CHAPTER 98-159

Committee Substitute for
Committee Substitute for Senate Bill No. 1800

An act relating to health insurance; amending s. 222.21, F.S.; exempting moneys paid into a Roth individual retirement account from creditors' claims; amending s. 222.22, F.S.; exempting moneys paid into a Medical Savings Account from attachment, garnishment, or legal process; amending s. 627.410, F.S.; exempting certain policies from rating requirements; amending s. 627.6425, F.S.; specifying exceptions to guaranteed renewability of individual health insurance policies; amending s. 627.6487, F.S.; redefining the term "eligible individual" for purposes of guaranteed-issuance of an individual health insurance policy; amending s. 627.6498, F.S.; requiring the Department of Insurance to annually establish standard risk rates for purposes of determining premium rates of coverage issued by the Florida Comprehensive Health Association; amending s. 627.6571, F.S.; specifying exceptions to guaranteed renewability of group health insurance policies; amending s. 627.6575, F.S.; providing that coverage may not be denied if specified notice is given; amending s. 627.6415, F.S.; providing that coverage may not be denied if specified notice is given; amending s. 627.6578, F.S.; providing that coverage may not be denied if specified notice is given; amending s. 627.6675, F.S.; requiring the Department of Insurance to annually establish standard risk rates for purposes of determining maximum premiums for conversion policies; revising standards for renewal of converted insurance policies; requiring the insurer to mail certain information to a person eligible for a converted policy, upon request; creating s. 627.6685, F.S.; requiring health insurers and health maintenance organizations to include in their plans that offer mental health coverage certain mental health benefits that are not less favorable than those for medical or surgical benefits covered by the plan; defining terms; providing exemptions; limiting applicability of this section; amending s. 627.6699, F.S.; redefining the term "health benefit plan" as used in the Employee Health Care Access Act; amending s. 627.674, F.S.; revising the minimum standards for Medicare Supplement policies; amending s. 627.6741, F.S.; revising requirements for insurers to issue, cancel, nonrenew, and replace Medicare supplement policies; restricting preexisting-condition exclusions; authorizing the Department of Insurance to adopt rules governing guaranteed issue of Medicare supplement coverage for continuously covered individuals; amending s. 627.9403, F.S.; specifying the provisions of the Long-term Care Insurance Act that apply to limited benefit policies; amending s. 627.9404, F.S.; defining the terms "limited benefit policy" and "qualified long-term care limited benefit insurance policy"; amending s. 627.9407, F.S.; revising the requirements for exclusion of coverage for preexisting conditions for long-term care policies; requiring limited-benefit policies to contain a disclosure statement regarding their qualification for favorable tax

treatment; amending s. 627.94073, F.S.; revising the notice requirement for long-term care policies regarding the right to designate a secondary person to receive notice of lapse of coverage; amending s. 641.225, F.S.; increasing surplus requirements for health maintenance organizations; amending s. 641.285, F.S.; increasing deposit requirements for health maintenance organizations; revising exceptions; amending s. 641.26, F.S.; requiring health maintenance organizations to file certain reports with the Department of Insurance; requiring that health maintenance organizations provide additional information upon the request of the department; amending s. 641.31, F.S.; providing that coverage may not be denied if specified notice is given; amending s. 641.31074, F.S.; revising requirements for guaranteed renewability of a health maintenance organization contract; amending s. 641.3111, F.S.; requiring health maintenance organization contracts to provide for an extension of benefits upon termination of the contract; amending s. 641.316, F.S.; revising the amount of the bond that a fiscal intermediary services organization is required to maintain; specifying certain additional requirements and conditions for the bond and the intermediary; amending s. 641.3922, F.S.; revising the method for establishing the maximum premium for converted contracts issued by health maintenance organizations; revising the exceptions to guaranteed renewability of converted health maintenance organization contracts; requiring a health maintenance organization to mail certain information to a person eligible for a converted contract; amending s. 641.495, F.S.; exempting from licensure under part I of ch. 395, F.S., certain beds of a health maintenance organization; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) of section 222.21, Florida Statutes, is amended to read:

222.21 Exemption of pension money and retirement or profit-sharing benefits from legal processes.—

(2)(a) Except as provided in paragraph (b), any money or other assets payable to a participant or beneficiary from, or any interest of any participant or beneficiary in, a retirement or profit-sharing plan that is qualified under s. 401(a), s. 403(a), s. 403(b), s. 408, s. 408A, or s. 409 of the Internal Revenue Code of 1986, as amended, is exempt from all claims of creditors of the beneficiary or participant.

Section 2. Section 222.22, Florida Statutes, is amended to read:

222.22 Exemption of moneys in the Prepaid Postsecondary Education Expense Trust Fund and in a Medical Savings Account from legal process.—

(1) Moneys paid into or out of the Prepaid Postsecondary Education Expense Trust Fund by or on behalf of a purchaser or qualified beneficiary pursuant to an advance payment contract made under s. 240.551, which contract has not been terminated, are not liable to attachment, garnish-

ment, or legal process in the state in favor of any creditor of the purchaser or beneficiary of such advance payment contract.

(2) Moneys paid into or out of a Medical Savings Account by or on behalf of a person depositing money into such account or a qualified beneficiary are not liable to attachment, garnishment, or legal process in the state in favor of any creditor of such person or beneficiary of such Medical Savings Account.

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

627.410 Filing, approval of forms.—

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the department a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the department applicable premium rates and any change in applicable premium rates.

(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. 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.

(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, shall be prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.

2. Premium class definitions which classify insured based on year of issue or duration since issue.

3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides to the department in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the department, the insurer shall no longer offer for sale the policy form or certificate form in this state.

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 5 years after the insurer provides notice to the department of the discontinuance. The period of discontinuance may be reduced if the department determines that a shorter period is appropriate.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes.

