provided the patient can complete check-in without assistance from anyone other than the entity's staff. For purposes of this Section, the number of employees of a covered entity includes the employees of every other entity under common ownership with it, whether or not that other entity is itself a covered entity or is located at the same site.

Section 9. Enforcement. The Agency for Health Care Administration shall enforce this section for facilities it licenses; the Department of Health and the applicable boards shall enforce it for practitioner offices. A violation is a first-offense notice and 30-day correction period, followed by administrative fines of up to $500 per violation for a second violation and $2,500 for each subsequent violation within 24 months. Complaints may be filed through existing AHCA and DOH complaint systems.

Section 10. Effective date. Effective July 1, 2027, for hospitals and entities with 50 or more employees; January 1, 2028, for all other covered entities.

VII. Implementation, Cost, Enforcement, and Evaluation

The Act can be implemented with existing agencies and existing staff, at low marginal cost.

A. Implementation Steps

Once the act is signed, the following steps would be taken:

- DOH publishes model signage

- AHCA/DOH add item to inspection checklists
- Large entities comply July 1, 2027
- All entities comply Jan 1, 2028
- Report to Legislature Dec 1, 2029

The timeline gives the state six months to publish model signs and training materials and gives small practices an extra six months.

B. Cost

- **Providers.** Most covered entities already staff a front desk. Direct costs are signage (under $100 per site with state templates), a short staff training module, and interpreter-line access, which most hospitals and many clinics already hold under federal obligations.
- **State.** AHCA and DOH add one item to existing inspection and complaint processes. A fiscal note should estimate staff time for rulemaking and complaint handling; a modest nonrecurring appropriation for DOH signage translation and design is likely sufficient.
- **Savings.** Fewer missed appointments and delayed diagnoses reduce avoidable emergency visits and hospitalizations, a large share of which are paid by Medicare and Florida Medicaid.

C. Enforcement

Enforcement uses a warn-then-fine model. Most violations are expected to be corrected at the notice stage, which keeps the Act from becoming a litigation vehicle while still giving it teeth. The Act creates no private right of action.

D. Evaluation

By December 1, 2029, AHCA and DOH should jointly report to the Governor and Legislature on:

- complaints received, violations found, and corrections made;
- results of a patient-experience question added to existing state or facility surveys ("Were you able to check in the way you preferred?"), broken out by age group and preferred language; and
- any available data on no-shows or left-without-being-seen rates at participating facilities before and after the Act.

VIII. Stakeholders, Objections, and Responses

The Act's natural coalition is broad: senior advocates, disability advocates, immigrant and faith communities, and patient-safety groups, with provider associations persuadable if the burden stays light.

Stakeholder	Likely position	Engagement strategy
AARP Florida, Area Agencies on Aging, Department of Elder Affairs	Support	Lead advocates; share constituent stories
Disability Rights Florida, Centers for Independent Living	Support	Align with Section 504 work-around standard
Immigrant, Haitian, and Hispanic community organizations; faith groups	Support	Testimony on reliance on strangers and forgone care
Florida Hospital Association, Florida Medical Association	Neutral to cautious	Emphasize low cost, cure period, no private right of action
Commercial lab and urgent-care chains	Possible opposition	Show that the Act does not ban kiosks, only guarantees a backup
Check-in technology vendors	Neutral	The Act is technology-neutral and creates demand for accessible design

A. Anticipated Objections

"This is an unfunded mandate on small practices." Small practices almost always have someone answering phones or greeting patients. Section 8 lets them comply with a phone or intercom, and the cure period prevents first-time fines.

"Staff shortages are why we adopted kiosks." The Act does not require added staff or ban kiosks. If most patients use the kiosk, the few who need help consume little staff time, and providers keep the efficiency gains.

"Florida's official language is English; why require Spanish and Haitian Creole signs?" Article II, section 9 of the Florida Constitution makes English the official language but does not prohibit government-required notices in other languages for health and safety. The signage is a narrow safety notice, and patients must first understand that help exists before they can ask for it in English.

"Federal law already covers this." Only for disability, and only for federally funded providers. The Act reaches the seniors and LEP residents federal law leaves out, and it provides a stable state floor if federal rules change.

"Just teach seniors to use the technology." Training helps and should continue, but it cannot reach patients with cognitive decline, vision loss, or no device, and it shifts the burden onto the patient at the moment they are sick.

IX. Conclusion

Florida should enact the Florida Accessible Check-In Act in the next legislative session.

Multiple-streams framework holds that policy change happens when a recognized problem, an available solution, and favorable politics converge. All three are present: the problem grows with every new kiosk, the solution already exists in federal disability rules, and protecting older Floridians is a priority across party lines. The Act asks little of providers and guarantees a great deal to patients: that walking through the door of a doctor's office, lab, or hospital will never depend on owning a smartphone, reading English, or finding a kind stranger.

References

Administration for Community Living. (2024). Final rule implementing Section 504 of the Rehabilitation Act. U.S. Department of Health and Human Services. https://acl.gov/504rule

Ali, M. M., Lunos, S., Henderson, Z., Allen, M., Adam, P., Melton, G. B., & Rizvi, R. (2026, January 12). Insights into patient portal engagement leveraging observational electronic health data. American Journal of Managed Care. https://www.ajmc.com/view/insights-into-patient-portal-engagement-leveraging-observational-electronic-health-data

America's Health Rankings. (2025). Population age 65 and older, Florida. United Health Foundation. https://www.americashealthrankings.org/explore/measures/pct_65plus/FL

Fla. Stat. § 381.026. (2025). Florida Patient's Bill of Rights and Responsibilities. https://www.flsenate.gov/Laws/Statutes/2025/381.026

Florida Health CHARTS. (n.d.). Population that speaks English less than "very well." Florida Department of Health. Retrieved September 27, 2026, from https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalIndRateOnly.Dataviewer&cid=299

Haldar, S., Pillai, D., & Artiga, S. (2023, July 7). Overview of health coverage and care for individuals with limited English proficiency (LEP). KFF. https://www.kff.org/racial-equity-and-health-policy/overview-of-health-coverage-and-care-for-individuals-with-limited-english-proficiency/

Jeong, C. H., & Kim, B. (2023). Navigating the digital divide: Factors influencing patient portal adoption by older adults during the pandemic. Innovation in Aging, 7(Suppl. 1). https://doi.org/10.1093/geroni/igad104.3489

National Immigrant Women's Advocacy Project. (2023). Florida demographics. American University Washington College of Law. https://niwaplibrary.wcl.american.edu/wp-content/uploads/Demographics_Florida-updated-9.20.2023-1.pdf

Park, J., Kim, B., Cho, J., & Park, S. (2025). Bridging the digital divide: Factors influencing eHealth use among homebound older adults during the COVID-19 pandemic. Journal of Applied Gerontology. Advance online publication. https://doi.org/10.1177/07334648251343407

Pew Research Center. (2017, May 17). Technology use among seniors. https://www.pewresearch.org/internet/2017/05/17/technology-use-among-seniors/

Pew Research Center. (2026, January 8). Internet use, smartphone ownership, digital divides in the U.S. https://www.pewresearch.org/short-reads/2026/01/08/internet-use-smartphone-ownership-digital-divides-in-u-s/

Reed Smith. (2024, May). HHS's Section 504 final rule includes digital accessibility standards. https://www.reedsmith.com/articles/hhss-section-504-final-rule-includes-digital-accessibility-standards/

RegLantern. (2026). Section 504 final rule: What FQHCs need to know about the new disability nondiscrimination requirements. https://reglantern.com/blog/section-504-final-rule-what-fqhcs-need-to-know-about-the-new-disability-nondiscrimination-requirements

USAFacts. (n.d.). How many people live in Florida? Retrieved September 27, 2026, from https://usafacts.org/answers/how-many-people-live-in-the-us/state/florida/

A PUBLIC POLICY PROPOSAL FOR THE STATE OF FLORIDA

Consumer Recognition for Eligible Direct Insurance Transactions (CREDIT Act)

A Targeted Fairness Reform for Healthcare Cost-Sharing

Presented by: Carol Taylor, JM-Compliance, REBC

September 2026

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I. Executive Summary

Consumer Recognition for Eligible Direct Insurance Transactions, or the CREDIT Act, is a narrow, evidence-based reform proposed for the State of Florida. It requires state-regulated health insurers to credit a member's verified, direct out-of-pocket payment for medically necessary, covered healthcare services toward that member's deductible and annual out-of-pocket maximum, whenever the amount the member pays is at or below what the insurer would otherwise have paid for the same service. The Act does not require insurers to pay anything additional; it requires them only to recognize a payment their own member has already made.

The Act applies to both in-network and out-of-network services, prohibits balance billing that would defeat a properly negotiated lower cash price, and protects providers from penalties for offering direct-pay discounts. It creates no new mandated benefit and does not alter existing cost-sharing structures: deductible levels, coinsurance percentages, and copayments remain exactly as each plan already sets them. Florida would follow a model already enacted in Texas and Tennessee, supported by independent research showing that self-pay prices for many covered services are often lower than the rates insurers negotiate with providers.

II. Statement of the Issue

Under current Florida law, when an insured individual pays out of pocket for a medically necessary, covered healthcare service, such as imaging, laboratory work, behavioral health visits, outpatient procedures, or prescription drugs, that payment often does not count toward the individual's deductible or annual out-of-pocket maximum. Cost-sharing accumulators are generally credited only when a claim is processed through the insurer at the insurer's own negotiated rate.

This creates a structural penalty for cost-conscious behavior. A consumer who finds a covered service available at a lower price and pays for it directly may see that spending disappear from their plan's accumulator entirely, even though the identical service purchased at a higher price through routine in-network billing would count in full toward the same deductible. Patients are effectively forced to choose between paying less today and preserving their financial protection for the remainder of the plan year. Plus, under the current framework, choosing the lower price often means paying twice: once directly for the care, and again later when the full deductible resets against a balance that never reflected the earlier payment.

III. Background: The High-Deductible Landscape and the Cost of Delayed Care

High-deductible health coverage has become the norm rather than the exception. Nationally, 87% of covered workers with single coverage are enrolled in a plan carrying a general annual deductible, with an average deductible of $1,787 for single coverage in 2024, and roughly a third of covered workers face a deductible of $2,000 or more, a share that has nearly doubled over the past decade (KFF, 2024). As deductibles have grown, so has the share of routine care that patients pay for directly before insurance contributes anything at all.

