Amendment No. (for drafter’s use only)

CHAMBER ACTION

Senate	House
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Representative Farkas offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause, and insert:

Section 1. Subsections (7) is added to section 395.301, Florida Statutes, to read:

395.301 Itemized patient bill; form and content prescribed by the agency.--

(7)(a) Each licensed facility not operated by the state shall make available to the public on its Internet website or by other electronic means a list of charges and codes and a description of services of the top 100 diagnosis-related groups discharged from the hospital for that year using the CMS grouper applicable to that year and the top 100 outpatient occasions of diagnostic and therapeutic procedures performed using the Healthcare Common Procedure Coding System. For purposes of this paragraph, the term "CMS grouper" means a system of

classification used by the Centers for Medicare and Medicaid Services to assign an inpatient discharge into a diagnosis-related group based on diagnosis codes, procedure codes, and demographic information. The facility shall place a notice in the reception areas that such information is available electronically. The facility's list of charges and codes and the description of services shall be consistent with federal electronic transmission uniform standards under the Health Insurance Portability and Accountability Act (HIPAA). Changes to the data shall be posted and updated electronically at least 30 days prior to implementation.

(b) A health care facility shall, upon request, furnish a patient, prior to provision of medical services, a reasonable estimate of charges for such services. Such estimate shall not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient’s condition or treatment needs.

(c) A licensed facility not operated by the state shall make available to a patient, or a payor acting on behalf of the patient, the records that are necessary to verify the accuracy of the patient’s bill or payor’s claim related to such patient’s bill within a reasonable time after a request. The verification information must be made available in the facility’s offices. Such records shall be available to the patient or payor prior to and after payment of the bill or claim. The facility may not charge the patient or payor for making such verification records available, except the facility may charge its usual charge for providing copies of records as specified in s. 395.3025.

Section 2. Paragraph (e) of subsection (2), subsection (3), paragraph(c) of subsection (5), and subsection (10) of section 408.909, Florida Statutes, are amended to read:

408.909 Health flex plans.--

(2) DEFINITIONS.--As used in this section, the term:

(e) "Health flex plan" means a health plan approved under subsection (3) which guarantees payment for specified health care coverage provided to the enrollee <u>who purchases coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government</u>.

(3) PILOT PROGRAM.--The agency and the department shall each approve or disapprove health flex plans that provide health care coverage for eligible participants who reside in the three areas of the state that have the highest number of uninsured persons, as identified in the Florida Health Insurance Study conducted by the agency and in Indian River County. A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees <u>or the term of coverage</u>, or may take any combination of those actions.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care.

(b) The department shall develop guidelines for the review of health flex plan applications and shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices; or

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided.

(c) The agency and the department may adopt rules as needed to administer this section.

(5) ELIGIBILITY.--Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

(c) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, or another public health care program, such as KidCare, and have not been covered at any time during the past 6 months<u>, except that a small business purchasing arrangement sponsored by a local government may limit enrollment to residents of this state who have not been covered at any time during the past 12 months</u>; and

(10) EXPIRATION.--This section expires July 1, <u>2008</u> ~~2004~~.

Section 3. Paragraph (b) of subsection (6) of section 627.410, Florida Statutes, is amended to read:

627.410 Filing, approval of forms.--

(6)

(b) The department may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health plan policy offered or delivered to an individual or to a group of 51 or more persons that provides coverage as described in s. 627.6561(5)(a)2. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.

Section 4. Effective July 1, 2004, section 627.6410, Florida Statutes, is amended to read:

627.6410 Optional coverage for speech, language, swallowing, and hearing disorders.--

(1) Insurers issuing individual health insurance policies in this state shall make available to the policyholder as part of the application for any such policy of insurance, for an appropriate additional premium, the benefits or levels of benefits specified in the December 1999 Florida Medicaid Therapy Services Handbook for genetic or congenital disorders or conditions involving speech, language, swallowing, and hearing and a hearing aid and earmolds benefit at the level of benefits

specified in the January 2001 Florida Medicaid Hearing Services Handbook.

(2) This section does not apply to specified accident, specified disease, hospital indemnity, limited benefit, disability income, or long-term care insurance policies.

(3) Such optional coverage is not required to be offered when substantially similar benefits are included in the policy of insurance issued to the policyholder.

(4) This section does not require or prohibit the use of a provider network.

(5) This section does not prohibit an insurer from requiring prior authorization for the benefits under this section.