Section 4. Subsection (3) of section 627.6425, Florida Statutes, is amended to read:

627.6425 Renewability of individual coverage.—

(3)(a) In any case in which an insurer decides to discontinue offering a particular policy form for health insurance coverage offered in the individual market, coverage under such form may be discontinued by the insurer only if:

1. The insurer provides notice to each covered individual provided coverage under this policy form in the individual market of such discontinuation at least 90 days prior to the date of the nonrenewal ~~discontinuation~~ of such coverage;

2. The insurer offers to each individual in the individual market provided coverage under this policy form the option to purchase any other individual health insurance coverage currently being offered by the insurer for individuals in such market in the state; and

3. In exercising the option to discontinue coverage of this policy form and in offering the option of coverage under subparagraph 2., the insurer acts uniformly without regard to any health-status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(b)1. Subject to subparagraph (a)3., in any case in which an insurer elects to discontinue offering all health insurance coverage in the individual market in this state, health insurance coverage may be discontinued by the insurer only if:

a. The insurer provides notice to the department and to each individual of such discontinuation at least 180 days prior to the date of the nonrenewal ~~expiration~~ of such coverage; and

b. All health insurance issued or delivered for issuance in the state in the individual market is discontinued and coverage under such health insurance coverage in such market is not renewed.

2. In the case of a discontinuation under subparagraph 1. in the individual market, the insurer may not provide for the issuance of any individual health insurance coverage in this state during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

Section 5. Subsection (3) of section 627.6487, Florida Statutes, is amended 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:

(a)1. For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage, as defined in s. 627.6561(5) and (6), is 18 or more months; and

2.a. Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan; or

b. Whose most recent prior creditable coverage was under an individual plan issued by a health insurer or health maintenance organization, which coverage is terminated due to the insurer or health maintenance organization becoming insolvent or discontinuing the offering of all individual coverage in the state, or due to the insured no longer living in the service area of the insurer or health maintenance organization that provides coverage through a network plan;

(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 employer plan;

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;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph ~~(1)~~(a) was not terminated based on a factor described in s. 627.6571(2)(a) or (b), relating to nonpayment of premiums or fraud, unless such nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

(d) Who, having been offered the option of continuation coverage under a COBRA continuation provision or under s. 627.6692, elected such coverage; and

(e) Who, if the individual elected such continuation provision, has exhausted such continuation coverage under such provision or program.

Section 6. Paragraph (a) of subsection (4) of section 627.6498, Florida Statutes, is amended to read:

627.6498 Minimum benefits coverage; exclusions; premiums; deductibles.—

(4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.—

(a) The plan shall provide for annual deductibles for major medical expense coverage in the amount of $1,000 or any higher amounts proposed by the board and approved by the department, plus the benefits payable under any other type of insurance coverage or workers' compensation. The schedule of premiums and deductibles shall be established by the association. With regard to any preferred provider arrangement utilized by the association, the deductibles provided in this paragraph shall be the minimum deductibles applicable to the preferred providers and higher deductibles, as approved by the department, may be applied to providers who are not preferred providers.

1. Separate schedules of premium rates based on age may apply for individual risks.

2. Rates are subject to approval by the department.

3. Standard risk rates for coverages issued by the association shall be established by the department, pursuant to s. 627.6675(3) ~~association, subject to approval by the department, using reasonable actuarial techniques, and shall reflect anticipated experience and expenses of such coverages for standard risks~~.

4. The board shall establish separate premium schedules for low-risk individuals, medium-risk individuals, and high-risk individuals and shall revise premium schedules annually ~~pursuant to this section for each 6-month policy period~~ beginning January 1999 ~~1992~~. ~~For the calendar year 1991 and thereafter,~~ No rate shall exceed 200 percent of the standard risk rate for low-risk individuals, 225 percent of the standard risk rate for medium-risk individuals, or 250 percent of the standard risk rate for high-risk individuals. For the purpose of determining what constitutes a low-risk individual, medium-risk individual, or high-risk individual, the board shall consider the anticipated claims payment for individuals based upon an individual's health condition.

Section 7. Paragraphs (a) and (b) of subsection (3) of section 627.6571, Florida Statutes, are amended to read:

627.6571 Guaranteed renewability of coverage.—

(3)(a) An insurer may discontinue offering a particular policy form of group health insurance coverage offered in the small-group market or large-group market only if:

1. The insurer provides notice to each policyholder provided coverage of this form in such market, and to participants and beneficiaries covered under such coverage, of such discontinuation at least 90 days prior to the date of the nonrenewal ~~discontinuation~~ of such coverage;

2. The insurer offers to each policyholder provided coverage of this form in such market the option to purchase all, or in the case of the large-group market, any other health insurance coverage currently being offered by the insurer in such market; and

3. In exercising the option to discontinue coverage of this form and in offering the option of coverage under subparagraph 2., the insurer acts uniformly without regard to the claims experience of those policyholders or any health-status-related factor that relates to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(b)1. In any case in which an insurer elects to discontinue offering all health insurance coverage in the small-group market or the large-group market, or both, in this state, health insurance coverage may be discontinued by the insurer only if:

a. The insurer provides notice to the department and to each policyholder, and participants and beneficiaries covered under such coverage, of such discontinuation at least 180 days prior to the date of the nonrenewal ~~discontinuation~~ of such coverage; and

b. All health insurance issued or delivered for issuance in this state in such market ~~markets~~ is discontinued and coverage under such health insurance coverage in such market is not renewed.

2. In the case of a discontinuation under subparagraph 1. in a market, the insurer may not provide for the issuance of any health insurance coverage in the market in this state during the 5-year period beginning on the date of the discontinuation of the last insurance coverage not renewed.

Section 8. Subsection (4) of section 627.6575, Florida Statutes, is amended to read:

627.6575 Coverage for newborn children.—

(4) A policy or contract may require the insured to notify the insurer of the birth of a child within a time period, as specified in the policy, of not less than 30 days after the birth. If timely notice is given, the insurer may not charge an additional premium for coverage of the newborn child for the duration of the notice period. If timely notice is not given, the insurer may charge an additional premium from the date of birth. If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

Section 9. Subsection (2) of section 627.6415, Florida Statutes, is amended to read:

627.6415 Coverage for natural-born, adopted, and foster children; children in insured's custodial care.—

(2) A policy may require the insured to notify the insurer of the birth or placement of an adopted child within a specified time period of not less than 30 days after the birth or placement in the residence of a child adopted by the insured. If timely notice is given, the insurer may not charge an additional premium for coverage of the child for the notice period. If timely notice is not given, the insurer may charge an additional premium from the date of birth or placement. If notice is given within 60 days of the birth or placement of the child, the insurer may not deny coverage for the child due to the failure of the insured to timely notify the insurer of the birth or placement of the child.

