Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
	.
	.
	.

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

28 Services to assign an inpatient discharge into a diagnosis-
29 related group based on diagnosis codes, procedure codes, and
30 demographic information. The facility shall place a notice in
31 the reception areas that such information is available
32 electronically. The facility's list of charges and codes and the
33 description of services shall be consistent with federal
34 electronic transmission uniform standards under the Health
35 Insurance Portability and Accountability Act (HIPAA). Changes to
36 the data shall be posted and updated electronically at least 30
37 days prior to implementation.
38 (b) A health care facility shall, upon request, furnish a
39 patient, prior to provision of medical services, a reasonable
40 estimate of charges for such services. Such estimate shall not
41 preclude the health care provider or health care facility from
42 exceeding the estimate or making additional charges based on
43 changes in the patient's condition or treatment needs.
44 (c) A licensed facility not operated by the state shall
45 make available to a patient, or a payor acting on behalf of the
46 patient, the records that are necessary to verify the accuracy
47 of the patient's bill or payor's claim related to such patient's
48 bill within a reasonable time after a request. The verification
49 information must be made available in the facility's offices.
50 Such records shall be available to the patient or payor prior to
51 and after payment of the bill or claim. The facility may not
52 charge the patient or payor for making such verification records
53 available, except the facility may charge its usual charge for
54 providing copies of records as specified in s. 395.3025.

55 Section 2. Paragraph (e) of subsection (2), subsection
56 (3), paragraph(c) of subsection (5), and subsection (10) of
57 section 408.909, Florida Statutes, are amended to read:
58 408.909 Health flex plans.--
59 (2) DEFINITIONS.--As used in this section, the term:
60 (e) "Health flex plan" means a health plan approved under
61 subsection (3) which guarantees payment for specified health
62 care coverage provided to the enrollee who purchases coverage
63 directly from the plan or through a small business purchasing
64 arrangement sponsored by a local government.
65 (3) PILOT PROGRAM.--The agency and the department shall
66 each approve or disapprove health flex plans that provide health
67 care coverage for eligible participants who reside in the three
68 areas of the state that have the highest number of uninsured
69 persons, as identified in the Florida Health Insurance Study
70 conducted by the agency and in Indian River County. A health
71 flex plan may limit or exclude benefits otherwise required by
72 law for insurers offering coverage in this state, may cap the
73 total amount of claims paid per year per enrollee, may limit the
74 number of enrollees or the term of coverage, or may take any
75 combination of those actions.
76 (a) The agency shall develop guidelines for the review of
77 applications for health flex plans and shall disapprove or
78 withdraw approval of plans that do not meet or no longer meet
79 minimum standards for quality of care and access to care.
80 (b) The department shall develop guidelines for the review
81 of health flex plan applications and shall disapprove or shall
82 withdraw approval of plans that:

83 1. Contain any ambiguous, inconsistent, or misleading
84 provisions or any exceptions or conditions that deceptively
85 affect or limit the benefits purported to be assumed in the
86 general coverage provided by the health flex plan;
87 2. Provide benefits that are unreasonable in relation to
88 the premium charged or contain provisions that are unfair or
89 inequitable or contrary to the public policy of this state, that
90 encourage misrepresentation, or that result in unfair
91 discrimination in sales practices; or
92 3. Cannot demonstrate that the health flex plan is
93 financially sound and that the applicant is able to underwrite
94 or finance the health care coverage provided.
95 (c) The agency and the department may adopt rules as
96 needed to administer this section.
97 (5) ELIGIBILITY.--Eligibility to enroll in an approved
98 health flex plan is limited to residents of this state who:
99 (c) Are not covered by a private insurance policy and are
100 not eligible for coverage through a public health insurance
101 program, such as Medicare or Medicaid, or another public health
102 care program, such as KidCare, and have not been covered at any
103 time during the past 6 months, except that a small business
104 purchasing arrangement sponsored by a local government may limit
105 enrollment to residents of this state who have not been covered
106 at any time during the past 12 months; and
107 (10) EXPIRATION.--This section expires July 1, 2008 ~~2004~~.
108 Section 3. Paragraph (b) of subsection (6) of section
109 627.410, Florida Statutes, is amended to read:
110 627.410 Filing, approval of forms.--
111 (6)