Section 5. Paragraph (b) of subsection (3) of section 627.6487, Florida Statutes, is amended, and paragraph (c) is added to subsection (4) of said section, to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.--

(3) For the purposes of this section, the term "eligible individual" means an individual:

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act;

2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured or self-insured group health ~~employer~~ plan or group health insurance policy;

3. Part A or part B of Title XVIII of the Social Security Act; or

4. A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage;

(4)

(c) If the individual's most recent period of creditable coverage was earned in a state other than this state, an insurer issuing a policy that complies with paragraph (a) may impose a surcharge or charge a premium for such policy equal to that permitted in the state in which such creditable coverage was earned.

Section 6. Paragraph (c) of subsection (8) of section 627.6561, Florida Statutes, is amended to read:

627.6561 Preexisting conditions.--

(8)

(c) The certification described in this section is a written certification that must include:

1. The period of creditable coverage of the individual under the policy and the coverage, if any, under such COBRA continuation provision or continuation pursuant to s. 627.6692.~~;~~ ~~and~~

2. The waiting period, if any, imposed with respect to the individual for any coverage under such policy.

3. A statement that the creditable coverage was provided under a group health plan, a group or individual health insurance policy, or a health maintenance organization contract, the state in which such coverage was provided, and whether or

not such individual was eligible for a conversion policy under such coverage.

Section 7. Subsection (6) of section 627.667, Florida Statutes, is amended to read:

627.667 Extension of benefits.--

(6) This section also applies to holders of group certificates which are renewed, delivered, or issued for delivery to residents of this state under group policies effectuated or delivered outside this state~~, unless a succeeding carrier under a group policy has agreed to assume liability for the benefits~~.

Section 8. Effective July 1, 2004, section 627.66912, Florida Statutes, is created to read:

627.66912 Optional coverage for speech, language, swallowing, and hearing disorders.--

(1) Insurers issuing group health insurance policies in this state shall make available to the policyholder as part of the application for any such policy of insurance, for an appropriate additional premium, the benefits or levels of benefits specified in the December 1999 Florida Medicaid Therapy Services Handbook for genetic or congenital disorders or conditions involving speech, language, swallowing, and hearing and a hearing aid and earmolds benefit at the level of benefits specified in the January 2001 Florida Medicaid Hearing Services Handbook.

(2) This section does not apply to specified accident, specified disease, hospital indemnity, limited benefit, disability income, or long-term care insurance policies.

(3) Such optional coverage is not required to be offered when substantially similar benefits are included in the policy of insurance issued to the policyholder.

(4) This section does not require or prohibit the use of a provider network.

(5) This section does not prohibit an insurer from requiring prior authorization for the benefits under this section.

Section 9. Paragraph (e) of subsection (5) of section 627.6692, Florida Statutes, is amended to read:

627.6692 Florida Health Insurance Coverage Continuation Act.--

(5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--

(e)1. A covered employee or other qualified beneficiary who wishes continuation of coverage must pay the initial premium and elect such continuation in writing to the insurance carrier issuing the employer's group health plan within 63 ~~30~~ days after receiving notice from the insurance carrier under paragraph (d). Subsequent premiums are due by the grace period expiration date. The insurance carrier or the insurance carrier's designee shall process all elections promptly and provide coverage retroactively to the date coverage would otherwise have terminated. The premium due shall be for the period beginning on the date coverage would have otherwise terminated due to the qualifying event. The first premium payment must include the coverage paid to the end of the month in which the first payment is made. After the election, the insurance carrier must bill the qualified beneficiary for premiums once each month, with a due

date on the first of the month of coverage and allowing a 30-day grace period for payment.

2. Except as otherwise specified in an election, any election by a qualified beneficiary shall be deemed to include an election of continuation of coverage on behalf of any other qualified beneficiary residing in the same household who would lose coverage under the group health plan by reason of a qualifying event. This subparagraph does not preclude a qualified beneficiary from electing continuation of coverage on behalf of any other qualified beneficiary.

Section 10. Paragraphs (h) and (u) of subsection (3), paragraph(c) of subsection (5), and paragraph (b) of subsection(6) of section 627.6699, Florida Statutes, are amended, and paragraph (k) is added to subsection (5) of said section, to read:

627.6699 Employee Health Care Access Act.--

(3) DEFINITIONS.--As used in this section, the term:

(h) "Eligible employee" means an employee who works full time, having a normal workweek of 25 or more hours <u>and is paid wages or a salary at least equal to the federal minimum hourly wage applicable to such employee</u>, and who has met any applicable waiting-period requirements or other requirements of this act. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.

(u) "Self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which necessitates that the individual file federal income tax forms, with supporting schedules and accompanying income reporting forms ~~results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years~~.