Section 10. Subsection (2) of section 627.6578, Florida Statutes, is amended to read:

627.6578 Coverage for natural-born, adopted, and foster children; children in insured's custodial care.—

(2) A policy or contract may require the insured to notify the insurer of the birth or placement of an adopted child within a specified time period of not less than 30 days after the birth or placement in the residence of a child adopted by the insured. If timely notice is given, the insurer may not charge an additional premium for coverage of the child for the duration of the notice period. If timely notice is not given, the insurer may charge an additional premium from the date of birth or placement. If notice is given within 60 days of the birth or placement of the child, the insurer may not deny coverage for the child due to the failure of the insured to timely notify the insurer of the birth or placement of the child.

Section 11. Subsection (3), paragraph (b) of subsection (7), and subsection (17) of section 627.6675, Florida Statutes, are amended to read:

627.6675 Conversion on termination of eligibility.—Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR GROUP COVERAGE.—

(a) The premium for the converted policy shall be determined in accordance with premium rates applicable to the age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. However, the premium for the converted policy may not exceed 200 percent of the standard risk rate as established by the department, pursuant to this subsection ~~Florida Comprehensive Health Association, adjusted for differences in benefit levels and structure between the converted policy and the policy offered by the Florida Comprehensive Health Association~~.

(b) Actual or expected experience under converted policies may be combined with such experience under group policies for the purposes of determining premium and loss experience and establishing premium rate levels for group coverage.

(c) The department shall annually determine standard risk rates, using reasonable actuarial techniques and standards adopted by the department by rule. The standard risk rates must be determined as follows:

1. Standard risk rates for individual coverage must be determined separately for indemnity policies, preferred provider/exclusive provider policies, and health maintenance organization contracts.

2. The department shall survey insurers and health maintenance organizations representing at least an 80 percent market share, based on premiums earned in the state for the most recent calendar year, for each of the categories specified in subparagraph 1.

3. Standard risk rate schedules must be determined, computed as the average rates charged by the carriers surveyed, giving appropriate weight to each carrier's statewide market share of earned premiums.

4. The rate schedule shall be determined from analysis of the one county with the largest market share in the state of all such carriers.

5. The rate for other counties must be determined by using the weighted average of each carrier's county factor relationship to the county determined in subparagraph 4.

6. The rate schedule must be determined for different age brackets and family-size brackets.

(7) INFORMATION REQUESTED BY INSURER.—

(b) The converted policy may provide that the insurer may refuse to renew the policy or the coverage of any person only for one or more of the following reasons:

1. Either the benefits provided under the sources referred to in subparagraphs (a)1. and 2. for the person or the benefits provided or available under the sources referred to in subparagraph (a)3. for the person, together with

the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards on file with the department.

2. The converted policyholder fails to provide the information requested pursuant to paragraph (a).

3. Fraud or intentional ~~material~~ misrepresentation in applying for any benefits under the converted policy.

~~4. Eligibility of the insured person for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.~~

4.~~5.~~ Other reasons approved by the department.

(17) NOTIFICATION.—A notification of the conversion privilege shall be included in each certificate of coverage. The insurer shall mail an election and premium notice form, including an outline of coverage, on a form approved by the department, within 14 days after an individual who is eligible for a converted policy gives notice to the insurer that the individual is considering applying for the converted policy or otherwise requests such information. The outline of coverage must contain a description of the principal benefits and coverage provided by the policy and its principal exclusions and limitations, including, but not limited to, deductibles and coinsurance.

Section 12. Section 627.6685, Florida Statutes, is created to read:

627.6685 Mental health coverage.—

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

(a) "Aggregate lifetime limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(b) "Annual limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(c) "Medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage, but does not include mental health benefits.

(d) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of the plan or coverage, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

(e) "Health insurance coverage" means coverage provided by an authorized insurer or by a health maintenance organization.

(2) BENEFITS.—

(a)1. In the case of a group health plan, or health insurance coverage offered in connection with such a plan, which provides both medical and surgical benefits and mental health benefits:

a. If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

b. If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage must:

(I) Apply that applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(II) Not include any aggregate lifetime limit on mental health benefits which is less than that applicable lifetime limit.

c. For any plan or coverage that is not described in sub-subparagraph a. or sub-subparagraph b. and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the department shall establish rules under which sub-subparagraph b. is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

2. In the case of a group health plan, or health insurance coverage offered in connection with such a plan, which provides both medical and surgical benefits and mental health benefits:

a. If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

b. If the plan or coverage includes an annual limit on substantially all medical and surgical benefits, the plan or coverage must:

(I) Apply that applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(II) Not include any annual limit on mental health benefits which is less than the applicable annual limit.

c. For any plan or coverage that is not described in sub-subparagraph a. or sub-subparagraph b. and that includes no or different annual limits on different categories of medical and surgical benefits, the department shall establish rules under which sub-subparagraph b. is applied to such plan or coverage with respect to mental health benefits by substituting for the

applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(b) This section may not be construed:

1. As requiring a group health plan, or health insurance coverage offered in connection with such a plan, to provide any mental health benefits; or

2. In the case of a group health plan, or health insurance coverage offered in connection with such a plan, which provides mental health benefits, as affecting the terms and conditions, including cost-sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity, relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in paragraph (a) with respect to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

(3) EXEMPTIONS.—

(a) This section does not apply to any group health plan, or group health insurance coverage offered in connection with a group health plan, for any plan year of a small employer as defined in s. 627.6699.

(b) This section does not apply with respect to a group health plan, or health insurance coverage offered in connection with a group health plan, if the application of this section to such plan or coverage results in an increase in the cost under the plan or for such coverage of at least 1 percent.

(4) SEPARATE APPLICATION TO EACH OPTION OFFERED.—For any group health plan that offers a participant or beneficiary two or more benefit-package options under the plan, the requirements of this section apply separately with respect to each such option.

(5) DURATION.—This section does not apply to benefits for services furnished on or after September 30, 2001.

(6) CONFLICTING PROVISIONS.—The provisions of this section prevail over any conflicting provision of s. 627.668.