This cost exposure has measurable consequences for whether people seek care at all. Using 2023 federal survey data, KFF found that more than one in four adults, 28 percent, reported delaying

or forgoing medical care because of cost, with the burden falling hardest on adults in fair or poor health and those without insurance (KFF, n.d.). A reform that lets patients pursue lower-cost, covered care without losing ground on their deductible directly addresses this pattern of cost-driven care avoidance.

At the same time, evidence increasingly shows that the price an insured patient pays through their plan is not always the lowest price available for the same service. Research using hospitals' published price-transparency data found that a substantial share of hospitals set discounted cash prices below their median negotiated commercial rates for common services (Jiang et al., 2021; Rodriguez, 2021), and a separate analysis by a Trinity College economist found that self-pay cash prices were lower than insurer-negotiated rates for the majority of procedures studied (Cole, 2022). Under current Florida law, a patient who takes advantage of exactly this kind of lower price gains nothing toward their deductible for having done so.

The pattern holds specifically for the two service categories most relevant to everyday care. The Trinity College analysis treated office visits, CT scans, and MRIs as three of the fourteen "shoppable" hospital services it studied, finding cash prices below the insurer-negotiated rate across most of them (Cole, 2022). A 2021 research letter in JAMA Network Open by Johns Hopkins researchers, focused specifically on imaging, found that the share of hospitals pricing a service in cash below their own median negotiated commercial rate ranged from 39 percent for a CT scan of the abdomen and pelvis to 44 percent for a lower-back X-ray, with a median cash price for a brain MRI of $2,306 (Jiang et al., 2021; Stempniak, 2021). A third JAMA Network Open study comparing physician-owned and non-physician-owned hospitals found cash prices for MRI and CT services were roughly a third lower at physician-owned facilities (Association of Clinical Documentation Integrity Specialists, 2023; Wang et al., 2023).

This body of research, however, is drawn almost entirely from hospital price-transparency filings required since 2021; independent physician offices and freestanding imaging centers are not subject to the same disclosure mandate, so systematic price comparisons for those settings are scarce. The available evidence there is largely anecdotal but illustrative: in one widely reported case, a Florida patient paid $268 for a CT scan at a freestanding imaging center, then was billed $8,897 for the same scan performed at a hospital emergency department months later (Kodjak, 2018). Cases like this are consistent with the broader pattern the hospital data show, even though a single case cannot be generalized the way a systematic study can.

IV. What the CREDIT Act Does

The CREDIT Act requires an insurer to credit a member's direct payment toward the member's deductible and annual out-of-pocket maximum when each of the following conditions is met. "Medically necessary, covered" care is defined broadly and consistently across the Act: it reaches all medically necessary treatment and procedures a member's plan covers; physician and facility services, imaging, laboratory work, behavioral health visits, and outpatient procedures, as well as prescription drugs dispensed through a pharmacy. A prescription is not treated differently from any other covered service for purposes of the credit.

- The service, procedure, or prescription drug is medically necessary and is a covered benefit under the member's plan.
- The amount the member actually paid is at or below the benchmark price the insurer would otherwise have recognized: its negotiated, allowed amount for the service (in-network) or a comparably documented negotiated cash price (out-of-network).
- The member submits reasonably available documentation of payment, such as an itemized receipt or comparable proof of the service rendered and the amount paid, within a defined submission window.

The Act applies to both in-network and out-of-network services. It applies only to fully insured health plans regulated by the State of Florida and requires no reimbursement obligation from insurers; insurers pay nothing beyond what they already would have paid; they simply recognize what the member has already spent. Consumer documentation requirements are limited by design, mirroring the streamlined receipt-and-verification process used in the states that have already implemented this model.

Insurers must approve or deny a crediting request within 30 days and must provide a written explanation for any denial. Denials remain subject to Florida's existing insurance appeal and external-review protections, so no new adjudicatory body or process is required.

Two further provisions protect the integrity of the reform. First, the Act prohibits balance billing from any party seeking to enforce a higher negotiated rate once a lower cash price has been agreed to and paid. This closes a gap that could otherwise let a provider or facility undo the benefit after the fact. Second, it protects providers from penalties, network sanctions, or rate clawbacks for offering a legitimate direct-pay discount. The Act does not create new benefits and does not alter any plan's underlying cost-sharing structure; deductibles, coinsurance, and copayment amounts remain exactly as each plan currently sets them.

Prescription Drugs and Pharmacy Benefit Manager Contracts

Because the credit reaches prescription drugs on the same terms as any other covered service, it applies even though a member's pharmacy benefit is typically administered by a pharmacy benefit manager (PBM) rather than the carrier directly. Some PBM contracts include provisions requiring that all of a plan's prescriptions be processed exclusively through the PBM's own network and claims system. To the extent such a provision would block a member's direct cash payment for a covered prescription from being credited under this Act, it would generally conflict with existing federal law: the Patient Right to Know Drug Prices Act and the companion Know the Lowest Price Act already prohibit health plans, insurers, and PBMs from restricting a pharmacy's ability to tell an enrollee when the cash price of a drug is lower than the plan's copay, and they confirm the enrollee's right to pay that lower price directly (Know the Lowest Price Act of 2018, 2018; Patient Right to Know Drug Prices Act, 2018). The CREDIT Act's treatment of prescription drugs is therefore consistent with, rather than in tension with, this existing federal gag-clause prohibition, and a PBM exclusivity clause used to defeat the credit would already be operating outside current law.

V. Rationale: Why It Makes Sense

The CREDIT Act is a measured consumer-protection reform that reinforces, rather than replaces, Florida's existing transparency and affordability initiatives. Its case rests on a small number of straightforward points:

- It recognizes legitimate out-of-pocket spending for covered care that has already occurred; it does not create a new payment obligation for insurers.
- It allows patients to shop for lower-cost, covered services without losing progress toward their deductible, addressing the reality that high-deductible plans are now the majority experience for insured Floridians.
- It encourages use of services priced below insurers' own negotiated rates, a market-based incentive that rewards efficient providers rather than penalizing patients for finding them.
- It ensures consumers do not pay twice for the same care: once directly, and again through a deductible that never reflected the earlier payment.

Without this reform, Florida consumers with high-deductible coverage are left to choose between short-term affordability and long-term financial protection: a choice the data above suggests many are already resolving by delaying or skipping care altogether. The CREDIT Act removes that trade-off for the specific, narrow set of cases where a member has already paid for medically necessary, covered care.

VI. Legislative Precedent: Texas and Tennessee

Texas

In 2023, the 88th Texas Legislature enacted House Bill 2002, which allowed any out-of-pocket cash payment made by an individual for medically necessary services and supplies to be credited toward that individual's deductible and annual maximum out-of-pocket expenses (H.B. 2002, 2023). Legislative analysis of the follow-up bill, House Bill 1687, explains that before H.B. 2002's passage, patients had no incentive to seek out lower cash prices because those payments did not count toward cost-sharing limits, even when the cash price was lower than the plan's negotiated rate (Texas House of Representatives, 2025). H.B. 1687 subsequently extended the same crediting requirement to certain government employee health plans that the original act did not reach.

Tennessee

Tennessee's reform builds on its 2019 Right to Shop Act, which already required carriers to help enrollees compare prices for healthcare services (Tennessee Right to Shop Act, 2019). Senate Bill 1392 and its companion House Bill 1213 (2023–2024) amended that Act to let enrollees pay out of pocket to an out-of-network provider and negotiate a lower price directly; once the insurer verifies that the negotiated amount is below the plan's average allowed amount for the service, that payment counts toward the enrollee's deductible, coinsurance, copayment, or other cost-

sharing amount (H.B. 1213, 2024; S.B. 1392, 2024; The Source on Healthcare Price & Competition, n.d.-a, n.d.-b).

Commentary on both reforms has noted that they ask nothing extra of insurers financially while giving providers the benefit of prompt, direct payment rather than a drawn-out insurance claims cycle, and that patients gain the freedom to use any provider offering better value without being financially disadvantaged for doing so (Pope, 2023). The CREDIT Act adapts this same basic mechanism to Florida's insurance code, adding a defined 30-day insurer response window and routing disputes through Florida's existing appeal framework rather than creating a new one.

What Consumers Must Submit Under the Texas and Tennessee Models

Neither state leaves the crediting process undocumented, but the two take different approaches to defining what a consumer must provide. Texas's statute does not itself list required documents; instead, it requires each insurer to establish its own procedure for claiming the credit and to identify, on its own website, the documentation it will accept to support a claim (Tex. Ins. Code § 1301.140, 2023). In practice, insurers administering the Texas credit have generally required a paid, itemized receipt or invoice identifying the provider, the date and description of the service, and the amount the patient paid.

Tennessee's statute is more prescriptive, requiring the enrollee to send documentation directly to the carrier before a negotiated out-of-network payment is verified and credited (H.B. 1213, 2024; S.B. 1392, 2024). Comparable direct-pay accumulator-credit legislation built on this same model, such as a 2025 Oklahoma bill expressly modeled on the Texas and Tennessee approach, spells out the categories of documentation typically required in more detail: (1) identification of the health care service received and the treating provider's name and contact information; (2) any required referral or physician's order, together with the final bill or statement for the service; (3) proof of the negotiated price the enrollee actually paid out of pocket; and (4) confirmation that the provider is not separately billing the carrier for the same service (H.B. 1853, 2025; S.B. 515, 2025). The CREDIT Act adopts this same limited documentation approach: an itemized receipt or comparable proof of service and payment, so that consumers face no paperwork burden beyond what a routine medical payment already generates.

VII. Complementing Existing Transparency and Consumer-Protection Tools

The CREDIT Act is designed to work alongside, not around, federal and state tools already in place. Federal hospital and insurer price-transparency rules already require the disclosure of cash prices and negotiated rates; the CREDIT Act gives that disclosed information practical financial consequence by letting patients act on it without losing deductible progress.