112 (b) The department may establish by rule, for each type of
113 health insurance form, procedures to be used in ascertaining the
114 reasonableness of benefits in relation to premium rates and may,
115 by rule, exempt from any requirement of paragraph (a) any health
116 insurance policy form or type thereof (as specified in such
117 rule) to which form or type such requirements may not be
118 practically applied or to which form or type the application of
119 such requirements is not desirable or necessary for the
120 protection of the public. A law restricting or limiting
121 deductibles, coinsurance, copayments, or annual or lifetime
122 maximum payments shall not apply to any health plan policy
123 offered or delivered to an individual or to a group of 51 or
124 more persons that provides coverage as described in s.
125 627.6561(5)(a)2. With respect to any health insurance policy
126 form or type thereof which is exempted by rule from any
127 requirement of paragraph (a), premium rates filed pursuant to
128 ss. 627.640 and 627.662 shall be for informational purposes.
129 Section 4. Effective July 1, 2004, section 627.6410,
130 Florida Statutes, is amended to read:
131 627.6410 Optional coverage for speech, language,
132 swallowing, and hearing disorders.--
133 (1) Insurers issuing individual health insurance policies
134 in this state shall make available to the policyholder as part
135 of the application for any such policy of insurance, for an
136 appropriate additional premium, the benefits or levels of
137 benefits specified in the December 1999 Florida Medicaid Therapy
138 Services Handbook for genetic or congenital disorders or
139 conditions involving speech, language, swallowing, and hearing
140 and a hearing aid and earmolds benefit at the level of benefits

141 specified in the January 2001 Florida Medicaid Hearing Services
142 Handbook.
143 (2) This section does not apply to specified accident,
144 specified disease, hospital indemnity, limited benefit,
145 disability income, or long-term care insurance policies.
146 (3) Such optional coverage is not required to be offered
147 when substantially similar benefits are included in the policy
148 of insurance issued to the policyholder.
149 (4) This section does not require or prohibit the use of a
150 provider network.
151 (5) This section does not prohibit an insurer from
152 requiring prior authorization for the benefits under this
153 section.
154 Section 5. Paragraph (b) of subsection (3) of section
155 627.6487, Florida Statutes, is amended, and paragraph (c) is
156 added to subsection (4) of said section, to read:
157 627.6487 Guaranteed availability of individual health
158 insurance coverage to eligible individuals.--
159 (3) For the purposes of this section, the term "eligible
160 individual" means an individual:
161 (b) Who is not eligible for coverage under:
162 1. A group health plan, as defined in s. 2791 of the
163 Public Health Service Act;
164 2. A conversion policy or contract issued by an authorized
165 insurer or health maintenance organization under s. 627.6675 or
166 s. 641.3921, respectively, offered to an individual who is no
167 longer eligible for coverage under either an insured or self-
168 insured group health ~~employer~~ plan or group health insurance
169 policy;

170 3. Part A or part B of Title XVIII of the Social Security
171 Act; or
172 4. A state plan under Title XIX of such act, or any
173 successor program, and does not have other health insurance
174 coverage;
175 (4)
176 (c) If the individual's most recent period of creditable
177 coverage was earned in a state other than this state, an insurer
178 issuing a policy that complies with paragraph (a) may impose a
179 surcharge or charge a premium for such policy equal to that
180 permitted in the state in which such creditable coverage was
181 earned.
182 Section 6. Paragraph (c) of subsection (8) of section
183 627.6561, Florida Statutes, is amended to read:
184 627.6561 Preexisting conditions.--
185 (8)
186 (c) The certification described in this section is a
187 written certification that must include:
188 1. The period of creditable coverage of the individual
189 under the policy and the coverage, if any, under such COBRA
190 continuation provision or continuation pursuant to s. 627.6692.~~;~~
191 ~~and~~
192 2. The waiting period, if any, imposed with respect to the
193 individual for any coverage under such policy.
194 3. A statement that the creditable coverage was provided
195 under a group health plan, a group or individual health
196 insurance policy, or a health maintenance organization contract,
197 the state in which such coverage was provided, and whether or