Section 13. Paragraph (k) of subsection (3) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.—

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

(k) "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying

health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

Section 14. Paragraphs (a) and (d) of subsection (2) and subsection (3) of section 627.674, Florida Statutes, are amended to read:

627.674 Minimum standards; filing requirements.—

(2)(a) The department must adopt rules establishing minimum standards for Medicare supplement policies that, taken together with the requirements of this part, are no less comprehensive or beneficial to persons insured or covered under Medicare supplement policies issued, delivered, or issued for delivery in this state, including certificates under group or blanket policies issued, delivered, or issued for delivery in this state, than the standards provided in 42 U.S.C. Section 1395ss, or the most recent version of the NAIC Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act adopted by the National Association of Insurance Commissioners ~~on July 31, 1991, or the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508)~~.

(d) For policies issued on or after January 1, 1991, the department may adopt rules to establish minimum policy standards to authorize the types of policies specified by 42 U.S.C. Section 1395ss(p)(2)(C) and any optional benefits to facilitate policy comparisons.

(3) A policy may not be filed with the department as a Medicare supplement policy unless the policy meets or exceeds~~, either in a single policy or, in the case of nonprofit health care services plans, in one or more policies issued in conjunction with one another,~~ the requirements of 42 U.S.C. Section 1395ss, or the most recent version of the NAIC Medicare Supplement Insurance Minimum Standards Model Act, adopted by the National Association of Insurance Commissioners ~~on July 31, 1991, and the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508)~~.

Section 15. Section 627.6741, Florida Statutes, is amended to read:

627.6741 Issuance, cancellation, nonrenewal, and replacement.—

(1) An insurer issuing Medicare supplement policies in this state shall offer the opportunity of enrolling in a Medicare supplement policy, without conditioning the issuance or effectiveness of the policy on, and without discriminating in the price of the policy based on, the medical or health status or receipt of health care by the individual:

(a) To any individual who is 65 years of age or older and who resides in this state, upon the request of the individual during the 6-month period beginning with the first month in which the individual has attained 65 years of age and is enrolled in Medicare part B; or

(b) To any individual who is 65 years of age or older and is enrolled in Medicare part B, who resides in this state, upon the request of the individual

during the 2-month period following termination of coverage under a group health insurance policy.~~;~~

A Medicare supplement policy issued to an individual under paragraph (a) or paragraph (b) may not exclude benefits based on a pre-existing condition if the individual has a continuous period of creditable coverage, as defined in s. 627.6561(5), of at least 6 months as of the date of application for coverage.

~~the opportunity of enrolling in a Medicare supplement policy, without conditioning the issuance or effectiveness of the policy on, and without discriminating in the price of the policy based on, the medical or health status or receipt of health care by the individual.~~

(2) For both individual and group Medicare supplement policies:

(a) An insurer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If it is not replacing an existing policy, a Medicare supplement policy shall not limit or preclude liability under the policy for a period longer than 6 months because of a health condition existing before the policy is effective. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(c) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate or creditable coverage as defined in s. 627.6561(5) ~~a group health insurance policy or certificate~~, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original policy, subject to the requirements of s. 627.6561(6)-(11).

(3) For group Medicare supplement policies:

(a) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph (c), the insurer shall offer certificateholders an individual Medicare supplement policy. The insurer shall offer the certificateholder at least the following choices:

1. An individual Medicare supplement policy that provides for continuation of the benefits contained in the group policy.

2. An individual Medicare supplement policy that provides only the benefits required to meet the minimum standards.

(b) If membership in a group is terminated, the insurer shall:

1. Offer the certificateholder conversion opportunities specified in paragraph (a); or

2. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(c) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(4) If a policy is canceled, the insurer must return promptly the unearned portion of any premium paid. If the insured cancels the policy, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.

(5) The department shall by rule prescribe standards relating to the guaranteed issue of coverage, without exclusions for preexisting conditions, for continuously covered individuals consistent with the provisions of 42 U.S.C. Section 1395ss(s)(3).

Section 16. Section 627.9403, Florida Statutes, is amended to read:

627.9403 Scope.—The provisions of this part shall apply to long-term care insurance policies delivered or issued for delivery in this state, and to policies delivered or issued for delivery outside this state to the extent provided in s. 627.9406, by an insurer, a fraternal benefit society as defined in s. 632.601, a health care services plan as defined in s. 641.01, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, or a multiple-employer welfare arrangement as defined in s. 624.437. A policy which is advertised, marketed, or offered as a long-term care policy and as a Medicare supplement policy shall meet the requirements of this part and the requirements of ss. 627.671-627.675 and, to the extent of a conflict, be subject to the requirement that is more favorable to the policyholder or certificateholder. The provisions of this part shall not apply to a continuing care contract issued pursuant to chapter 651 and shall not apply to guaranteed renewable policies issued prior to October 1, 1988. Any limited benefit policy that limits coverage to care in a nursing home or to one or more lower levels of care required or authorized to be provided by this part or by department rule must meet all requirements of this part that apply to long-term care insurance policies, except s. 627.9407(3)(c), (9), (10)(f), and (12), and s. 627.94073(2) ~~s. 627.9407(3)(c) and (9)~~. If the limited benefit policy does not provide coverage for care in a nursing home, but does provide coverage for one or more lower levels of care, the policy shall also be exempt from the requirements of s. 627.9407(3)(d).

Section 17. Section 627.9404, Florida Statutes, is amended to read:

627.9404 Definitions.—For the purposes of this part:

(1) "Long-term care insurance policy" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(2) "Applicant" means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

(b) In the case of a group long-term care insurance policy, the proposed certificateholder.

(3) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(4) "Chronically ill" means certified by a licensed health care practitioner as:

(a) Being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

(b) Requiring substantial supervision for protection from threats to health and safety due to severe cognitive impairment.

(5) "Cognitive impairment" means a deficiency in a person's short-term or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(6) "Licensed health care practitioner" means any physician, nurse licensed under chapter 464, or psychotherapist licensed under chapter 490 or chapter 491, or any individual who meets any requirements prescribed by rule by the department.

(7) "Limited benefit policy" means any policy that limits coverage to care in a nursing home or to one or more lower levels of care required or authorized to be provided by this part or by department rule.