The Act's balance-billing prohibition is narrower than, and complements, two protections already on the books. The federal No Surprises Act (2020; see also Hospital Price Transparency, 2019; Transparency in Coverage, 2020) addresses unexpected out-of-network bills in emergency and certain non-emergency settings, and Florida's own balance-billing law goes further for state-regulated plans: it bars out-of-network providers from billing PPO enrollees for any amount beyond in-network cost-sharing for emergency services, and for non-emergency services

rendered by an out-of-network provider at an in-network facility when the enrollee had no opportunity to choose a participating provider, with a parallel protection for HMO enrollees (Baptist Health South Florida, n.d.; Fla. Stat. § 627.64194, 2025; Fla. Stat. § 641.3154, 2025). The CREDIT Act targets a different, everyday scenario that neither law reaches: a provider or intermediary attempting to collect a higher amount after a patient and provider have already agreed on and paid a lower negotiated cash price outside the emergency and facility-based contexts those laws cover. Together, the three protections narrow the range of situations in which a Florida patient can be charged more than what was actually negotiated or agreed upon.

Because the Act does not create a new benefit or change any plan's cost-sharing design, it also requires no substantive change to Florida's existing rate-filing and plan-approval review conducted by the Office of Insurance Regulation (OIR): insurers simply administer an additional crediting rule within systems they already operate.

VIII. Implementation and Administration

- Scope: Applies only to fully insured health plans regulated by the State of Florida; as with the Texas and Tennessee models, it does not reach self-funded employer plans governed by federal ERISA preemption.
- Documentation: Limited to an itemized receipt or comparable proof of the service and amount paid, so there is no new consumer paperwork burden beyond what is already generated at the point of payment.
- Insurer timeline: Insurers must approve or deny a crediting request within 30 days of submission, with a written explanation accompanying any denial.
- Appeals: Denials are handled through Florida's existing insurance appeal and external-review protections administered by OIR and the Department of Financial Services. No new appellate body is created.
- Provider protection: Network contracts and insurer policies may not penalize a provider for offering a legitimate, disclosed direct-pay discount.

Because the Act imposes no new payment obligation and no new benefit mandate, its administrative footprint is limited to bookkeeping and verification: the same limited scope that has allowed the Texas and Tennessee versions of this reform to be implemented without significant disruption to insurer operations.

IX. Addressing Anticipated Concerns

Verification burden. Because the crediting requirement is triggered only by a documented payment at or below an already-known benchmark price, insurers can verify requests using data they already maintain for claims adjudication. The 30-day response window mirrors standard claims-processing timelines.

Risk of misuse. The benchmark-price condition, where crediting is available only when the amount paid is at or below what the insurer would otherwise have paid, limits the Act to cases

that are, by definition, cost-neutral or cost-saving for the insurer, reducing any incentive to submit inflated claims for credit.

Coverage gap for self-funded plans. Because Florida's regulatory authority extends only to fully insured plans, employees in self-funded plans would not be covered by this state-level reform. This is the same limitation present in the Texas and Tennessee statutes and reflects a boundary set by federal law rather than a defect in the Act's design.

X. Conclusion

The CREDIT Act asks Florida insurers to do one thing: recognize money their own members have already spent on medically necessary, covered care. It creates no new benefit, imposes no new payment obligation, and changes no plan's underlying cost-sharing structure. What it does change is the incentive structure facing a Florida consumer who finds a lower, legitimate price for covered care, therefore replacing a rule that currently penalizes that choice with one that rewards it.

Texas and Tennessee have already implemented this model, and the data on cost-driven care avoidance and the frequent gap between cash and negotiated prices make the underlying problem a documented, current one rather than a hypothetical. The CREDIT Act offers Florida a low-cost, high-fairness reform that builds on the state's existing leadership in patient protection and price transparency, and it is offered here for consideration and adoption.

References

Association of Clinical Documentation Integrity Specialists. (2023, June 29). News: Negotiated and cash prices lower at physician-owned hospitals, new study shows. *CDI Strategies, 17*(26). https://www.acdis.org/articles/news-negotiated-and-cash-prices-lower-physician-owned-hospitals-new-study-shows

Baptist Health South Florida. (n.d.). *Your rights and protections against surprise medical bills*. https://baptisthealth.net/patient-resources/billing-and-financial-assistance/your-rights-and-protections-against-surprise-medical-bills

Cole, K. (2022, November 21). *Study: Hospitals often charge more to insured than uninsured for same services*. Trinity College. https://www.trincoll.edu/news/hospitals-often-charge-more-to-insured-than-uninsured-for-same-services/

Fla. Stat. § 627.64194 (2025).

Fla. Stat. § 641.3154 (2025).

H.B. 1213, 113th Gen. Assemb. (Tenn. 2024).

H.B. 1853, 60th Leg., 1st Sess. (Okla. 2025).

H.B. 2002, 88th Leg., Reg. Sess. (Tex. 2023).

Hospital Price Transparency, 45 C.F.R. pt. 180 (2019).

Jiang, J. X., Makary, M. A., & Bai, G. (2021). Comparison of US hospital cash prices and commercial negotiated prices for 70 services. *JAMA Network Open, 4*(12), Article e2140526. https://doi.org/10.1001/jamanetworkopen.2021.40526

KFF. (n.d.). *How does cost affect access to care?* Peterson-KFF Health System Tracker. https://www.kff.org/96f8192

KFF. (2024, October 9). *2024 employer health benefits survey*. https://www.kff.org/report/2024-employer-health-benefits-survey/

Know the Lowest Price Act of 2018, Pub. L. No. 115-262, 132 Stat. 3667 (2018).

Kodjak, A. (2018, April 9). *Bill of the month: A tale of 2 CT scanners — one richer, one poorer*. NPR; Kaiser Health News. https://www.upr.org/2018-04-09/bill-of-the-month-a-tale-of-2-ct-scanners-one-richer-one-poorer

No Surprises Act, 42 U.S.C. § 300gg-111 et seq. (2020).

Patient Right to Know Drug Prices Act, Pub. L. No. 115-263, 132 Stat. 3672 (2018).

Pope, C. (2023, November 8). *New TN & TX price transparency laws prevent patients from getting ripped off*. Forbes. https://www.forbes.com/sites/theapothecary/2023/11/08/new-tn--tx-price-transparency-laws-prevent-patients-from-getting-ripped-off/

Rodriguez, S. (2021, December 28). *Hospital prices for most services less than payer-negotiated rates*. RevCycleIntelligence. https://www.techtarget.com/revcyclemanagement/news/366601054/Hospital-Prices-for-Most-Services-Less-than-Payer-Negotiated-Rates

S.B. 515, 60th Leg., 1st Sess. (Okla. 2025). https://oklegislature.gov/cf_pdf/2025-26%20ENGR/SB/SB515%20ENGR.PDF

S.B. 1392, 113th Gen. Assemb. (Tenn. 2024).

The Source on Healthcare Price & Competition. (n.d.-a). *Tennessee S.B. 1392 / H.B. 1213* [Database record]. https://sourceonhealthcare.org/?p=61311

The Source on Healthcare Price & Competition. (n.d.-b). *Tennessee S.B. 1392 / H.B. 1213* [Database record]. https://sourceonhealthcare.org/?p=61318

Stempniak, M. (2021, December 22). *Cash cost for imaging often lower than payer-negotiated price, with widespread variation across hospitals*. Radiology Business. https://radiologybusiness.com/topics/healthcare-policy/cash-imaging-payer-negotiated-price-jama-hopkins

Tennessee Right to Shop Act, Tenn. Code Ann. § 56-7-3501 et seq. (2019).

Tex. Ins. Code § 1301.140 (2023). https://codes.findlaw.com/tx/insurance-code/ins-sect-1301-140/

Texas House of Representatives. (2025). *Bill analysis: H.B. 1687, 89th Legislature, Regular Session*. Texas Legislature Online. https://capitol.texas.gov/tlodocs/89R/analysis/html/HB01687H.htm

Transparency in Coverage, 26 C.F.R. § 54.9815-2715A3 (2020).

Wang, Y., Plummer, E., Wang, Y., Cram, P., & Bai, G. (2023). Comparison of commercial negotiated price and cash price between physician-owned hospitals and other hospitals in the same hospital referral region. *JAMA Network Open, 6*(6), Article e2319980. https://doi.org/10.1001/jamanetworkopen.2023.19980

STATE OF FLORIDA

PUBLIC POLICY PROPOSAL

Extending Florida's Balance-Billing Protections to Self-Funded and Level-Funded Employer Health Plans: A Voluntary Opt-In Framework

A proposal for relief for Florida Employers from the Cost Volatility of the Federal No Surprises Act Independent Dispute Resolution Process

Proposed by Carol Taylor, JM-Compliance, REBC
September 2026

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I. EXECUTIVE SUMMARY

Florida employers that sponsor self-funded and level-funded group health plans, arrangements now covering a majority of the state's employer-sponsored workforce, are categorically excluded from the balance-billing protections the Florida Legislature enacted in 2016 through CS/CS/HB 221, codified at sections 627.64194, 641.513(5), and 395.1041, Florida Statutes. Because these employer plans are self-insured arrangements governed by the federal Employee Retirement Income Security Act of 1974 (ERISA), Florida's state insurance law cannot reach them; the only backstop available to their participants and plan sponsors is the federal No Surprises Act (NSA) and its Independent Dispute Resolution (IDR) process.

That federal backstop has become exactly the kind of unpredictable, high-cost system the 2016 Florida law was designed to avoid. According to the most recent *Health Affairs Forefront* analysis (Hoadley & Watts, August 2026), the federal IDR process generated an estimated $22.4 billion in cumulative costs from 2022 through 2025. This is more than four times early federal projections, with $16.6 billion incurred in 2025 alone, a 3.5-fold jump over 2024. Providers now win roughly 85 to 88 percent of disputes, with median awards reaching 445 percent of the in-network benchmark rate (the qualifying payment amount, or QPA), and a small number of well-capitalized, often private-equity-backed billing organizations, chiefly Radiology Partners, TeamHealth, HaloMD, and SCP Health. These four providers account for more than half of all disputes filed nationally, with individual win rates as high as 96 percent and awards reaching many multiples of typical in-network reimbursement.

These costs are already reaching Florida employers through stop-loss premium increases and claims experience on level-funded and self-funded plans, with no ability to redirect qualifying claims to Florida's own, more moderate, statutory framework. Six other states, including Georgia, Maine, Nevada, New Jersey, Virginia, and Washington, have already addressed this gap by enacting laws that let self-funded employer plans voluntarily elect to be governed by the state's balance-billing protections in place of the federal IDR track. This proposal recommends that Florida adopt a comparable voluntary opt-in mechanism, administered by the Office of Insurance Regulation (OIR) using a simple election and attestation process modeled closely on Washington's, so that Florida employers who choose self-funded or level-funded coverage are not forced into the nation's most expensive and provider-favorable dispute resolution system by default.