(5) AVAILABILITY OF COVERAGE.--

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Beginning July 1, 2000, offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

2. Beginning July 1, 2000, and until July 31, 2001, offer and issue basic and standard small employer health benefit plans on a guaranteed-issue basis to every eligible small employer which is eligible for guaranteed renewal, has less than two eligible employees, is not formed primarily for the purpose of buying health insurance, elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or

increased benefits may be medically underwritten and may be added only to the standard benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children shall constitute a single eligible employee if that person and spouse are employed by the same small employer and either one has a normal work week of less than 25 hours.

3. Beginning June 1, 2004 ~~August 1, 2001~~, offer and issue basic and standard small employer health benefit plans on a guaranteed-issue basis, during a 30-day open enrollment period of June 1 through June 30 and during a 31-day open enrollment period of December ~~August~~ 1 through December ~~August~~ 31 of each year, to every eligible small employer, with fewer than two eligible employees, which small employer is not formed primarily for the purpose of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. Coverage provided under this subparagraph shall begin 60 days after ~~on October 1 of the same year as~~ the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children constitute a single eligible employee if that person and spouse are

employed by the same small employer and either that person or his or her spouse has a normal work week of less than 25 hours.

4. This paragraph does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.

(k) Beginning January 1, 2004, every small employer shall provide, on an annual basis, information on at least three different health benefit plans for employees. Nothing in this paragraph shall be construed as requiring a small employer to provide the health benefit plan or contribute to the cost of such plan. Nothing in this paragraph shall be construed as requiring a small employer or an individual carrier to offer these health plan benefits on a guaranteed-issue basis.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans subject to this section are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j) and in which the premium may be adjusted as permitted by this paragraph.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be

developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to department review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the department that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the department. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. Nothing in this subparagraph exempts an alliance or group association from licensure for any activities that require licensure under the insurance code. A carrier

issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the department, to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 3 ~~5~~ percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the department. For any

subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 3 ~~5~~ percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to department review and approval.

6. A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

7. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, a "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

8.a. A carrier may separate the experience of small employer groups with less than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

b. If a carrier separates the experience of small employer groups as provided in sub-subparagraph a., the rate to be charged to small employer groups of less than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

9. In addition to the separation allowed under sub-subparagraph 8.a., a carrier may also separate the experience of small employer groups of 1-50 eligible employees using a health reimbursement arrangement, as defined in Internal Revenue Service Notice 2002-45, 2002-28 Internal Revenue Bulletin 93, and Revenue Ruling 2002-41, 2002-28 Internal Revenue Bulletin 75, from the experience of small employer groups of 1-50 eligible employees not using such a health reimbursement arrangement for purposes of determining an alternative modified community rating.

Section 11. Subsection (2) and paragraph (d) of subsection (3) of section 641.31, Florida Statutes, are amended, and subsections (40) and (41) are added to said section, to read:

641.31 Health maintenance contracts.--

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance organization contract offered or delivered to an individual or a group of 51 or more persons that provides coverage as described in s. 641.31071(5)(a)2. The department, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(3)

(d) Any change in rates charged for the contract must be filed with the department not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the department. The approval of the filing by the department constitutes a waiver of any unexpired portion of such waiting period. The department may extend by not more than an additional

15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved. This paragraph does not apply to group health contracts effectuated and delivered in this state insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claims costs over the lifetime of the contract due to advancing age or duration is refunded in the premium.

(40) Health maintenance organizations shall make available to the contract holder as part of the application for any such contract, for an appropriate additional premium, the benefits or level of benefits specified in the December 1999 Florida Medicaid Therapy Services Handbook for genetic or congenital disorders or conditions involving speech, language, swallowing, and hearing and a hearing aid and earmolds benefit at the level of benefits specified in the January 2001 Florida Medicaid Hearing Services Handbook.

(a) Such optional coverage is not required to be offered when substantially similar benefits are included in the contract issued to the subscriber.

(b) This subsection does not require or prohibit the use of a provider network.

(c) This subsection does not prohibit an organization from requiring prior authorization for the benefits under this subsection.

(d) This subsection does not apply to health maintenance organizations issuing individual coverage to fewer than 50,000 members.

(e) This subsection shall take effect July 1, 2004.

(41) Every health maintenance organization shall make available to its subscribers the estimated co-pay, co-insurance, or deductible, whichever is applicable, for any covered service, the status of the subscriber's maximum annual out-of-pocket payments for a covered individual or family, and the status of the subscriber's maximum lifetime benefit. Each health maintenance organization shall, upon request of a subscriber, provide an estimate of the amount the health maintenance organization will pay for a particular medical procedure or service. The estimate may be in the form of a range of payments or an average payment. A health maintenance organization that provides a subscriber with a good faith estimate is not bound by the estimate.