(8)~~(7)~~ "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the

disabilities as a result of which the individual is a chronically ill individual, including the protection from threats to health and safety due to severe cognitive impairment.

(9)~~(8)~~ "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by any of the entities specified in s. 627.9403.

(10) "Qualified limited benefit insurance policy" means an accident and health insurance contract as defined in s. 7702B of the Internal Revenue Code and all applicable sections of this part.

(11)~~(9)~~ "Qualified long-term care services" means necessary diagnostic, preventive, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(12)~~(10)~~ "Qualified long-term care insurance policy" means an accident and health insurance contract as defined in s. 7702B of the Internal Revenue Code and all applicable sections of this part.

Section 18. Paragraph (a) of subsection (4) of section 627.9407, Florida Statutes, is amended, and subsection (13) is added to that section, to read:

627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—

(4) PREEXISTING CONDITION.—

(a) A long-term care insurance policy or certificate, other than a policy or certificate issued to a group referred to in s. 627.9405(1)(a), may not use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" means ~~the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or~~ a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person.

(13) ADDITIONAL DISCLOSURE.—A limited benefit policy qualified under s. 7702B of the Internal Revenue Code must include a disclosure statement within the policy and within the outline of coverage that the policy is intended to be a qualified limited benefit insurance contract. A limited benefit policy that is not intended to be a qualified limited benefit insurance contract must include a disclosure statement within the policy and within the outline of coverage that the policy is not intended to be a qualified limited benefit insurance contract. The disclosure must be prominently displayed and must read as follows: "This limited benefit insurance policy is not intended to be a qualified limited benefit insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about such potential income tax consequences."

Section 19. Subsection (2) of section 627.94073, Florida Statutes, is amended to read:

627.94073 Notice of cancellation; grace period.—

(2) A long-term care policy may not be canceled for nonpayment of premium unless, after expiration of the grace period in subsection (1), and at least 30 days prior to the effective date of such cancellation, the insurer has mailed a notification of possible lapse in coverage to the policyholder and to a specified secondary addressee if such addressee has been designated in writing by name and address by the policyholder. For policies issued or renewed on or after October 1, 1996, the insurer shall notify the policyholder, at least once every 2 years, of the right to designate a secondary addressee. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse.—I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care or limited benefit ~~long-term care~~ insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice." Notice shall be given by first class United States mail, postage prepaid, and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

Section 20. Subsections (1) and (2) of section 641.225, Florida Statutes, are amended to read:

641.225 Surplus requirements.—

(1) Each health maintenance organization shall at all times maintain a minimum surplus in an amount that ~~which~~ is the greater of $1,500,000, ~~$500,000~~ or 10 percent of total liabilities, or 2 percent of total annualized premium. All health maintenance organizations that ~~which~~ have a valid certificate of authority before October 1, 1998 ~~1988~~, or an entity described in subsection (3), and that ~~which~~ do not meet the minimum surplus requirement, shall increase their surplus as follows:

Date	Amount
September 30, 1998 ~~1989~~	$800,000, ~~$200,000~~ or 10 ~~6~~ percent of total liabilities, or 1 percent of annualized premium, whichever is greater
September 30, 1999 ~~1990~~	$1,150,000, ~~$350,000~~ or 10 ~~8~~ percent of total liabilities, or 1.25 percent of annualized premium, whichever is greater
September 30, 2000 ~~1991~~	$1,500,000, ~~$500,000~~ or 10 percent of total liabilities, or 2 percent of annualized premium, whichever is greater

(2) The department shall not issue a certificate of authority, except as provided in subsection (3), unless the health maintenance organization has a minimum surplus in an amount which is the greater of:

~~(a) $1,500,000;~~

(a)~~(b)~~ Ten percent of their total liabilities based on their startup ~~actuarial~~ projection as set forth in this part; ~~or~~

(b) Two percent of their total projected premiums based on their startup projection as set forth in this part; or

(c) $1,500,000, ~~$500,000~~ plus all startup losses, excluding profits, projected to be incurred on their startup ~~actuarial~~ projection until the projection reflects statutory net profits for 12 consecutive months.

Section 21. Section 641.285, Florida Statutes, is amended to read:

641.285 Insolvency protection.—

(1) ~~Unless otherwise provided in this section,~~ Each health maintenance organization shall deposit with the department cash or securities of the type eligible under s. 625.52, which shall have at all times a market value in the amount set forth in this subsection. The amount of the deposit shall be reviewed annually, or more often, as the department deems necessary. The market value of the deposit shall be a minimum of $300,000. ~~the greater of:~~

~~(a) Twice its reasonably estimated average monthly uncovered expenditures; or~~

~~(b) $100,000.~~

(2) If securities or assets deposited by a health maintenance organization under this part are subject to material fluctuations in market value, the department may, in its discretion, require the organization to deposit and maintain on deposit additional securities or assets in an amount as may be reasonably necessary to assure that the deposit will at all times have a market value of not less than the amount specified under this section.

~~(a)~~ If for any reason the market value of assets and securities of a health maintenance organization held on deposit in this state under this code falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency. If the health maintenance organization has failed to cure the deficiency within 30 days after receipt of notice thereof by registered or certified mail from the department, the department may revoke the certificate of authority of the health maintenance organization.