II. PURPOSE

This proposal urges the Florida Legislature to enact, and the Office of Insurance Regulation to implement, enabling legislation that permits self-funded and level-funded employer group health plans to voluntarily elect coverage under the balance-billing and reimbursement standards Florida created

in 2016, as an alternative to mandatory reliance on the federal No Surprises Act's Independent Dispute Resolution process.

III. BACKGROUND: FLORIDA'S 2016 BALANCE-BILLING LAW

In 2016, the Florida Legislature passed CS/CS/HB 221, the state's first comprehensive balance-billing law, effective July 1, 2016. The law was a direct response to consumer complaints about surprise bills from out-of-network emergency physicians, anesthesiologists, radiologists, and pathologists who treated patients at in-network facilities without the patient's meaningful choice of provider.

The statute's core protections, still in effect today, include:

- **§ 627.64194, Fla. Stat.** requires insurers offering PPO and EPO coverage to hold members harmless for covered emergency services and for certain non-emergency services rendered by nonparticipating providers at in-network facilities where the patient had no meaningful choice of provider; the insurer becomes solely liable for payment beyond the patient's normal cost-sharing.
- **§ 641.513(5), Fla. Stat.** establishes the reimbursement standard HMOs must pay nonparticipating providers for emergency services, incorporated by reference into § 627.64194's PPO/EPO framework so both markets share a common payment benchmark.
- **§ 395.1041, Fla. Stat.** governs hospital emergency services access and disclosure obligations that intersect with the balance-billing framework.
- **§ 408.7057, Fla. Stat.** provides a voluntary claim dispute resolution program that insurers and providers may use in lieu of litigation to resolve reimbursement disputes arising under these provisions.

Together, these sections prohibit an out-of-network provider from collecting, or attempting to collect, any amount from the patient beyond in-network cost-sharing in covered circumstances, and they establish a defined, moderate payment benchmark and dispute pathway between the provider and the insurer.

The ERISA Gap

Because §§ 627.64194 and 641.513 are insurance statutes, they apply only to fully insured individual and group health insurance policies and HMO contracts "delivered or issued for delivery" in Florida by a licensed insurer. Under ERISA's broad preemption of state laws that "relate to" self-insured employee benefit plans, Florida cannot compel a self-funded employer plan, one in which the employer, not an insurer, bears the financial risk for claims, to follow the state's balance-billing rules. Level-funded plans are, for this purpose, legally self-funded: the employer pays a fixed monthly amount that combines expected claims, administrative fees, and stop-loss insurance premium, with any surplus or deficit reconciled at year-end, but the arrangement remains an ERISA self-insured plan wrapped in stop-loss coverage. Both categories are therefore outside the reach of Florida's 2016 law.

This is not a small carve-out. According to KFF's 2025 Employer Health Benefits Survey, 67 percent of covered workers nationally are enrolled in self-funded plans, including 80 percent of workers at large firms and, notably, 27 percent of workers at firms with 10 to 199 employees. This smaller employer segment is most likely to be moving toward level-funded arrangements to gain underwriting flexibility and the possibility of a year-end refund. In other words, the very employers most sensitive to premium cost, small and mid-size Florida businesses, are increasingly choosing coverage that Florida's own consumer-protection framework cannot reach.

IV. THE FEDERAL BACKDROP: THE NO SURPRISES ACT'S IDR PROCESS HAS BECOME COSTLY AND DYSFUNCTIONAL

The federal No Surprises Act (NSA), effective January 1, 2022, extended balance-billing protections nationwide and created a federal Independent Dispute Resolution (IDR) process for out-of-network payment disputes that are not otherwise governed by an applicable state law. For self-funded and level-funded plans which, as described above, fall outside Florida's state law, the federal IDR is not a backstop; it is the only game in town. And it has proven far more costly and far more favorable to a concentrated set of large provider organizations than Congress anticipated.

Costs Have Exceeded Projections by Roughly Four to One

The most recent and authoritative accounting comes from *Health Affairs Forefront* (Jack Hoadley and Kennah Watts, "Spending On IDR Process Pushes No Surprises Act Costs To More Than $22.4 Billion Over Just Four Years," Aug. 26, 2026). The authors find that the IDR process generated an estimated $22.4 billion in total costs from 2022 through 2025, composed of $15.6 billion in payment awards exceeding in-network rates, $4.2 billion in plans' internal administrative costs, and $2.7 billion in IDR entity and administrative fees. Original congressional and CBO-adjacent estimates anticipated total IDR-related costs closer to $5 billion and a net *reduction* in premiums; the actual trajectory has moved sharply in the opposite direction.

The growth curve is steep: 2025 alone accounted for $16.6 billion, nearly 3.5 times the 2024 total, as dispute volume rose 77 percent year-over-year to 2.6 million new disputes and the size of payment awards surged 264 percent. Separately, the Georgetown University Center on Health Insurance Reforms (CHIR) reports that cumulative federal IDR filings reached 4.8 million by year-end 2025, against an original federal projection of roughly 17,000 disputes *per year*; administrative fees alone totaled $844 million in just the first half of 2025, nearly matching the entire 2022–2024 total.

Providers Win Nearly Nine of Every Ten Disputes, at Multiples of In-Network Rates

Providers initiate the overwhelming majority of disputes: 99.9 percent, per CHIR, and win them at rates far above what a balanced arbitration process would predict: roughly 85 to 88 percent of disputes decided in 2025. When providers prevail, the *Health Affairs* analysis finds a median award of 445 percent of the qualifying payment amount (QPA), Congress's chosen benchmark for a reasonable in-

network rate, with the 90th percentile of awards reaching 1,771 percent of QPA. When plans prevail instead, awards average only about 105 percent of QPA. This underscores how lopsided outcomes are once a dispute reaches arbitration. Emergency medicine and radiology together account for 70 percent of dispute volume, but the highest-dollar outcomes are concentrated in neurology, general surgery, and plastic/reconstructive procedures, where median awards have reached as much as 24 to 32 times the QPA.

A Small Number of Organizations Are Driving, and Arguably Gaming, the System

Both the *Health Affairs* analysis and Georgetown CHIR's review of 2025 data identify the same small set of entities responsible for the majority of disputes nationally. The table below summarizes the pattern:

Entity	Approx. Share of Federal IDR Disputes (2025)	Provider Win Rate	Typical Award vs. In-Network Rate (QPA)
Radiology Partners (private-equity-backed)	~30%	~96%	582%–594% of QPA
TeamHealth (private-equity-backed)	~16–20%	~95%	~277% of QPA
HaloMD (billing/arbitration middleman filing on providers' behalf)	~17–27% (up from ~1% in 2023)	~90%	835%–920% of QPA
SCP Health	Substantial, combined with Radiology Partners among top filers	High	~370% of QPA

Sources: Hoadley & Watts, Health Affairs Forefront (Aug. 26, 2026); Georgetown University CHIR, "The No Surprises Act IDR Process: An Early Look at 2025 Data" (2025); Healthcare Dive reporting on CMS IDR disclosures.

These four organizations, with three of them backed by private equity and the fourth (HaloMD) a billing-arbitration "middleman" that files disputes on providers' behalf for a contingency fee, together account for more than half of all federal IDR disputes. HaloMD's share of disputes rose from roughly 1 percent in 2023 to as much as 27 percent in 2025, a trajectory that has drawn direct allegations of gaming the system. Beginning in December 2024, health plans filed at least nine lawsuits, including RICO claims, alleging that these organizations "weaponized" the IDR process by flooding it with claims, including a large share that CHIR and plan litigants say are later found ineligible. This has been observed by many as an effort to overwhelm arbitration capacity and trigger default awards when plans cannot respond in time, and by strategically routing disputes to the specific IDR entities with the most provider-favorable track records. CMS data cited by CHIR show, for example, that one IDR entity ruled for providers in 99.4 percent of cases while another ruled for providers only 54.5 percent

of the time, a spread that sophisticated, high-volume filers are well positioned to exploit and less sophisticated, lower-volume filers are not.

These Costs Are Already Reaching Florida Employers Through Premiums

The premium pass-through is no longer theoretical. The *Health Affairs* article reports that New York's state employee health plan attributed a nearly 10 percent premium increase in 2025 to IDR costs exceeding $200 million, and that UnitedHealthcare has reported IDR "driving a 2 to 6 percent incremental increase in total premium expenses" for its commercial book of business. Florida employers with level-funded and self-funded plans experience these same cost pressures indirectly, through stop-loss premium renewals and claims experience, without any ability to instead route a qualifying dispute through Florida's own statutory framework, which produces far more moderate outcomes.

That the alternative can work is demonstrated by Virginia's experience operating its own state-level dispute process for opted-in plans: CHIR reports Virginia handled just 252 disputes over twelve months (compared to roughly 34,000 disputes handled federally for a comparable population over the same period), with providers winning only about 45 percent of disputes, versus 85 percent under the federal process. A state-based framework with defined, moderate benchmarks and fewer opportunities for high-volume, contingency-fee filing produces a smaller, more balanced dispute caseload.

V. PRECEDENT: SIX STATES ALREADY ALLOW SELF-FUNDED PLANS TO OPT IN

Florida would not be breaking new legal grounds. Six states including: Georgia, Maine, Nevada, New Jersey, Virginia, and Washington, have already enacted laws permitting self-insured employer plans to voluntarily elect coverage under the state's own balance-billing protections, an approach federal regulators recognize because the plan sponsor itself makes the election; the state is not attempting to regulate the plan without its consent, which avoids the ERISA preemption problem that would arise from a mandatory state requirement.

State	Mechanism for Self-Funded Opt-In	Notes
Georgia	Statutory election allowing self-insured plans to opt into the state surprise/balance-billing law.	Plan sponsor elects coverage under state consumer protections.
Maine	Self-insured plans may elect to be subject to Maine's balance-billing statute.	Voluntary, plan-year election.
Nevada	Self-funded plans may opt into Nevada's balance-billing and payment-standard provisions.	Administered through the state insurance division.
New Jersey	Self-funded plans may opt into the New Jersey Out-of-Network Consumer Protection,	One of the earliest opt-in models (2018).