198 not such individual was eligible for a conversion policy under
199 such coverage.
200 Section 7. Subsection (6) of section 627.667, Florida
201 Statutes, is amended to read:
202 627.667 Extension of benefits.--
203 (6) This section also applies to holders of group
204 certificates which are renewed, delivered, or issued for
205 delivery to residents of this state under group policies
206 effectuated or delivered outside this state~~, unless a succeeding~~
207 ~~carrier under a group policy has agreed to assume liability for~~
208 ~~the benefits~~.
209 Section 8. Effective July 1, 2004, section 627.66912,
210 Florida Statutes, is created to read:
211 627.66912 Optional coverage for speech, language,
212 swallowing, and hearing disorders.--
213 (1) Insurers issuing group health insurance policies in
214 this state shall make available to the policyholder as part of
215 the application for any such policy of insurance, for an
216 appropriate additional premium, the benefits or levels of
217 benefits specified in the December 1999 Florida Medicaid Therapy
218 Services Handbook for genetic or congenital disorders or
219 conditions involving speech, language, swallowing, and hearing
220 and a hearing aid and earmolds benefit at the level of benefits
221 specified in the January 2001 Florida Medicaid Hearing Services
222 Handbook.
223 (2) This section does not apply to specified accident,
224 specified disease, hospital indemnity, limited benefit,
225 disability income, or long-term care insurance policies.

226 (3) Such optional coverage is not required to be offered
227 when substantially similar benefits are included in the policy
228 of insurance issued to the policyholder.
229 (4) This section does not require or prohibit the use of a
230 provider network.
231 (5) This section does not prohibit an insurer from
232 requiring prior authorization for the benefits under this
233 section.
234 Section 9. Paragraph (e) of subsection (5) of section
235 627.6692, Florida Statutes, is amended to read:
236 627.6692 Florida Health Insurance Coverage Continuation
237 Act.--
238 (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--
239 (e)1. A covered employee or other qualified beneficiary
240 who wishes continuation of coverage must pay the initial premium
241 and elect such continuation in writing to the insurance carrier
242 issuing the employer's group health plan within 63 ~~30~~ days after
243 receiving notice from the insurance carrier under paragraph (d).
244 Subsequent premiums are due by the grace period expiration date.
245 The insurance carrier or the insurance carrier's designee shall
246 process all elections promptly and provide coverage
247 retroactively to the date coverage would otherwise have
248 terminated. The premium due shall be for the period beginning on
249 the date coverage would have otherwise terminated due to the
250 qualifying event. The first premium payment must include the
251 coverage paid to the end of the month in which the first payment
252 is made. After the election, the insurance carrier must bill the
253 qualified beneficiary for premiums once each month, with a due

254 date on the first of the month of coverage and allowing a 30-day
255 grace period for payment.
256 2. Except as otherwise specified in an election, any
257 election by a qualified beneficiary shall be deemed to include
258 an election of continuation of coverage on behalf of any other
259 qualified beneficiary residing in the same household who would
260 lose coverage under the group health plan by reason of a
261 qualifying event. This subparagraph does not preclude a
262 qualified beneficiary from electing continuation of coverage on
263 behalf of any other qualified beneficiary.
264 Section 10. Paragraphs (h) and (u) of subsection (3),
265 paragraph(c) of subsection (5), and paragraph (b) of
266 subsection(6) of section 627.6699, Florida Statutes, are
267 amended, and paragraph (k) is added to subsection (5) of said
268 section, to read:
269 627.6699 Employee Health Care Access Act.--
270 (3) DEFINITIONS.--As used in this section, the term:
271 (h) "Eligible employee" means an employee who works full
272 time, having a normal workweek of 25 or more hours and is paid
273 wages or a salary at least equal to the federal minimum hourly
274 wage applicable to such employee, and who has met any applicable
275 waiting-period requirements or other requirements of this act.
276 The term includes a self-employed individual, a sole proprietor,
277 a partner of a partnership, or an independent contractor, if the
278 sole proprietor, partner, or independent contractor is included
279 as an employee under a health benefit plan of a small employer,
280 but does not include a part-time, temporary, or substitute
281 employee.