~~(b) A health maintenance organization may, at its option, deposit assets or securities in an amount exceeding its deposit required or otherwise permitted under this code by not more than 20 percent of the required or permitted deposit, or $20,000, whichever is the larger amount, for the purpose of absorbing fluctuations in the value of securities and assets deposited~~

~~and to facilitate the exchange and substitution of securities and assets. During the solvency of the health maintenance organization, any excess shall be released to the organization upon its request. During the insolvency of the health maintenance organization, any excess deposit shall be released only as provided in s. 625.62.~~

(3) Whenever the department determines that the financial condition of a health maintenance organization has deteriorated to the point that the policyholders' or subscribers' best interests are not being preserved by the activities of a health maintenance organization, the department may require such health maintenance organization to deposit and maintain deposited in trust with the department for the protection of the health maintenance organization's policyholders, subscribers, and creditors, for such time as the department deems necessary, securities eligible for such deposit under s. 625.52 having a market value of not less than the amount that the department determines is necessary, which amount must not be less than $100,000 or greater than $2 million. The deposit required under this subsection is in addition to any other deposits required of a health maintenance organization pursuant to subsections (1) and (2). ~~The department shall waive the deposit requirements set forth in subsection (1) whenever it is satisfied that:~~

~~(a) The health maintenance organization has sufficient surplus and an adequate history of generating net income to assure its financial viability for the next year;~~

~~(b) The performance and obligations of the health maintenance organization are guaranteed by a guaranteeing organization of the type and subject to the same provisions as outlined in s. 641.225; or~~

~~(c) The assets of the health maintenance organization or its contracts with any insurer, health care provider, governmental entity, or other person are reasonably sufficient to assure the performance of the obligations of the organization.~~

(4) All income from deposits shall belong to the depositing health maintenance organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit, or any part thereof, after making a substitute deposit of cash or eligible securities or any combination of these or other acceptable measures of equal amount and value.

~~(5)(a) The requirements of this section do not apply to an applying or licensed health maintenance organization which has a plan, approved by the department, for handling insolvency which provides for continuation of benefits and payments to unaffiliated providers for services rendered both prior to and after insolvency for the duration of the contract period for which payment has been made, except that benefits to members who are confined on the date of insolvency in an inpatient facility shall be continued until their discharge. This plan shall include at least one of the following:~~

~~1. Contracts of insurance or reinsurance on file with the department that will protect subscribers in the event the health maintenance organization~~

~~is unable to meet its obligations. Each agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. Each agreement and any modification thereto shall be filed with and approved by the department. Each agreement shall remain in full force and in effect until replaced or for at least 90 days following written notification to the department by registered mail of cancellation or termination by either party. The department shall be endorsed on the agreement as an additional insured party;~~

~~2. Contractual arrangements with health care providers that include a guarantee by the provider to continue providing health care services to any subscriber of the health maintenance organization, upon insolvency of the organization, until the end of the contract period for which payment by or on behalf of the subscriber has been made or the discharge of the subscriber from an inpatient facility, whichever occurs later; or~~

~~3. Other measures acceptable to the department.~~

~~(b) The department shall reduce the deposit requirements specified in subsection (1) whenever the department has determined that the health maintenance organization has a plan for handling insolvency which partially meets the requirements of this section. The amount of the deposit reduction shall be based on the extent to which the organization meets the requirements of this section.~~

Section 22. Section 641.26, Florida Statutes, is amended to read:

641.26 Annual report.—

(1) Every health maintenance organization shall, annually within 3 months after the end of its fiscal year, or within an extension of time therefor as the department, for good cause, may grant, in a form prescribed by the department, file a report with the department, verified by the oath of two officers of the organization or, if not a corporation, of two persons who are principal managing directors of the affairs of the organization, properly notarized, showing its condition on the last day of the immediately preceding reporting period. Such report shall include:

(a) A financial statement of the health maintenance organization filed on a computer diskette using a format acceptable to the department.~~;~~

(b) A financial statement of the health maintenance organization filed on forms acceptable to the department.~~;~~

(c) An audited financial statement of the health maintenance organization, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant, prepared in accordance with statutory accounting principles.~~;~~

(d) The number of health maintenance contracts issued and outstanding and the number of health maintenance contracts terminated.~~;~~

(e) The number and amount of damage claims for medical injury initiated against the health maintenance organization and any of the providers

engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim.~~;~~

(f) An actuarial certification that:

1. The health maintenance organization is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of, the organization.~~;~~

2. The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed.~~;~~

3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.~~; and~~

(g) A report prepared by the Certified Public Accountant and filed with the department describing material weaknesses in the health maintenance organization's internal control structure as noted by the Certified Public Accountant during the audit. The report must be filed with the annual audited financial report as required in paragraph (c). The health maintenance organization shall provide a description of remedial actions taken or proposed to correct material weaknesses, if the actions are not described in the independent certified public accountant's report.

(h)~~(g)~~ Such other information relating to the performance of health maintenance organizations as is required by the department.

(2) The department may require updates of the actuarial certification as to a particular health maintenance organization if the department has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the health maintenance organization. Workpapers in support of the statement of the updated actuarial certification must be provided to the department upon request.

(3)~~(2)~~ Every health maintenance organization shall file quarterly, within 45 days after each of its quarterly reporting periods, an unaudited financial statement of the organization as described in paragraphs (1)(a) and (b). The quarterly report shall be verified by the oath of two officers of the organization, properly notarized.

(4)~~(3)~~ Any health maintenance organization that ~~which~~ neglects to file an annual report or quarterly report in the form and within the time required by this section shall forfeit up to $1,000 for each day for the first 10 days during which the neglect continues and shall forfeit up to $2,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the department to that effect, the organization's authority to enroll new subscribers or to do business in this state shall cease while such default continues. The department shall deposit all sums collected by it under this section to the credit of the Insurance Commissioner's Regulatory Trust Fund. The department shall not collect more than $100,000 for each report.

(5)~~(4)~~ Each authorized health maintenance organization shall retain an independent certified public accountant, ~~hereinafter~~ referred to in this section as "CPA," who agrees by written contract with the health maintenance

organization to comply with the provisions of this part. ~~The contract shall state:~~

(a) The CPA shall provide to the HMO audited financial statements consistent with this part.

(b) Any determination by the CPA that the health maintenance organization does not meet minimum surplus requirements as set forth in this part shall be stated by the CPA, in writing, in the audited financial statement.

(c) The completed work papers and any written communications between the CPA firm and the health maintenance organization relating to the audit of the health maintenance organization shall be made available for review on a visual-inspection-only basis by the department at the offices of the health maintenance organization, at the department, or at any other reasonable place as mutually agreed between the department and the health maintenance organization. The CPA must retain for review the work papers and written communications for a period of not less than 6 years.

(d) The CPA shall provide to the department a written report describing material weaknesses in the health maintenance organizations's internal control structure as noted during the audit.

(6)~~(5)~~ To facilitate uniformity in financial statements and to facilitate department analysis, the department may by rule adopt the form for financial statements of a health maintenance organization, including supplements as approved by the National Association of Insurance Commissioners in 1995, and may adopt subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each health maintenance organization to submit to the department all or part of the information contained in the annual statement in a computer-readable form compatible with the electronic data processing system specified by the department.