State	Mechanism for Self-Funded Opt-In	Notes
	Transparency, Cost Containment and Accountability Act.	
Virginia	Self-funded plans may elect Virginia's balance-billing protections and state arbitration process.	State IDR data show materially lower provider win rates (~45%) than the federal process (~85%).
Washington	Self-funded plans file a written election (with 15 days' advance notice) with the Office of the Insurance Commissioner under the Balance Billing Protection Act (RCW 48.49).	Election runs a full plan year, renews automatically absent 30 days' notice of withdrawal; TPAs must also comply.

Source: CMS/CCIIO Federal Independent Dispute Resolution state-law applicability materials; state insurance department guidance (Washington Office of the Insurance Commissioner; Virginia State Corporation Commission Bureau of Insurance).

Washington's model is the most fully documented and the most administratively simple: a self-funded plan (or its TPA) files a written election with the Office of the Insurance Commissioner at least 15 days before the plan year in which it wants coverage to begin, the election runs for a full plan year and renews automatically unless the plan gives 30 days' notice of withdrawal, and TPAs administering the plan must comply with the same standards as fully insured carriers once the election is in effect.

VI. THE PROPOSAL

Consistent with the six-state precedent above, this proposal recommends that the Florida Legislature enact enabling legislation. For example, a new subsection to § 627.64194, Fla. Stat., with conforming cross-references in § 641.513, to establish a voluntary opt-in mechanism with the following elements:

1. **Voluntary election.** Any self-funded or level-funded group health plan sponsored by a Florida employer (including a plan administered through a third-party administrator and reinsured through stop-loss coverage) may file a written election with the Office of Insurance Regulation to be bound by the balance-billing and reimbursement standards of §§ 627.64194, 641.513(5), and 395.1041, and to direct qualifying payment disputes to Florida's voluntary provider dispute resolution process under § 408.7057 in lieu of the federal IDR process for those claims.
2. **Simple attestation process.** OIR should adopt an election and attestation form modeled closely on Washington's, requiring notice at least 15 days before the start of the plan year for which the election applies.
3. **Full plan-year term with automatic renewal.** An election remains in effect for a full plan year and renews automatically unless the plan provides 30 days' advance notice of withdrawal, giving providers, TPAs, and OIR administrative certainty.
4. **Notice to stakeholders.** Electing plans must notify enrollees, network providers, and their TPA of the election, consistent with existing disclosure duties under §§ 627.64194 and 641.513.

5. **Legislative oversight.** OIR should report to the Legislature every two years on election uptake, claims experience, and dispute-resolution outcomes for electing plans, mirroring the type of transparency Washington and Colorado already provide for their own balance-billing programs.
6. **Effective date and rulemaking window.** The Legislature should direct OIR to adopt implementing rules within 180 days of enactment, with elections first available for plan years beginning on or after the following January 1, giving TPAs and stop-loss carriers time to update systems and disclosures.

VII. ANTICIPATED BENEFITS FOR FLORIDA EMPLOYERS AND ENROLLEES

- **Predictable, moderate reimbursement.** Florida's in-network-based benchmark under § 641.513(5) is a fraction of the 445–1,771 percent of QPA seen in federal IDR awards, reducing the volatility that flows through to stop-loss premiums and claims experience.
- **Reduced exposure to a documented gaming pattern.** Electing out of federal IDR for qualifying claims reduces a plan's exposure to the small set of high-volume filers being Radiology Partners, TeamHealth, HaloMD, and SCP Health, that account for more than half of federal disputes and that health plans have separately accused of flooding the system with ineligible claims to trigger default awards.
- **No mandate, no ERISA conflict.** Because the mechanism is a voluntary election made by the plan sponsor itself, it does not raise the ERISA preemption problems a mandatory state requirement would, consistent with the experience of six other states.
- **Particularly valuable for small and mid-size employers.** Small Florida businesses are the segment most likely to be moving into level-funded arrangements for cash-flow and underwriting flexibility; they are also the least equipped to absorb stop-loss volatility driven by a small number of sophisticated national filers.
- **Minimal new state infrastructure.** The proposal reuses OIR's existing regulatory role and the existing § 408.7057 dispute process rather than creating a new agency function.

VIII. FISCAL AND POLITICAL FEASIBILITY

Fiscal Impact

The fiscal footprint is limited to OIR's administrative cost of processing elections, maintaining a registry of electing plans, and preparing the biennial legislative report, a function comparable in scale to Washington's existing opt-in program. No new state expenditure program, subsidy, or claims fund is required, because the mechanism shifts qualifying disputes from the federal IDR track to Florida's existing voluntary dispute resolution process.

Political Feasibility

The proposal is designed to draw support from both business and consumer constituencies that do not typically align: it reduces cost exposure for Florida employers (a natural fit for the Florida Chamber of Commerce, NFIB, NABIP-FL, NAIFA, and other insurance broker associations) while extending without weakening, the consumer balance-billing protections that Florida enacted with strong support from groups such as Consumer Reports' advocacy arm in 2016. Likely opposition would come primarily from the private-equity-backed physician staffing and billing organizations identified above, which currently benefit from the federal process's provider-favorable outcomes, and potentially from specialty physician groups broadly concerned about any reduction in out-of-network leverage. The six-state precedent, spanning politically diverse legislatures from Georgia and Nevada to New Jersey and Washington, suggests the underlying mechanism is not itself a partisan flashpoint.

IX. ANTICIPATED OBJECTIONS AND RESPONSES

"ERISA preempts any state role here."

This proposal does not attempt to regulate self-funded plans directly; it creates a purely voluntary mechanism that a plan sponsor may or may not use. Because the plan itself elects to be bound, rather than being compelled by the state, this approach has already been implemented without a successful ERISA preemption challenge in Georgia, Maine, Nevada, New Jersey, Virginia, and Washington.

"This will simply cut provider payments."

Florida's 2016 benchmark was developed with stakeholder input from providers, hospitals, and insurers, and it is not punitive — it ties reimbursement to in-network rates rather than eliminating fair payment. Virginia's experience shows that a state-based process can produce a smaller, more balanced caseload (45 percent provider win rate) without eliminating providers' ability to prevail on the merits of a given claim.

"Adding a second track will confuse TPAs and providers."

Washington's program demonstrates that a simple, time-bound election and attestation, which is filed once per plan year and automatically renews annually, is administrable at scale by TPAs and stop-loss carriers without new technology builds. This proposal recommends OIR adopt substantially similar procedures for that reason.

X. RECOMMENDATION AND NEXT STEPS

The Legislature should direct the introduction of enabling legislation in the 2027 Regular Session (or as a committee bill developed during the 2026 interim by the House Health & Human Services Committee and Senate Banking and Insurance Committee) to: (1) create a voluntary opt-in mechanism for self-funded and level-funded employer plans under §§ 627.64194, 641.513(5), and 395.1041,

Florida Statutes; (2) direct OIR to adopt an election and reporting process modeled on Washington's; and (3) require a biennial report to the Legislature on uptake and outcomes. Given the documented, worsening cost trajectory of the federal IDR process with $22.4 billion in cumulative costs, $16.6 billion in 2025 alone, and more than half of all disputes driven by four large filers, the cost of inaction to Florida's self-funded and level-funded employers is rising each renewal cycle. A voluntary opt-in framework offers Florida employers a lower-cost, more predictable alternative without displacing any employer's right to remain solely under federal law if that plan sponsor prefers it.

XI. CONCLUSION

Florida led on balance-billing protection in 2016. A decade later, the federal alternative created for the employer plans that framework could not reach has become the very thing Florida's law was designed to prevent: high, unpredictable, provider-favorable awards driven disproportionately by a handful of sophisticated national filers. Six states have already built the fix. Florida is well positioned to become the seventh, giving its employers, particularly its small and mid-size businesses choosing level-funded coverage, a voluntary, lower-cost path back to the moderate, predictable framework the state already built.

References

Hoadley, Jack, and Kennah Watts. "Spending On IDR Process Pushes No Surprises Act Costs To More Than $22.4 Billion Over Just Four Years." Health Affairs Forefront, Aug. 26, 2026. https://www.healthaffairs.org/content/forefront/spending-idr-process-pushes-no-surprises-act-costs-more-than-22-4-billion-over-just

Georgetown University Center on Health Insurance Reforms (CHIR). "The No Surprises Act IDR Process: An Early Look At 2025 Data." 2025. https://chir.georgetown.edu/the-no-surprises-act-idr-process-an-early-look-at-2025-data/

Healthcare Dive. "No Surprises disputes continue to swell, CMS finds" and "No Surprises dispute resolution has generated $22B in extra costs, research finds." 2025–2026. https://www.healthcaredive.com/news/no-surprises-idr-created-22-billion-costs-georgetown-surprise-billing/828817/

Kaiser Family Foundation. 2025 Employer Health Benefits Survey, Summary of Findings. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/

Washington State Office of the Insurance Commissioner. "Self-funded group health plans and surprise billing" (Balance Billing Protection Act, RCW 48.49). https://www.insurance.wa.gov/insurers-regulated-entities/laws-and-rules-insurers-and-regulated-entities/protections-surprise-medical-billing/self-funded-group-health-plans-and-surprise-billing

Centers for Medicare & Medicaid Services (CMS). Federal Independent Dispute Resolution state-law applicability materials. https://www.google.com/goto?url=CAESggEB6zswFfEnA5cVJxvF6rhxHnNoiraSnwkbfYUFo-Y8GcJ7LybKhV-DQptqM8sC9o6pRTHYEHG1DSD7YIDq7Tm0LagDcG8QwiN5c1gixpO3L2GB_yKlnvADIcOctaBT1iMJtjgCaypCK9-h3QmFyFKHB6wDY7DDBKVSUoy8SID5hsGK

Florida Senate. CS/CS/HB 221 (2016) bill analyses; Florida Statutes §§ 627.64194, 641.513, 395.1041, 408.7057 (2016, as amended).