282 (u) "Self-employed individual" means an individual or sole
283 proprietor who derives his or her income from a trade or
284 business carried on by the individual or sole proprietor which
285 necessitates that the individual file federal income tax forms,
286 with supporting schedules and accompanying income reporting
287 forms ~~results in taxable income as indicated on IRS Form 1040,~~
288 ~~schedule C or F, and which generated taxable income in one of~~
289 ~~the 2 previous years~~.
290 (5) AVAILABILITY OF COVERAGE.--
291 (c) Every small employer carrier must, as a condition of
292 transacting business in this state:
293 1. Beginning July 1, 2000, offer and issue all small
294 employer health benefit plans on a guaranteed-issue basis to
295 every eligible small employer, with 2 to 50 eligible employees,
296 that elects to be covered under such plan, agrees to make the
297 required premium payments, and satisfies the other provisions of
298 the plan. A rider for additional or increased benefits may be
299 medically underwritten and may only be added to the standard
300 health benefit plan. The increased rate charged for the
301 additional or increased benefit must be rated in accordance with
302 this section.
303 2. Beginning July 1, 2000, and until July 31, 2001, offer
304 and issue basic and standard small employer health benefit plans
305 on a guaranteed-issue basis to every eligible small employer
306 which is eligible for guaranteed renewal, has less than two
307 eligible employees, is not formed primarily for the purpose of
308 buying health insurance, elects to be covered under such plan,
309 agrees to make the required premium payments, and satisfies the
310 other provisions of the plan. A rider for additional or

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

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

339 employed by the same small employer and either that person or
340 his or her spouse has a normal work week of less than 25 hours.
341 4. This paragraph does not limit a carrier's ability to
342 offer other health benefit plans to small employers if the
343 standard and basic health benefit plans are offered and
344 rejected.
345 (k) Beginning January 1, 2004, every small employer shall
346 provide, on an annual basis, information on at least three
347 different health benefit plans for employees. Nothing in this
348 paragraph shall be construed as requiring a small employer to
349 provide the health benefit plan or contribute to the cost of
350 such plan. Nothing in this paragraph shall be construed as
351 requiring a small employer or an individual carrier to offer
352 these health plan benefits on a guaranteed-issue basis.
353 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
354 (b) For all small employer health benefit plans that are
355 subject to this section and are issued by small employer
356 carriers on or after January 1, 1994, premium rates for health
357 benefit plans subject to this section are subject to the
358 following:
359 1. Small employer carriers must use a modified community
360 rating methodology in which the premium for each small employer
361 must be determined solely on the basis of the eligible
362 employee's and eligible dependent's gender, age, family
363 composition, tobacco use, or geographic area as determined under
364 paragraph (5)(j) and in which the premium may be adjusted as
365 permitted by this paragraph.
366 2. Rating factors related to age, gender, family
367 composition, tobacco use, or geographic location may be