(7) In addition to information called for and furnished in connection with its annual or quarterly statements, the health maintenance organization shall furnish to the department as soon as reasonably possible such information as to its material transactions which, in the department's opinion, may have a material adverse effect on the health maintenance organizations financial condition, as the department may request in writing. All such information furnished pursuant to the department's request must be verified by the oath of two executive officers of the health maintenance organization.

(8) Each health maintenance organization shall file one copy of its annual statement convention blank in electronic form, along with such additional filings as prescribed by the department for the preceding year, with the National Association of Insurance Commissioners. Each health maintenance organization shall pay to the department a reasonable fee to cover costs associated with the filing and analysis of the documents by the National Association of Insurance Commissioners.

Section 23. Paragraph (a) of subsection (9) of section 641.31, is amended to read:

641.31 Health maintenance contracts.—

(9) All health maintenance contracts that provide coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, provide also that the coverage, benefits, or services applicable for children must be provided with respect to a newborn child of the subscriber, or covered family member of the subscriber, from the moment of birth. However, with respect to a newborn child of a covered family member other than the spouse of the insured or subscriber, the coverage for the newborn child terminates 18 months after the birth of the newborn child. The coverage, benefits, or services for newborn children must consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending physician as medically necessary to protect the health and safety of the newborn child.

(a) A contract may require the subscriber to notify the plan of the birth of a child within a time period, as specified in the contract, of not less than 30 days after the birth, or a contract may require the preenrollment of a newborn prior to birth. However, if timely notice is given, a plan may not charge an additional premium for additional coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not given, the plan may charge an additional premium from the date of birth. <u>If notice is given within 60 days of the birth of the child,</u> the contract may not deny coverage of the child due to failure of the subscriber to timely notify the plan of the birth of the child or to preenroll the child.

Section 24. Paragraph (d) of subsection (2), and paragraphs (a) and (b) of subsection (3) of section 641.31074, Florida Statutes, are amended to read:

641.31074 Guaranteed renewability of coverage.—

(2) A health maintenance organization may nonrenew or discontinue a contract based only on one or more of the following conditions:

(d) The health maintenance organization is ceasing to offer coverage in such a market in accordance with subsection (3) ~~and applicable state law~~.

(3)(a) A health maintenance organization may discontinue offering a particular contract form for group coverage offered in the small group market or large group market only if:

1. The health maintenance organization provides notice to each contract holder provided coverage of this form in such market, and participants and beneficiaries covered under such coverage, of such discontinuation at least 90 days prior to the date of the <u>nonrenewal</u> ~~discontinuation~~ of such coverage;

2. The health maintenance organization offers to each contract holder provided coverage of this form in such market the option to purchase all<u>, or in the case of the large-group market, any</u> other health insurance coverage

currently being offered by the health maintenance organization in such market; and

3. In exercising the option to discontinue coverage of this form and in offering the option of coverage under subparagraph 2., the health maintenance organization acts uniformly without regard to the claims experience of those contract holders or any health-status-related factor that relates to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(b)1. In any case in which a health maintenance organization elects to discontinue offering all coverage in the small group market or the large group market, or both, in this state, coverage may be discontinued by the insurer only if:

a. The health maintenance organization provides notice to the department and to each contract holder, and participants and beneficiaries covered under such coverage, of such discontinuation at least 180 days prior to the date of the nonrenewal ~~discontinuation~~ of such coverage; and

b. All health insurance issued or delivered for issuance in this state in such market is ~~markets are~~ discontinued and coverage under such health insurance coverage in such market is not renewed.

2. In the case of a discontinuation under subparagraph 1. in a market, the health maintenance organization may not provide for the issuance of any health maintenance organization contract coverage in the market in this state during the 5-year period beginning on the date of the discontinuation of the last insurance contract not renewed.

Section 25. 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 ~~by the health maintenance organization~~ 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. 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.

(2) For the purposes of this section, an individual is totally disabled if the individual has a condition resulting from an illness or injury which prevents an individual from engaging in any employment or occupation for which the individual is or may become qualified by reason of education, training, or experience, and the individual is under the regular care of a physician.

(3) In the case of maternity coverage, when not covered by the succeeding carrier, a reasonable extension of benefits or accrued liability provision is required, which provision provides for continuation of the contract benefits in connection with maternity expenses for a pregnancy that commenced while the policy was in effect. The extension shall be for the period of that pregnancy and shall not be based upon total disability.

(4) Except as provided in subsection (1), no subscriber is entitled to an extension of benefits if the termination of the contract by the health maintenance organization is based upon any event referred to in s. 641.3922(7)(a), (b), or (e)~~(a)-(g)~~.

Section 26. Section 641.316, Florida Statutes, is amended to read:

641.316 Fiscal intermediary services.—

(1) It is the intent of the Legislature, through the adoption of this section, to ensure the financial soundness of fiscal intermediary services organizations established to develop, manage, and administer the business affairs of health care professional providers such as medical doctors, doctors of osteopathy, doctors of chiropractic, doctors of podiatric medicine, doctors of dentistry, or other health professionals regulated by the Department of Health.

(2)(a) The term “fiduciary” or “fiscal intermediary services” means reimbursements received or collected on behalf of health care professionals for services rendered, patient and provider accounting, financial reporting and auditing, receipts and collections management, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations.

(b) The term “fiscal intermediary services organization” means a person or entity which performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance organizations other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health service organization licensed under chapter 636, a health maintenance organization licensed under this chapter, or physician group practices as defined in s. 455.654(3)(f) ~~s. 455.236(3)(f)~~.