Becker's Hospital Review. "Florida governor signs law limiting balance billing: 5 things to know." 2016. https://www.beckershospitalreview.com/finance/florida-governor-signs-law-limiting-balance-billing-5-things-to-know/

STATE OF FLORIDA

PUBLIC POLICY PROPOSAL

Closing the Ground Ambulance Gap: Extending Florida's Balance-Billing Protections to Emergency and Non-Emergency Ground Ambulance Transport

A proposal to amend the Florida Insurance Code (chs. 627 & 641, F.S.) to prohibit balance billing by nonparticipating ground ambulance service providers and to establish a statutory reimbursement standard

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September 2026

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I. Executive Summary

Florida enacted comprehensive balance-billing protections for emergency medical care in 2016. Under sections 627.64194 and 641.513, Florida Statutes, a patient who receives covered emergency care from a hospital, physician, or other nonparticipating provider cannot be billed for more than in-network cost-sharing, no matter which insurer or which provider treats them (Fla. Stat. § 627.64194, 2016). That protection has one significant hole: it does not reach the ground ambulance that carries the patient to the hospital in the first place.

Congress created a parallel federal protection in the No Surprises Act of 2022, but Congress excluded ground ambulance transport from that law as well, even as it protected air ambulance transport, which the Florida Statutes also provide relief. The federal advisory committee that Congress convened to study the problem, the Ground Ambulance and Patient Billing (GAPB) Advisory Committee, spent 2023 documenting the gap and, in August 2024, recommended that Congress or the states act (Advisory Committee on Ground Ambulance and Patient Billing, 2024). Congress has not acted. As of this writing, neither federal law nor Florida law protects a Florida patient from a balance bill for ground ambulance transport.

The consequences are measurable. National data show that 51 percent of emergency ground ambulance transports and 39 percent of non-emergency ground ambulance transports for privately insured patients generate an out-of-network charge, by a wide margin the highest out-of-network rate of any category of emergency care (Amin et al., 2021). The median resulting balance bill is roughly $450, and bills exceeding $1,000 are common (Kelmar, 2023). Patients cannot shop for an ambulance in an emergency, and in most cases they have no ability to select an in-network provider even when one exists.

Florida has already tried, twice, to close this gap. CS/HB 639 and its Senate companion, SB 568 (2024 Regular Session), passed the House Select Committee on Health Innovation 11–0 and the House Appropriations Committee 27–0 before dying, without a recorded vote against it, in the House Health & Human Services Committee (Florida Senate, 2024a, 2024c). HB 425 and its Senate companion, SB 704 (2025 Regular Session), were reported favorably by the House Health Care Facilities & Systems Subcommittee before both bills died in later committees of reference at the end of the 2025 session (Florida Senate, 2025a, 2025b). In neither year did the proposal face a floor vote, an unfavorable committee report, or a gubernatorial veto, the pattern is one of committee-calendar attrition, not substantive rejection.

At least 22 states have already enacted some version of ground ambulance balance-billing protection, using approaches this proposal surveys in Section VI (Commonwealth Fund, n.d.). This proposal recommends that Florida adopt a comprehensive protection, covering both emergency and non-emergency ground ambulance transport, and both publicly and privately operated providers, built substantially on the language the Legislature has already vetted twice, and refined to address the concerns most likely to have slowed its progress: preserving local rate-setting authority, giving the reimbursement formula a floor generous enough to protect rural and volunteer emergency medical services (EMS), and folding the new protection into Florida's existing balance-billing dispute mechanism rather than creating a new one.

The core recommendation is a new section 627.64196, Florida Statutes, with a conforming amendment to section 641.513, Florida Statutes, that: (1) prohibits ground ambulance service providers from balance billing insured patients for covered emergency or non-emergency transport beyond in-network cost-sharing; (2) sets a default reimbursement standard equal to the lesser of a local government's rate-setting ordinance, 350 percent of the applicable Medicare rate, or the provider's billed charge; (3) requires that patient cost-sharing count toward in-network deductibles and out-of-pocket maximums; and (4) directs the Office of Insurance Regulation and the Department of Financial Services to extend Florida's existing emergency-services billing-dispute process to ground ambulance claims. Because the proposal regulates private insurance contracts rather than state expenditures, the 2024 legislative fiscal analysis of this same approach found no fiscal impact on the Medicaid program or the state group insurance program (Florida Senate, 2024b). This proposal follows recommended practices for structuring and communicating public policy documents (Smith, 2023).

II. Statement of the Problem

A ground ambulance transport is one of the only encounters in the American health care system in which the patient has no opportunity to choose the provider, no opportunity to confirm network status in advance, and because the patient is frequently in medical distress or unconscious, no opportunity to consent to a price. Approximately three million privately insured Americans use ground ambulance transport to an emergency department each year. Because most 911 dispatch systems assign whichever ambulance is closest or on duty, and because comparatively few ground ambulance providers hold contracts with commercial insurers, a large share of those transports are, by definition, delivered out-of-network, regardless of which hospital the patient is ultimately taken to or which physicians treat the patient there.

The scale of the resulting exposure is well documented:

- 51 percent of emergency ground ambulance transports, and 39 percent of non-emergency ground ambulance transports, for privately insured patients generate an out-of-network charge, the highest rate for any provider type studied (Amin et al., 2021).
- Median balance bill: approximately $450, with bills exceeding $1,000 common; in at least seven states, more than two-thirds of emergency ground transports could trigger a balance bill (Kelmar, 2023).
- A 2022 Texas Department of Insurance survey of ground ambulance providers found that 77 percent reported that they "always" or "sometimes" balance bill patients, that 86 percent of the amounts they billed were for out-of-network transports, and that 68 percent cited inadequate insurer reimbursement rates as their reason for remaining out-of-network, evidence that the current system is failing both patients and providers (Georgetown University Center on Health Insurance Reforms, 2022).
- Nationally, insured patients pay an estimated $129 million a year in ground ambulance balance bills, money that, unlike most medical debt, is owed for a service the patient had no ability to decline, negotiate, or select (Kelmar, 2023).

Florida already recognizes this problem for every other category of emergency care. A Florida patient treated by an out-of-network emergency physician, or transported by air ambulance, cannot be balance-billed. The same patient, transported the ten miles to the hospital by a ground ambulance, currently can be. This is not a gap Florida chose deliberately; it is a gap that has persisted because ground ambulance billing sits at the intersection of insurance regulation (chs. 627 and 641, F.S.), EMS licensure and local rate-setting (ch. 401, F.S., and county/municipal ordinances), and federal law that itself does not reach ground transport. Also, as Section V documents, the two bills that would have closed it ran out of legislative calendar before reaching the floor.

III. Background: The Federal Framework and Its Gap

A. The No Surprises Act (2022)

The federal No Surprises Act, effective January 1, 2022, prohibits balance billing for (1) emergency services, including emergency services furnished by out-of-network providers at in-network or out-of-network facilities; (2) certain non-emergency services furnished by out-of-network providers at in-network facilities; and (3) air ambulance transport by out-of-network providers. Congress deliberately extended the law to air ambulances after finding that air ambulance surprise bills were especially severe. Congress did not extend the same protection to ground ambulance transport. This is not because ground ambulance billing was found to be less of a problem, but because the ground ambulance industry's fragmented mix of fire-department, third-service, hospital-based, and private for-profit providers, combined with local government rate-setting authority, made a single federal payment standard politically and technically difficult to negotiate in 2021.

B. The Ground Ambulance and Patient Billing (GAPB) Advisory Committee

Recognizing the gap it had created, Congress directed the Secretaries of Health and Human Services, Labor, and the Treasury to convene the federal Advisory Committee on Ground Ambulance and Patient Billing (GAPB) to study the issue and recommend a fix. The committee held public meetings throughout 2023 and delivered its final report on August 28, 2024 (Advisory Committee on Ground Ambulance and Patient Billing, 2024). The committee unanimously recommended:

1. Prohibiting balance billing for ground ambulance emergency transport (and, in a majority recommendation, non-emergency transport as well) whenever the patient's plan covers ambulance services;
2. Capping patient cost-sharing at a fixed amount, the committee discussed a cap of the lesser of $100 or 10 percent of the applicable payment rate, applied before the deductible;
3. Establishing a payment-rate hierarchy that defers first to state-law rates, second to local government rate-setting, and third to a multiple of the Medicare rate as a federal fallback; and
4. Requiring standardized billing disclosures so patients know their rights and whether a claim has been finally adjudicated before they are asked to pay.

Congress has not acted on the committee's recommendations, and the committee itself is no longer active. The GAPB Committee's own preferred hierarchy, state law first, is the clearest possible federal invitation for Florida to act.

C. Why State Action Cannot Fully Close the Gap and Why It Still Matters

Because the Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of self-funded employer health plans, a Florida balance-billing law, like every other state's, would not reach the substantial share of Floridians (nationally, roughly 60 percent of people with employer coverage are in self-funded plans) whose employer has chosen to self-insure. This limitation applies equally to Florida's existing 2016 balance-billing law for hospital and physician services, and it has not been a reason to leave those patients unprotected. The same logic applies to ground ambulance: a state law that reaches fully-insured PPO, EPO, POS, and HMO plans, the individual market, and state and local government employee plans still protects a substantial majority of insured Floridians, and it is the only protection available until Congress acts on the recommendations its own advisory committee has already delivered. For this reason, another proposal to allow level-funded and self-funded employer based health benefit plans to opt into the state laws has been presented separately.

IV. Current Florida Law

Florida's existing balance-billing framework is built on two statutes enacted in 2016: § 627.64194, Florida Statutes (governing PPO and EPO health insurance policies), and § 641.513, Florida Statutes (governing HMO contracts). Together, these statutes:

- Make the insurer solely liable for payment to a nonparticipating provider of covered emergency services, regardless of whether the patient could choose an in-network provider;
- Prohibit the nonparticipating provider from collecting anything from the insured beyond applicable in-network copayments, coinsurance, and deductibles; and
- Set a statutory reimbursement standard and dispute-resolution process (incorporated by cross-reference between the two statutes) for what the insurer must pay the nonparticipating provider.

As the Legislature's own staff analyses of CS/HB 639 (2024) and HB 425 (2025) confirm, this framework *"prohibits balance billing for emergency facility-based services but explicitly excludes emergency ground transportation,"* (Florida Senate, 2024b), and, in the words of the 2025 analysis, *"[n]either federal laws nor Florida laws address balance billing related to non-participating or out-of-network emergency ground ambulance service providers."* (Florida House of Representatives, 2025). Ground ambulance providers are licensed and regulated separately, under chapter 401, Florida Statutes, and many operate under rates set by county or municipal ordinance, a structure this proposal preserves rather than displaces (see Section IX).

The result is an internal inconsistency in Florida law: a patient's emergency-department physician bill and hospital bill are protected from balance billing, but the ambulance bill that got the patient to the emergency department in the first place is not.

