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Florida: What the New Balance Billing Law Means for Physicians

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This year two bills became law in Florida that are intended to equip Floridians with tools to make health care decisions based on cost and to protect them from significant unanticipated medical bills. The first (HB1175) requires hospitals and ambulatory surgery centers to post publicly the average price they are paid for certain procedures, as well as information about their financial assistance policies and collection procedures. The second (HB221) expands the existing Florida balance billing prohibition and limits physicians and other providers and facilities in the amount that they can bill PPO patients for their services in certain scenarios. Physicians should be aware of both laws, but their billing staff needs to understand the intricacies of the expanded balance billing law, which became law on July 1, 2016, to mitigate a drop in physician income.

Balance billing is a practice of physicians charging patients for a bill, or any remainder of a bill that was not paid for by the patient's insurance company in addition to any co-pay or deductible due from the patient. Balance billing typically becomes an issue when a patient sees a physician who is not in the network or is not a participating provider of the patient's insurer. This is because participating or network physicians are required to charge patients only the rate contractually agreed to by the physician and the insurance company.

The expanded Florida balance billing law creates a new statute, Section 627.64194, which prohibits physicians from charging PPO patients for any balance not paid by insurance, even if the physician has not contractually agreed to rates with the insurance company. This prohibition applies to two types of patient services:

1. Emergency Services by an out-of-network provider; and
2. Non-emergency services by an out-of-network provider at an in-network facility when the insured did not have an opportunity to select a participating provider.

When a physician provides services to a patient under one of these two scenarios, the physician's payment is limited by Florida law to be the lesser of (1) the physician's charges; (2) the usual and customary charge for similar services in the community where the services were provided; or (3) the mutually agreed upon charge between the physician and the insurance company.

Any dispute between the physician and the insurer can be resolved through the voluntary Statewide Provider and Health Plan Claim Dispute Program operated by MAXIMUS, Inc., under state contract. The MAXIMUS program has been in place since 2001 and physicians who are not already using it should become aware of its procedures and operations.

As a result of this law, physicians are required to provide medical services to PPO patients where the payment for these services will be dictated by Florida law whether or not the physician has agreed to accept a contracted rate from insurers. This will be a risk a physician takes when providing emergency services and when providing services in an in-network provider facility. This payment structure will be forced upon hospital-based physicians who must provide services in a facility or who are required to provide emergency services to maintain staff privileges. Insurers may also use this law to force a physician into a lower contractual rate than the physician would have accepted had this law not been in place, or risk arguing with an insurer over what is a usual and customary charge. And, the formula for what is a "usual and customary charge" is not clear. Some physicians are advocating for the use of the National FAIR Health database in determining proper charges in the implementation of this law. In any event, physicians should monitor the standards to be applied. Some physicians may be able to use this change in law to advocate for increased on-call pay. Also, since this law also applies in non-emergency situations, where a patient is in an in-network facility but did not have an opportunity to select a participating provider, a physician should document carefully the patient's opportunity to select a participating provider should the patient elect to go out of network. Physicians must plan now for how to manage out of network PPO patients in these service scenarios to mitigate or avoid the payment rates they did not bargain for and which they do not wish to accept.

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