(3) A fiscal intermediary services organization that ~~which~~ is operated for the purpose of acquiring and administering provider contracts with managed care plans for professional health care services, including, but not limited to, medical, surgical, chiropractic, dental, and podiatric care, and which performs fiduciary or fiscal intermediary services shall be required to secure and maintain a fidelity bond in the minimum amount of 10 percent

of the funds handled by the intermediary in connection with its fiscal and fiduciary services during the prior year or $1 million, whichever is less. The minimum bond amount shall be $50,000. The fidelity bond shall protect the fiscal intermediary from loss caused by the dishonesty of its employees and must remain unimpaired for as long as the intermediary continues in business in the state. ~~$10 million. This requirement shall apply to all persons or entities engaged in the business of providing fiduciary or fiscal intermediary services to any contracted provider or provider panel. The fidelity bond shall provide coverage against misappropriation of funds by the fiscal intermediary or its officers, agents, or employees; must be posted with the department for the benefit of managed care plans, subscribers, and providers; and must be on a form approved by the department. The fidelity bond must be maintained and remain unimpaired as long as the fiscal intermediary services organization continues in business in this state and until the termination of its registration.~~

(4) A fiscal intermediary services organization, as described in subsection (3), shall secure and maintain a surety bond on file with the department, naming the intermediary as principal. The bond must be obtained from a company authorized to write surety insurance in the state, and the department shall be obligee on behalf of itself and third parties. The penal sum of the bond may not be less than 5 percent of the funds handled by the intermediary in connection with its fiscal and fiduciary services during the prior year or $250,000, whichever is less. The minimum bond amount must be $10,000. The condition of the bond must be that the intermediary shall register with the department and shall not misappropriate funds within its control or custody as a fiscal intermediary or fiduciary. The aggregate liability of the surety for any and all breaches of the conditions of the bond may not exceed the penal sum of the bond. The bond must be continuous in form, must be renewed annually by a continuation certificate, and may be terminated by the surety upon its giving 30 days' written notice of termination to the department.

(5)~~(4)~~ A fiscal intermediary services organization may not collect from the subscriber any payment other than the copayment or deductible specified in the subscriber agreement.

(6)~~(5)~~ Any fiscal intermediary services organization, other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health service organization licensed under chapter 636, a health maintenance organization licensed under this chapter, or physician group practices as defined in s. 455.654(3)(f) ~~s. 455.236(3)(f)~~, must register with the department and meet the requirements of this section. In order to register as a fiscal intermediary services organization, the organization must comply with ss. 641.21(1)(c) and (d) and 641.22(6). Should the department determine that the fiscal intermediary services organization does not meet the requirements of this section, the registration shall be denied. In the event that the registrant fails to maintain compliance with the provisions of this section, the department may revoke or suspend the registration. In lieu of

revocation or suspension of the registration, the department may levy an administrative penalty in accordance with s. 641.25.

(7)~~(6)~~ The department shall adopt ~~promulgate~~ rules necessary to administer ~~implement the provisions of~~ this section.

Section 27. Subsections (3), (7), and (14) of section 641.3922, Florida Statutes, are amended to read:

641.3922 Conversion contracts; conditions.—Issuance of a converted contract shall be subject to the following conditions:

(3) CONVERSION PREMIUM.—The premium for the converted contract shall be determined in accordance with premium rates applicable to the age and class of risk of each person to be covered under the converted contract and to the type and amount of coverage provided. However, the premium for the converted contract may not exceed 200 percent of the standard risk rate, as established by the department under s. 627.6675(3) ~~Florida Comprehensive Health Association and adjusted for differences in benefit levels and structure between the converted policy and the policy offered by the Florida Comprehensive Health Association~~. The mode of payment for the converted contract shall be quarterly or more frequently at the option of the organization, unless otherwise mutually agreed upon between the subscriber and the organization.

(7) REASONS FOR CANCELLATION; TERMINATION.—The converted health maintenance contract must contain a cancellation or nonrenewability clause providing that the health maintenance organization may refuse to renew the contract of any person covered thereunder, but cancellation or nonrenewal must be limited to one or more of the following reasons:

(a) Fraud or intentional ~~material~~ misrepresentation, subject to the limitations of s. 641.31(23), in applying for any benefits under the converted health maintenance contract;

~~(b) Eligibility of the covered person for coverage under Medicare, Title XVIII of the Social Security Act, as added by the Social Security Amendments of 1965, or as later amended or superseded, or under any other state or federal law providing for benefits similar to those provided by the converted health maintenance contract, except for Medicaid, Title XIX of the Social Security Act, as amended by the Social Security Amendments of 1965, or as later amended or superseded.~~

(b)~~(c)~~ Disenrollment for cause, after following the procedures outlined in s. 641.3921(4).

(c)~~(d)~~ Willful and knowing misuse of the health maintenance organization identification membership card by the subscriber or the willful and knowing furnishing to the organization by the subscriber of incorrect or incomplete information for the purpose of fraudulently obtaining coverage or benefits from the organization.

~~(d)~~(e) Failure, after notice, to pay required premiums.

~~(e)~~(f) The subscriber has left the geographic area of the health maintenance organization with the intent to relocate or establish a new residence outside the organization's geographic area.

~~(f)~~(g) A dependent of the subscriber has reached the limiting age under the converted contract, subject to subsection (12); but the refusal to renew coverage shall apply only to coverage of the dependent, except in the case of handicapped children.

~~(g)~~(h) A change in marital status that makes a person ineligible under the original terms of the converted contract, subject to subsection (12).

(14) NOTIFICATION.—A notification of the conversion privilege shall be included in each health maintenance contract and in any certificate or member's handbook. The organization shall mail an election and premium notice form, including an outline of coverage, on a form approved by the department, within 14 days after any individual who is eligible for a converted health maintenance contract gives notice to the organization that the individual is considering applying for the converted contract or otherwise requests such information. The outline of coverage must contain a description of the principal benefits and coverage provided by the contract and its principal exclusions and limitations, including, but not limited to, deductibles and coinsurance.

Section 28. Subsection (12) is added to section 641.495, Florida Statutes, to read:

641.495 Requirements for issuance and maintenance of certificate.—

(12) The provisions of part I of chapter 395 do not apply to a health maintenance organization that, on or before January 1, 1991, provides not more than 10 outpatient holding beds for short-term and hospice-type patients in an ambulatory care facility for its members, provided that such health maintenance organization maintains current accreditation by the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association for Ambulatory Health Care, or the National Committee for Quality Assurance.

Section 29. This act shall take effect January 1, 1999.

Became a law without the Governor's approval May 22, 1998.

Filed in Office Secretary of State May 21, 1998.