V. Legislative Record in Florida (2024–2025)

Florida has a directly relevant record: two consecutive legislative sessions in which nearly identical ground ambulance balance-billing bills advanced through initial policy committees before stalling (Florida Senate, 2024a, 2024c, 2025a, 2025b).

Session	Bills	Outcome
2024	CS/HB 639 (House); SB 568 (Senate companion)	Favorable, Select Cmte. on Health Innovation, 11–0 (Feb. 2, 2024). Favorable, Appropriations Cmte., 27–0 (Feb. 14, 2024). Died in Health & Human Services Committee, Mar. 8, 2024 — no floor vote.
2025	HB 425 (House); SB 704 (Senate companion)	HB 425: Favorable, Health Care Facilities & Systems Subcmte. (Mar. 27, 2025); died in Commerce Committee, June 16, 2025. SB 704: indefinitely postponed and withdrawn (May 3, 2025); died in Banking & Insurance, June 16, 2025.

Both bills used substantially the same payment standard this proposal recommends: reimbursement at the lesser of a local government rate-setting ordinance, 350 percent of the applicable Medicare rate, or the provider's billed charge, coupled with a ban on balance billing and a cap on patient cost-sharing at in-network levels. The 2024 House staff analysis projected no fiscal impact on the Medicaid program or the state group insurance program, because the bill regulated privately funded insurance contracts rather than state spending (Florida Senate, 2024b).

What the record shows: no committee returned an unfavorable report, no floor vote was ever taken against the concept, and the bill died from calendar attrition in a second or third committee of reference in a 60-day session which is a common fate for bills carrying insurance-industry cost implications that are filed without an early, cross-chamber champion in leadership. This is a favorable record for renewal, and it argues for three specific adjustments discussed in Sections VIII–IX: filing companion bills early with a Senate sponsor positioned on the relevant substantive committee (Banking and Insurance), building an explicit coalition of the Florida Fire Chiefs' Association, county EMS directors, and private ambulance operators before the committee weeks begin, and limiting the number of committees of reference where possible.

VI. Comparative Analysis of State Approaches

At least 22 states have enacted some form of ground ambulance balance-billing protection (Commonwealth Fund, n.d.; Stovicek, 2024). Approaches differ along three dimensions relevant to Florida's design choice: (1) whether the protection covers emergency transport only or also non-emergency (interfacility, dialysis, psychiatric, and similar) transport; (2) whether it covers publicly

operated (fire-department/municipal) providers, privately operated providers, or both; and (3) how the reimbursement rate is set.

State	Scope	Payment Standard
Texas	Emergency only	Lesser of the local subdivision's rate, 325% of Medicare, or the provider's billed charge.
Colorado	Emergency; private ambulances only	Either 325% of Medicare or a negotiated independent-dispute rate.
Maryland	Emergency; public ambulances only	Locally set public-authority rate structure.
New York	Emergency + non-emergency; public + private	"Usual and customary" rate, not to be "excessive or unreasonable."
Washington	Emergency + non-emergency; public + private	Provider must bill the health plan directly; patient cost-sharing is capped at the in-network equivalent and counts toward the deductible/out-of-pocket maximum.
Delaware, Illinois, Indiana, Maine, Mississippi, Oklahoma	Emergency + non-emergency; public + private	State-specific rate benchmarks, generally tied to a percentage of Medicare or a negotiated/arbitrated rate.
Ohio, Vermont, West Virginia, Arkansas, Louisiana, California	Emergency only	State-specific benchmarks; several rely on a percentage-of-Medicare floor.

The clearest lesson from this survey is that states who limit protection to emergency-only or public-only providers leave a predictable population unprotected, patients on non-emergency interfacility transport (frequently dialysis, psychiatric, or post-acute patients, among the least able to advocate for themselves) and patients served by private ambulance companies, which in Florida transport roughly 30 percent of calls. Washington's direct-bill-the-plan model is the strongest patient protection, but standing alone it leaves the reimbursement rate to case-by-case negotiation or litigation, a risk to rural and volunteer EMS agencies with little negotiating leverage (Washington State Office of the Insurance Commissioner, n.d.). Texas's and Colorado's percentage-of-Medicare benchmark gives providers revenue certainty but, at 325%, is close to what Florida's own 2024–2025 bills judged necessary for provider sustainability (350%), evidence that Florida's homegrown figure is a defensible, evidence-based middle point rather than an outlier.

VII. Policy Options Considered

Option A: Status Quo (No State Action)

Retains the current gap. This leaves ground ambulance transport as the sole category of Florida emergency care without a balance-billing protection, contradicts the policy judgment the Legislature already made in 2016 for every other emergency provider, and ignores a problem the Legislature's own staff has now documented twice.

Option B: Emergency-Only Protection (Ohio/Vermont Model)

This option would ban balance billing for emergency ground transport only, modeled on states such as Ohio, Vermont, and Texas. This is simpler to enact and narrower in fiscal exposure to insurers, but it leaves non-emergency interfacility transport patients, often the most medically vulnerable and least able to dispute a bill without protection, and it does not address private, for-profit ambulance operators if paired with a public-only carve-out.

Option C: Comprehensive Protection for Emergency + Non-Emergency, Public + Private (Recommended)

Modeled on Delaware, Illinois, and Washington, this option bans balance billing for both emergency and covered non-emergency ground ambulance transport, regardless of whether the provider is a municipal fire department, a county EMS authority, a hospital-based service, or a private company. It uses a hybrid payment standard, deferring to local government rate ordinances where they exist, and otherwise applying a percentage-of-Medicare benchmark that preserves home rule while guaranteeing a statutory floor. This is the approach recommended in Section VIII.

Option D: Direct-Bill-the-Plan Without a Statutory Rate (Washington Model Alone)

This would ban balance billing and require providers to bill the plan directly, but would not set a statutory reimbursement benchmark, leaving the rate to negotiation or the courts. This maximizes patient protection but creates the greatest risk to rural and volunteer EMS agencies, which have the least ability to negotiate rates with insurers and the least ability to absorb a payment dispute. Not recommended as a stand-alone option, though its patient-facing billing mechanics (direct billing, deductible credit) are incorporated into the recommendation below.

VIII. Recommended Policy

This proposal recommends Option C: comprehensive balance-billing protection for both emergency and non-emergency ground ambulance transport, covering both publicly and privately operated providers, implemented through a new section 627.64196, Florida Statutes, and a conforming amendment to section 641.513, Florida Statutes. The recommendation builds on the bill language the Legislature has already advanced through two committees in two consecutive sessions (Section V), changing it only where it responds to the most plausible source of the bill's stalling and to the comparative lessons of Section VI.

The recommended policy has five components:

1. **Balance-billing prohibition.** A ground ambulance service provider that is not under contract with a patient's insurer may not bill the patient for covered emergency or non-emergency transport in an amount greater than the patient's in-network cost-sharing obligation.
2. **Insurer payment obligation.** The insurer must pay the nonparticipating provider directly, at the lesser of: (a) a rate established by county or municipal ordinance or contract under section 401.34, Florida Statutes, where one applies; (b) 350 percent of the rate the Centers for Medicare & Medicaid Services would pay for the same service in the same locality; or (c) the provider's billed charge.
3. **Cost-sharing protection.** Amounts the patient pays must be treated as in-network for purposes of the patient's deductible and annual out-of-pocket maximum, regardless of the provider's network status.
4. **Dispute resolution.** Payment disputes between insurers and nonparticipating ground ambulance providers are resolved through the same claims-dispute mechanism already established under section 641.513(5), Florida Statutes, for other emergency-services providers, avoiding the need for a new administrative process.
5. **Consumer disclosure.** Ground ambulance providers must give patients (or, where transport is arranged by a facility, the receiving facility) a written notice of billing rights, in the form the Department of Financial Services prescribes, no later than the date of billing.

This design preserves the local rate-setting authority that Florida counties and municipalities currently exercise over ambulance service maintaining the most likely institutional objection to a state mandate, by placing local ordinance rates first in the payment hierarchy, exactly as the 2024 and 2025 bills did. It sets the Medicare-multiple floor at 350 percent, higher than Texas's or Colorado's 325 percent, to address the concern (documented by the 2022 Texas survey, Section II) that inadequate reimbursement is what drives providers out of network in the first place, and to protect the financial viability of rural and volunteer EMS agencies that operate on thin margins. And it folds dispute resolution into Florida's existing emergency-services billing framework rather than creating new administrative machinery, reducing both the fiscal footprint and the regulatory complexity of the proposal. This directly addresses the committee-level cost and complexity concerns that likely contributed to the bill dying in committees of reference in both 2024 and 2025.

IX. Proposed Statutory Language

The following draft is presented in standard Florida bill-drafting format. It is intended as a starting text for legislative counsel drafting, not as final bill language.

Section 1. Section 627.64196, Florida Statutes, is created to read:

627.64196 Reimbursement of nonparticipating ground ambulance service providers; limitations on balance billing.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Ground ambulance service provider" means a person or entity licensed under chapter 401 to provide ground ambulance transportation, regardless of whether the provider is publicly or privately owned or operated.

(b) "Nonparticipating provider" means a ground ambulance service provider that does not have a contract with the insurer establishing payment amounts for services provided to an insured.

(c) "Covered ground ambulance services" means medically necessary emergency and non-emergency ground ambulance transportation services covered under the insured's health insurance policy.

(2) BALANCE BILLING PROHIBITED.—A nonparticipating ground ambulance service provider may not bill or attempt to collect from an insured, directly or indirectly, an amount for covered ground ambulance services in excess of the applicable copayment, coinsurance, or deductible that would apply if the services had been rendered by a participating provider.

(3) INSURER PAYMENT OBLIGATION.—An insurer shall reimburse a nonparticipating ground ambulance service provider for covered ground ambulance services in an amount equal to the lesser of:

(a) The rate established for such services by county or municipal ordinance, franchise agreement, or contract under s. 401.34, applicable to the jurisdiction in which the services originated;

(b) Three hundred fifty percent of the amount that would be paid under Medicare Part B for the same services in the same locality; or

(c) The provider's billed charge.

(4) COST-SHARING; CREDIT TOWARD DEDUCTIBLE.—Amounts paid or owed by an insured for covered ground ambulance services under this section shall be treated as payments to a participating provider for purposes of calculating the insured's deductible

and out-of-pocket maximum under the insured's policy.

