Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.3042, Florida Statutes, is created to read:

395.3042 Hospitals; Disclosure of Participating Providers Requirement

(1) A hospital, as defined by Chapter 395.002, shall post on the hospital's website:

(a) The health care plans in which the hospital is a participating provider;

(b) A statement that:

1. Physician services provided in the hospital are not included in the hospital's charges,

2. Physicians who provide services in the hospital may or may not participate with the same health care plans as the hospital; and

3. The prospective patient should check with the physician arranging for the hospital services to determine the health care plans in which the physician participates;

4. As applicable, the name, mailing address and telephone number of the physician groups that the hospital has contracted with to provide services and instruction on how to contact these groups to determine the health care plan participation of the physicians in these groups; and

5. As applicable, the name, mailing address, and telephone number of physicians employed by the hospital and whose services may be provided at the hospital, and the health care plans in which they participate.

Section 2. Section 627.443, Florida Statutes, is created to read:

627.443 Health Insurance Disclosure Requirements for Contracts of Coverage

(1) An insurer that issues, delivers, amends, or renews an individual or group policy of health insurance which includes coverage for services of a contracted provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule or otherwise negotiated rate as permitted by applicable law. YOU

CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card."

Section 3. Section 627.444, Florida Statutes, is created to read:

627.444 Health Insurer Network Directory Disclosure Requirement

(1) The requirements of this Section shall apply to any insurer authorized to transact health insurance in this state, as defined by s. 627.6482.

(a) Each insurer subject to this section shall supply each insured, and upon request each prospective insured prior to enrollment, written disclosure information, which may be incorporated into the insurance contract or certificate, containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the insurance contract or certificate, the terms of the insurance contract or certificate shall be controlling. The information to be disclosed shall include at least the following:

1. Where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals.

(b) The listing shall also be posted on the insurer's website and the insurer shall update the website within five (5) days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation.

Section 4. Section 627.64194, Florida Statutes, is created to read:

627.64194 Coverage for Emergency Services-

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

(a) “Coverage for emergency services” means the coverage provided by a health insurance policy for “emergency services and care” as defined in s. 641.47. For purposes of this Section “coverage for emergency services includes” emergency transportation or ambulance services, to the extent permitted by applicable state and federal law.

(b) “Participating provider” means any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment as provided for in s. 627.6471 or s. 627.6472.

(2) Coverage for emergency services:

(a) May not require a prior authorization determination.

(b) Must be provided regardless of whether the service is furnished by a participating or nonparticipating provider.

(c) May impose a coinsurance amount, copayment, or limitation of benefits requirement for a nonparticipating provider only if the same requirement applies to a participating provider.

(d) Must reimburse a nonparticipating provider within the applicable timeframe provided by s. 627.6131:

1. The billed amount,

2. An amount the insurer determines is reasonable for the emergency services and care rendered, or

3. A charge mutually agreed to by the insurer and the nonparticipating provider.

(e) Either party may initiate binding arbitration pursuant to s. 627.64196 to determine additional reimbursement for services provided.

(3) A nonparticipating provider may not be reimbursed an amount greater than that provided under paragraph (2)(d)-(e) and may not collect or attempt to collect, directly or indirectly, any excess amount from the beneficiary, insured, or enrollee.

Section 5. Section 627.64196, Florida Statutes, is created to read:

627.64196 Alternative Procedure for Resolution of Emergency Services Rendered by Nonparticipating Providers –

(1) Pursuant to Sections 627.64194 and 627.64195, an insurer or nonparticipating provider may initiate binding arbitration as provided under this Section to determine additional reimbursement for services provided. Arbitration shall be initiated by filing a request with the Department of Financial Services. The parties may agree to resolve disputes over additional reimbursement for services for multiple beneficiaries, insureds or enrollees.

(2) The Department of Financial Services shall publish a list of approved arbitrators or entities that shall provide binding arbitration. These arbitrators shall be American Arbitration Association or American Health Lawyers Association trained arbitrators. Both parties must agree on an arbitrator from the Department of Financial Services' list of arbitrators within five (5) business days. If no agreement can be reached, then a list of 5 arbitrators shall be provided by the Department of Financial Services. From the list of 5 arbitrators, the party initiating arbitration shall first veto 2 arbitrators and then the other party shall veto 2 arbitrators from the remaining list. The remaining arbitrator shall be the chosen arbitrator.

(3) The party requesting arbitration shall notify the other party that arbitration has been initiated and state its final offer to resolve the dispute over additional reimbursement for services provided before arbitration. In response to this notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs.

(4) The arbitration shall consist of a review of both parties' final offers submitted to resolve the dispute over additional reimbursement for services. The arbitrator's decision shall be one of the two amounts submitted by the parties as their final offers.

(5) In making a determination pursuant to this Section, the arbitrator may consider, and the parties shall provide at the arbitrator's request, documentation of the following:

(a) Individual patient characteristics;

(b) The level of training, education, and experience of the nonparticipating provider;

(c) The nonparticipating provider's usual charge for comparable services provided out-of-network with respect to any health care plans;

(d) The participating provider contracted rate of payment for comparable services;

(e) The usual and customary provider charges, as defined by a public independent database of charges, for the same or similar services in the same geographic area;

(f) The amount that would be paid under Medicare or Medicaid for the service;

(g) The circumstances and complexity of the particular case, including the time and place of the service.

(6) A written decision shall be rendered within 30 days after the request for arbitration is filed with the Department of Financial Services. Both parties shall be bound by the arbitrator's decision. The cost of arbitration shall be

reasonable and the insurer shall bear all of the cost of the arbitration.