368 developed by each carrier to reflect the carrier's experience.
369 The factors used by carriers are subject to department review
370 and approval.
371 3. Small employer carriers may not modify the rate for a
372 small employer for 12 months from the initial issue date or
373 renewal date, unless the composition of the group changes or
374 benefits are changed. However, a small employer carrier may
375 modify the rate one time prior to 12 months after the initial
376 issue date for a small employer who enrolls under a previously
377 issued group policy that has a common anniversary date for all
378 employers covered under the policy if:
379 a. The carrier discloses to the employer in a clear and
380 conspicuous manner the date of the first renewal and the fact
381 that the premium may increase on or after that date.
382 b. The insurer demonstrates to the department that
383 efficiencies in administration are achieved and reflected in the
384 rates charged to small employers covered under the policy.
385 4. A carrier may issue a group health insurance policy to
386 a small employer health alliance or other group association with
387 rates that reflect a premium credit for expense savings
388 attributable to administrative activities being performed by the
389 alliance or group association if such expense savings are
390 specifically documented in the insurer's rate filing and are
391 approved by the department. Any such credit may not be based on
392 different morbidity assumptions or on any other factor related
393 to the health status or claims experience of any person covered
394 under the policy. Nothing in this subparagraph exempts an
395 alliance or group association from licensure for any activities
396 that require licensure under the insurance code. A carrier

397 issuing a group health insurance policy to a small employer
398 health alliance or other group association shall allow any
399 properly licensed and appointed agent of that carrier to market
400 and sell the small employer health alliance or other group
401 association policy. Such agent shall be paid the usual and
402 customary commission paid to any agent selling the policy.
403 5. Any adjustments in rates for claims experience, health
404 status, or duration of coverage may not be charged to individual
405 employees or dependents. For a small employer's policy, such
406 adjustments may not result in a rate for the small employer
407 which deviates more than 15 percent from the carrier's approved
408 rate. Any such adjustment must be applied uniformly to the rates
409 charged for all employees and dependents of the small employer.
410 A small employer carrier may make an adjustment to a small
411 employer's renewal premium, not to exceed 10 percent annually,
412 due to the claims experience, health status, or duration of
413 coverage of the employees or dependents of the small employer.
414 Semiannually, small group carriers shall report information on
415 forms adopted by rule by the department, to enable the
416 department to monitor the relationship of aggregate adjusted
417 premiums actually charged policyholders by each carrier to the
418 premiums that would have been charged by application of the
419 carrier's approved modified community rates. If the aggregate
420 resulting from the application of such adjustment exceeds the
421 premium that would have been charged by application of the
422 approved modified community rate by 3 ~~5~~ percent for the current
423 reporting period, the carrier shall limit the application of
424 such adjustments only to minus adjustments beginning not more
425 than 60 days after the report is sent to the department. For any

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

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

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

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

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

472 9. In addition to the separation allowed under sub-
473 subparagraph 8.a., a carrier may also separate the experience of
474 small employer groups of 1-50 eligible employees using a health
475 reimbursement arrangement, as defined in Internal Revenue
476 Service Notice 2002-45, 2002-28 Internal Revenue Bulletin 93,
477 and Revenue Ruling 2002-41, 2002-28 Internal Revenue Bulletin
478 75, from the experience of small employer groups of 1-50
479 eligible employees not using such a health reimbursement
480 arrangement for purposes of determining an alternative modified
481 community rating.

482 Section 11. Subsection (2) and paragraph (d) of subsection
483 (3) of section 641.31, Florida Statutes, are amended, and
484 subsections (40) and (41) are added to said section, to read:
485 641.31 Health maintenance contracts.--
486 (2) The rates charged by any health maintenance
487 organization to its subscribers shall not be excessive,
488 inadequate, or unfairly discriminatory or follow a rating
489 methodology that is inconsistent, indeterminate, or ambiguous or
490 encourages misrepresentation or misunderstanding. A law
491 restricting or limiting deductibles, coinsurance, copayments, or
492 annual or lifetime maximum payments shall not apply to any
493 health maintenance organization contract offered or delivered to
494 an individual or a group of 51 or more persons that provides
495 coverage as described in s. 641.31071(5)(a)2. The department, in
496 accordance with generally accepted actuarial practice as applied
497 to health maintenance organizations, may define by rule what
498 constitutes excessive, inadequate, or unfairly discriminatory
499 rates and may require whatever information it deems necessary to
500 determine that a rate or proposed rate meets the requirements of
501 this subsection.
502 (3)
503 (d) Any change in rates charged for the contract must be
504 filed with the department not less than 30 days in advance of
505 the effective date. At the expiration of such 30 days, the rate
506 filing shall be deemed approved unless prior to such time the
507 filing has been affirmatively approved or disapproved by order
508 of the department. The approval of the filing by the department
509 constitutes a waiver of any unexpired portion of such waiting
510 period. The department may extend by not more than an additional