(5) DISPUTE RESOLUTION.—Disputes between an insurer and a nonparticipating ground ambulance service provider over the amount of reimbursement due under this section shall be resolved through the claims-dispute process established under s. 641.513(5).

(6) CONSUMER DISCLOSURE.—A ground ambulance service provider shall provide each patient, or the patient's representative, a written notice of billing rights under this section, in a form prescribed by the department, no later than the date of billing.

(7) RULEMAKING.—The office and the department may adopt rules to administer this section.

Section 2. Paragraph (a) of subsection (5) of section 641.513, Florida Statutes, is amended to read:

641.513 Payment of claims for treatment of subscribers.—

(5)(a) An HMO shall pay for covered emergency services, non-emergency post-evaluation and post-stabilization services, and covered ground ambulance services under s. 627.64196 rendered by a nonparticipating provider ... [remainder of subsection unchanged; cross-reference added to incorporate ground ambulance claims into the existing HMO payment-dispute mechanism].

Section 3. Effective date.

This act shall take effect July 1, 2027, consistent with the implementation timeline in Section XIII, and applies to ground ambulance services rendered on or after that date.

X. Evaluation Against Policy Criteria

The options in Section VII are scored below against five criteria: the breadth of consumer protection achieved, the sustainability of EMS provider revenue (particularly for rural and volunteer agencies), preservation of local government rate-setting authority, administrative simplicity, and political viability given Florida's own legislative record.

Criterion	A: Status Quo	B: Emergency-Only	C: Comprehensive (Recommended)	D: Direct-Bill, No Rate
Consumer protection breadth	None	Partial (ER only)	Full	Full
EMS revenue sustainability	N/A	Moderate	Strong (350% floor)	Weak (rate uncertain)
Preserves local rate authority	N/A	Yes	Yes	Yes
Administrative simplicity	N/A	High	High (reuses existing IDR)	Moderate
Political viability (FL record)	Fails to address known gap	Untested in FL	Builds on 2024–25 bills	Untested in FL

Option C is the only option that scores well across all five criteria simultaneously, which is why this proposal recommends it.

XI. Stakeholder Analysis and Anticipated Objections

Because neither the 2024 nor the 2025 bill received an unfavorable committee vote, the most useful evidence of likely opposition comes from the interests those bills' committees of reference were positioned to hear from, not from a recorded floor debate. Anticipating and addressing those interests directly is the central lesson this proposal draws from the legislative record in Section V.

Health insurers

Insurers can be expected to raise the cost of a new statutory payment floor. The response: the 2024 House staff analysis of this same payment structure found no fiscal impact on the Medicaid program or the state group insurance program, because the mandate falls on privately funded commercial contracts, not state spending; and a 350 percent Medicare benchmark is within the range states such as Texas and Colorado already apply to insurers operating there without evident market disruption.

Counties, municipalities, and fire-rescue departments

Local governments that operate ambulance services and set rates by ordinance can be expected to guard their rate-setting authority. The response: the recommended payment hierarchy places local ordinance and contract rates first, ahead of the state benchmark, so this proposal does not displace any local rate.

Private ambulance operators

Private operators, particularly in rural counties, can be expected to seek assurance that a state-mandated ceiling will not function as a below-cost rate. The response: the 350 percent benchmark exceeds the 325 percent benchmark used in Texas and Colorado and was calibrated in the 2024–2025 Florida bill

analyses specifically to address the reimbursement-adequacy concern documented in the 2022 Texas Department of Insurance survey (Section II).

Patient and consumer advocates

Consumer groups are the constituency most likely to support this proposal outright; their principal request, based on the national advocacy record, is likely to be that the protection reach non-emergency interfacility transport as well as emergency transport, which this proposal does, addressing the gap left by an emergency-only model such as Option B.

XII. Fiscal Impact

Because this proposal regulates the terms of private and HMO insurance contracts rather than creating a new state program, it does not require new general revenue appropriations. The Florida House staff analysis of the substantively identical 2024 proposal (CS/HB 639) found no fiscal impact on the Medicaid program and no fiscal impact on the state group health insurance program administered for state employees (Florida Senate, 2024b). Any effect on private insurance premiums is expected to be marginal and comparable to the premium effect already observed following Florida's 2016 balance-billing law and the federal No Surprises Act, both of which used a similar payment-standard design. The Office of Insurance Regulation and the Department of Financial Services would incur modest, absorbable administrative costs to extend the existing emergency-services dispute-resolution process (already funded and operating under s. 641.513(5)) to ground ambulance claims and to prescribe the consumer disclosure form required under subsection (6).

XIII. Implementation Plan

A statute that is not implemented with administrative agencies' engagement risks becoming a paper protection. The following steps are recommended.

1. **Pre-filing coalition (fall 2026).** Convene the Florida Fire Chiefs' Association, the Florida Association of Counties, the Florida Ambulance Association, and consumer groups (e.g., AARP Florida, Florida Health Justice Project) before bill filing to pre-negotiate the payment-standard percentage and confirm no objection to the local-ordinance-first hierarchy, directly responsive to the pattern in Section V.
2. **Early, cross-chamber filing (January 2027 committee weeks).** File House and Senate companions with sponsors seated on the committees of reference: Banking and Insurance in the Senate; Health Care Facilities & Systems and Insurance & Banking in the House. This is to reduce the number of discretionary committee stops between filing and a floor vote.
3. **Agency rulemaking (July 2027–January 2028, ahead of the effective date).** The Office of Insurance Regulation and the Department of Financial Services adopt the consumer-disclosure form under subsection (6) and issue guidance to insurers on applying the payment hierarchy, in consultation with the Department of Health's Bureau of Emergency Medical Services (ch. 401).
4. **Effective date and monitoring (July 1, 2027 forward).** The Office of Insurance Regulation includes ground ambulance balance-billing complaints in its existing annual consumer-complaint

reporting to the Legislature, allowing the Legislature to monitor implementation and adjust the Medicare-multiple benchmark if reimbursement-adequacy or access problems emerge.

XIV. Conclusion

Florida has already decided, as a matter of policy, that patients should not be financially punished for receiving emergency care from a provider they did not choose. That decision, made in 2016 and reinforced by the federal No Surprises Act in 2022, simply has not yet been extended to the one provider virtually every emergency patient encounters first. The federal government's own advisory committee has recommended state action; at least 22 states have already acted; and the Florida Legislature itself has twice advanced this exact reform through initial committees without a single unfavorable vote. What has been missing is not legislative support but legislative sequencing. This proposal offers a text, drawn from Florida's own vetted bill language and refined against the comparative record of other states, that the Legislature can enact in the 2027 Regular Session to finish the job it started in 2016.

References

Advisory Committee on Ground Ambulance and Patient Billing. (2024, March 29). Report of the Advisory Committee on Ground Ambulance and Patient Billing: Prevention of out-of-network ground ambulance emergency service balance billing. U.S. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/report-advisory-committee-ground-ambulance-and-patient-billing.pdf

Amin, K., Pollitz, K., Claxton, G., Rae, M., & Cox, C. (2021, June 24). Ground ambulance rides and potential for surprise billing. Peterson-KFF Health System Tracker. https://www.kff.org/health-costs/analysis-half-of-emergency-ambulance-rides-lead-to-out-of-network-bills-for-privately-insured-patients/

Centers for Medicare & Medicaid Services. (n.d.). Advisory Committee on Ground Ambulance and Patient Billing (GAPB). U.S. Department of Health and Human Services. Retrieved September 27, 2026, from https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory-committee-ground-ambulance-patient-billing-gapb

Commonwealth Fund. (2026). States protect consumers from surprise bills for ground ambulances. https://www.commonwealthfund.org/blog/2026/consumers-still-face-surprise-bills-ground-ambulances-states-are-trying-protect-them

Commonwealth Fund. (n.d.). Expanding the No Surprises Act to protect consumers from surprise ambulance bills: Map of state laws. Retrieved September 27, 2026, from https://www.commonwealthfund.org/publications/maps-and-interactives/expanding-no-surprises-act-protect-consumers-surprise-ambulance

Fla. Stat. § 627.64194 (2016). https://www.flsenate.gov/laws/statutes/2016/627.64194

Florida House of Representatives. (2025). Staff analysis: HB 425 (2025). https://www.flsenate.gov/Session/Bill/2025/425/Analyses/h0425a.HFS.PDF

Florida Senate. (2024a). Bill history: HB 639 (2024). https://www.flsenate.gov/Session/Bill/2024/639

Florida Senate. (2024b). Bill analysis and fiscal impact statement: CS/HB 639 (2024). https://www.flsenate.gov/Session/Bill/2024/639/Analyses/h0639c.APC.PDF

Florida Senate. (2024c). Bill analysis and fiscal impact statement: SB 568 (2024). https://www.flsenate.gov/Session/Bill/2024/568/Analyses/2024s00568.bi.PDF

Florida Senate. (2025a). Bill history: HB 425 (2025). https://www.flsenate.gov/Session/Bill/2025/425

Florida Senate. (2025b). Bill history: SB 704 (2025). https://www.flsenate.gov/Session/Bill/2025/704

Georgetown University Center on Health Insurance Reforms. (2022, December 19). As ground ambulance committee begins its work, new report on balance billing by ground ambulance providers highlights a gap in the No Surprises Act. https://chir.georgetown.edu/ground-ambulance-committee-begins-work-new-report-balance-billing-ground-ambulance-providers-highlights-gap-no-surprises-act/

Kelmar, P. (2023). Emergency: The high cost of ambulance surprise bills. U.S. PIRG Education Fund. https://pirg.org/edfund/resources/emergency-the-high-cost-of-ambulance-surprise-bills/

Smith, C. F. (2023). Writing public policy: A practical guide to communicating in the policymaking process (6th ed.). Oxford University Press.

Stovicek, N. (2024, July). Ground ambulance balance billing protections [Conference presentation]. National Council of Insurance Legislators. https://ncoil.org/wp-content/uploads/2024/07/Nadia-Stovicek-Presentation-REAL.pdf

Washington State Office of the Insurance Commissioner. (n.d.). Ground ambulance services and surprise billing. Retrieved September 27, 2026, from https://www.insurance.wa.gov/insurers-regulated-entities/laws-and-rules-insurers-and-regulated-entities/protections-surprise-medical-billing/ground-ambulance-services-and-surprise-billing