Section 12. Section 641.31075, Florida Statutes, is created to read:

641.31075 Requirements for replacing health coverage.--Any health maintenance organization that is replacing any other group health coverage with its group health maintenance coverage shall comply with s. 627.666.

Section 13. Subsection (1) of section 641.3111, Florida Statutes, is amended to read:

641.3111 Extension of benefits.--

(1) Every group health maintenance contract shall provide that termination of the contract shall be without prejudice to any continuous loss which commenced while the contract was in

force, but any extension of benefits beyond the period the contract was in force may be predicated upon the continuous total disability of the subscriber ~~and may be limited to payment for the treatment of a specific accident or illness incurred while the subscriber was a member~~. The extension is required regardless of whether the group contract holder or other entity secures replacement coverage from a new insurer or health maintenance organization or foregoes the provision of coverage. The required provision must provide for continuation of contract benefits in connection with the treatment of a specific accident or illness incurred while the contract was in effect. Such extension of benefits may be limited to the occurrence of the earliest of the following events:

(a) The expiration of 12 months.

(b) Such time as the member is no longer totally disabled.

(c) A succeeding carrier elects to provide replacement coverage without limitation as to the disability condition.

(d) The maximum benefits payable under the contract have been paid.

Section 14. Subsection (22) is added to section 641.19, Florida Statutes, to read:

641.19 Definitions.--As used in this part, the term:

(22) "Specialty" or "specialist" shall not include the services by a physician licensed under chapter 460.

Section 15. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the

invalid provision or application, and to this end the provisions of this act are declared severable.

Section 16. Except as otherwise provided herein, this act shall take effect upon becoming a law.

========== T I T L E A M E N D M E N T ==========

Remove the entire title, and insert:

A bill to be entitled

An act relating to health insurance; amending s. 395.301, F.S.; requiring health care providers and facilities to provide prospective patients with reasonable estimates of prospective charges; requiring certain licensed facilities to make available to payors certain records; providing that the facility may not charge for making records available but may charge a specified amount for providing copies; amending s. 408.909, F.S.; revising a definition; authorizing plans to limit the term of coverage; extending the required period without coverage before participation eligibility; authorizing a business purchasing arrangement sponsored by a local government subject to specified limitations; extending a program expiration date; amending s. 627.410, F.S.; exempting individuals and certain groups from laws restricting or limiting coinsurance, copayments, or annual or lifetime maximum payments; creating s. 627.6410, F.S.; providing for optional coverage in health insurance policies for speech, language, swallowing, and hearing disorders; providing exclusion; providing

exceptions; providing a limitation; amending s. 627.6487, F.S.; revising a definition of "eligible individual" for purposes of availability of individual health insurance coverage; authorizing insurers to impose certain surcharges or premium charges for creditable coverage earned in certain states; amending s. 627.6561, F.S.; requiring additional information in a certification relating to certain creditable coverage for purposes of eligibility for exclusion from preexisting condition requirements; amending s. 627.667, F.S.; deleting a limitation on certain application of extension of benefits provisions; creating s. 627.66912, F.S.; providing for optional coverage in group, blanket, and franchise health insurance policies for speech, language, swallowing, and hearing disorders; providing exclusion; providing exceptions; providing a limitation; amending s. 627.6692, F.S.; extending a time period for continuation of certain coverage under group health plans; amending s. 627.6699, F.S.; revising certain definitions; revising enrollment period criteria for certain health benefit plans; requiring small employers to provide certain health benefit plan information to employees; providing a limitation; revising certain rate adjustment criteria; authorizing separation of experience of certain small employer groups for certain purposes; amending s. 641.31, F.S.; specifying nonapplication of certain health maintenance contract filing requirements to certain group health insurance policies, with exceptions; requiring health maintenance organizations to make available coverage for certain speech, language, swallowing, and

hearing disorders or conditions, subject to certain criteria and limits, effective July 1, 2004; requiring health maintenance organizations to provide specific information to subscribers; creating s. 641.31075, F.S.; providing compliance requirements for health maintenance organizations replacing certain coverages; amending s. 641.3111, F.S.; providing additional requirements for extension of benefits under group health maintenance contracts; amending s. 641.19, F.S.; defining the term "specialty" or "specialist" to exclude services by a chiropractic physician; providing severability; providing effective dates.