511 15 days the period within which it may so affirmatively approve
512 or disapprove any such filing, by giving notice of such
513 extension before expiration of the initial 30-day period. At the
514 expiration of any such period as so extended, and in the absence
515 of such prior affirmative approval or disapproval, any such
516 filing shall be deemed approved. This paragraph does not apply
517 to group health contracts effectuated and delivered in this
518 state insuring groups of 51 or more persons, except for Medicare
519 supplement insurance, long-term care insurance, and any coverage
520 under which the increase in claims costs over the lifetime of
521 the contract due to advancing age or duration is refunded in the
522 premium.
523 (40) Health maintenance organizations shall make available
524 to the contract holder as part of the application for any such
525 contract, for an appropriate additional premium, the benefits or
526 level of benefits specified in the December 1999 Florida
527 Medicaid Therapy Services Handbook for genetic or congenital
528 disorders or conditions involving speech, language, swallowing,
529 and hearing and a hearing aid and earmolds benefit at the level
530 of benefits specified in the January 2001 Florida Medicaid
531 Hearing Services Handbook.
532 (a) Such optional coverage is not required to be offered
533 when substantially similar benefits are included in the contract
534 issued to the subscriber.
535 (b) This subsection does not require or prohibit the use
536 of a provider network.
537 (c) This subsection does not prohibit an organization from
538 requiring prior authorization for the benefits under this
539 subsection.

540 (d) This subsection does not apply to health maintenance
541 organizations issuing individual coverage to fewer than 50,000
542 members.
543 (e) This subsection shall take effect July 1, 2004.
544 (41) Every health maintenance organization shall make
545 available to its subscribers the estimated co-pay, co-insurance,
546 or deductible, whichever is applicable, for any covered service,
547 the status of the subscriber's maximum annual out-of-pocket
548 payments for a covered individual or family, and the status of
549 the subscriber's maximum lifetime benefit. Each health
550 maintenance organization shall, upon request of a subscriber,
551 provide an estimate of the amount the health maintenance
552 organization will pay for a particular medical procedure or
553 service. The estimate may be in the form of a range of payments
554 or an average payment. A health maintenance organization that
555 provides a subscriber with a good faith estimate is not bound by
556 the estimate.
557 Section 12. Section 641.31075, Florida Statutes, is
558 created to read:
559 641.31075 Requirements for replacing health coverage.--Any
560 health maintenance organization that is replacing any other
561 group health coverage with its group health maintenance coverage
562 shall comply with s. 627.666.
563 Section 13. Subsection (1) of section 641.3111, Florida
564 Statutes, is amended to read:
565 641.3111 Extension of benefits.--
566 (1) Every group health maintenance contract shall provide
567 that termination of the contract shall be without prejudice to
568 any continuous loss which commenced while the contract was in

569 force, but any extension of benefits beyond the period the
570 contract was in force may be predicated upon the continuous
571 total disability of the subscriber ~~and may be limited to payment~~
572 ~~for the treatment of a specific accident or illness incurred~~
573 ~~while the subscriber was a member~~. The extension is required
574 regardless of whether the group contract holder or other entity
575 secures replacement coverage from a new insurer or health
576 maintenance organization or foregoes the provision of coverage.
577 The required provision must provide for continuation of contract
578 benefits in connection with the treatment of a specific accident
579 or illness incurred while the contract was in effect. Such
580 extension of benefits may be limited to the occurrence of the
581 earliest of the following events:
582 (a) The expiration of 12 months.
583 (b) Such time as the member is no longer totally disabled.
584 (c) A succeeding carrier elects to provide replacement
585 coverage without limitation as to the disability condition.
586 (d) The maximum benefits payable under the contract have
587 been paid.
588 Section 14. Subsection (22) is added to section 641.19,
589 Florida Statutes, to read:
590 641.19 Definitions.--As used in this part, the term:
591 (22) "Specialty" or "specialist" shall not include the
592 services by a physician licensed under chapter 460.
593 Section 15. If any provision of this act or the
594 application thereof to any person or circumstance is held
595 invalid, the invalidity shall not affect other provisions or
596 applications of the act which can be given effect without the

597 invalid provision or application, and to this end the provisions
598 of this act are declared severable.
599 Section 16. Except as otherwise provided herein, this act
600 shall take effect upon becoming a law.
601
602 ================ T I T L E A M E N D M E N T =================
603
604 Remove the entire title, and insert:
605
606 A bill to be entitled
607 An act relating to health insurance; amending s. 395.301,
608 F.S.; requiring health care providers and facilities to
609 provide prospective patients with reasonable estimates of
610 prospective charges; requiring certain licensed facilities
611 to make available to payors certain records; providing that
612 the facility may not charge for making records available
613 but may charge a specified amount for providing copies;
614 amending s. 408.909, F.S.; revising a definition;
615 authorizing plans to limit the term of coverage; extending
616 the required period without coverage before participation
617 eligibility; authorizing a business purchasing arrangement
618 sponsored by a local government subject to specified
619 limitations; extending a program expiration date; amending
620 s. 627.410, F.S.; exempting individuals and certain groups
621 from laws restricting or limiting coinsurance, copayments,
622 or annual or lifetime maximum payments; creating s.
623 627.6410, F.S.; providing for optional coverage in health
624 insurance policies for speech, language, swallowing, and
625 hearing disorders; providing exclusion; providing

626 exceptions; providing a limitation; amending s. 627.6487,
627 F.S.; revising a definition of "eligible individual" for
628 purposes of availability of individual health insurance
629 coverage; authorizing insurers to impose certain surcharges
630 or premium charges for creditable coverage earned in
631 certain states; amending s. 627.6561, F.S.; requiring
632 additional information in a certification relating to
633 certain creditable coverage for purposes of eligibility for
634 exclusion from preexisting condition requirements; amending
635 s. 627.667, F.S.; deleting a limitation on certain
636 application of extension of benefits provisions; creating
637 s. 627.66912, F.S.; providing for optional coverage in
638 group, blanket, and franchise health insurance policies for
639 speech, language, swallowing, and hearing disorders;
640 providing exclusion; providing exceptions; providing a
641 limitation; amending s. 627.6692, F.S.; extending a time
642 period for continuation of certain coverage under group
643 health plans; amending s. 627.6699, F.S.; revising certain
644 definitions; revising enrollment period criteria for
645 certain health benefit plans; requiring small employers to
646 provide certain health benefit plan information to
647 employees; providing a limitation; revising certain rate
648 adjustment criteria; authorizing separation of experience
649 of certain small employer groups for certain purposes;
650 amending s. 641.31, F.S.; specifying nonapplication of
651 certain health maintenance contract filing requirements to
652 certain group health insurance policies, with exceptions;
653 requiring health maintenance organizations to make available
654 coverage for certain speech, language, swallowing, and

655 hearing disorders or conditions, subject to certain
656 criteria and limits, effective July 1, 2004; requiring
657 health maintenance organizations to provide specific
658 information to subscribers; creating s. 641.31075, F.S.;
659 providing compliance requirements for health maintenance
660 organizations replacing certain coverages; amending s.
661 641.3111, F.S.; providing additional requirements for
662 extension of benefits under group health maintenance
663 contracts; amending s. 641.19, F.S.; defining the term
664 "specialty" or "specialist" to exclude services by a
665 chiropractic physician; providing severability; providing
666 effective dates.
667
668