CHAPTER 99-204

Committee Substitute for Senate Bill No. 312

An act relating to insurance; amending s. 626.321, F.S.; providing requirements for limited licenses for credit life or disability insurance and credit insurance; amending s. 626.989, F.S.; defining the terms "insurer" and "insurance policy" for purposes of determining insurance fraud; creating s. 626.9892, F.S.; establishing the Anti-Fraud Reward Program in the department; providing for rewards under certain circumstances; requiring the department to adopt rules to implement the program; exempting review of department decisions relating to rewards; creating s. 641.3915, F.S.; requiring certain health maintenance organizations to comply with insurer anti-fraud requirements; providing construction; amending s. 775.15, F.S.; extending the statute of limitations for certain insurance fraud violations; amending s. 817.234, F.S.; specifying a schedule of criminal penalties for committing insurance fraud; providing definitions; providing application to health maintenance organizations and contracts; amending s. 817.505, F.S.; revising a penalty for patient brokering; reenacting s. 455.657(3), F.S., relating to kickbacks, to incorporate changes; providing an appropriation; creating s. 624.6085, Florida Statutes; defining the term "collateral protection insurance"; amending s. 626.321, F.S.; providing requirements for limited licenses for credit life or disability insurance and credit insurance; amending s. 627.6645, F.S.; revising the notice requirements for cancellation or nonrenewal of a group health insurance policy; specifying conditions under which the insurer may retroactively cancel coverage due to nonpayment of premium; amending s. 627.6675, F.S.; revising the time limits for an employee or group member to apply for an individual converted policy when termination of group coverage is due to failure of the employer to pay the premium; revising the requirements for the premium for the converted policy; allowing a group insurer to contract with another insurer to issue an individual converted policy under certain conditions; amending s. 641.3108, F.S.; revising the notice requirements for cancellation or nonrenewal of a health maintenance organization contract; specifying conditions under which the organization may retroactively cancel coverage due to nonpayment of premium; amending s. 641.3922, F.S.; revising the time limits for an employee or group member to apply for a converted contract from a health maintenance organization when termination of group coverage is due to failure of the employer to pay the premium; revising the requirements for the premium for the converted contract; providing an effective date.

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

Section 1. Paragraphs (e) and (f) of subsection (1) of section 626.321, Florida Statutes, 1998 Supplement, are amended to read:

626.321 Limited licenses.—

(1) The department shall issue to a qualified individual, or a qualified individual or entity under paragraphs (c), (d), and (e), a license as agent authorized to transact a limited class of business in any of the following categories:

(e) Credit life or disability insurance.—License covering only credit life or disability insurance. The license may be issued only to an individual employed by a life or health insurer as an officer or other salaried or commissioned representative, or to an individual employed by or associated with a lending or financing institution or creditor, and may authorize the sale of such insurance only with respect to borrowers or debtors of such lending or financing institution or creditor. However, only the individual or entity whose tax identification number is used in receiving or is credited with receiving the commission from the sale of such insurance shall be the licensed agent of the insurer. No individual while so licensed shall hold a license as an agent or solicitor as to any other or additional kind or class of life or health insurance coverage. An entity other than a lending or financial institution defined in s. 626.988 holding a limited license under this paragraph shall also be authorized to sell credit property insurance. An entity applying for a license under this section:

1. Is required to submit only one application for a license under s. 626.171.

2. Is required to obtain a license for each office, branch office, or place of business making use of the entity's business name by applying to the department for the license on a simplified form developed by rule of the department for this purpose.

3. Is not required to pay any additional application fees for a license issued to the offices or places of business referenced in subsection (2), but is required to pay the license fee as prescribed in s. 624.501, be appointed under s. 626.112, and pay the prescribed appointment fee under s. 624.501. The license obtained under this paragraph shall be posted at the business location for which it was issued so as to be readily visible to prospective purchasers of such coverage.

(f) Credit insurance.—License covering only credit insurance, as such insurance is defined in s. 624.605(1)(i), and no individual or entity so licensed shall, during the same period, hold a license as an agent or solicitor as to any other or additional kind of life or health insurance with the exception of credit life or disability insurance as defined in paragraph (e). The same licensing provisions as outlined in paragraph (e) apply to entities licensed as credit insurance agents under this paragraph.

Section 2. Subsection (1) of section 626.989, Florida Statutes, 1998 Supplement, is amended to read:

626.989 Division of Insurance Fraud; definition; investigative, subpoena powers; protection from civil liability; reports to division; division investigator's power to execute warrants and make arrests.—

(1) For the purposes of this section, a person commits a "fraudulent insurance act" if the person knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance fund, servicing corporation, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a claim for payment or other benefit pursuant to any insurance policy, which the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material thereto. For the purposes of this section, the term "insurer" also includes any health maintenance organization and the term "insurance policy" also includes a health maintenance organization subscriber contract.

Section 3. Section 626.9892, Florida Statutes, is created to read:

626.9892 Anti-Fraud Reward Program; reporting of insurance fraud.—

(1) The Anti-Fraud Reward Program is hereby established within the department, to be funded from the Insurance Commissioner's Regulatory Trust Fund.

(2) The department may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing complex or organized crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

(3) Only a single reward amount may be paid by the department for claims arising out of the same transaction or occurrence, regardless of the number of persons arrested and convicted and the number of persons submitting claims for the reward. The reward may be disbursed among more than one person in amounts determined by the department.

(4) The department shall adopt rules which set forth the application and approval process, including the criteria against which claims shall be evaluated, the basis for determining specific reward amounts, and the manner in which rewards shall be disbursed. Applications for rewards authorized by this section must be made pursuant to rules established by the department.

(5) Determinations by the department to grant or deny a reward under this section shall not be considered agency action subject to review under s. 120.569 or s. 120.57.

Section 4. Section 641.3915, Florida Statutes, is created to read:

641.3915 Health maintenance organization anti-fraud plans and investigative units.—Each authorized health maintenance organization and applicant for a certificate of authority shall comply with the provisions of ss. 626.989 and 626.9891 as though such organization or applicant were an authorized insurer. For purposes of this section, the reference to the year 1996 in s. 626.9891 means the year 2000 and the reference to the year 1995 means the year 1999.

Section 5. Paragraph (h) of subsection (2) of section 775.15, Florida Statutes, 1998 Supplement, is amended to read:

775.15 Time limitations.—

(2) Except as otherwise provided in this section, prosecutions for other offenses are subject to the following periods of limitation:

(h) A prosecution for a felony violation of s. 440.105 and s. 817.234 must be commenced within 5 years after the violation is committed.

Section 6. Subsections (1), (2), (3), (4), and (10) of section 817.234, Florida Statutes, 1998 Supplement, are amended, and subsections (11) and (12) are added to said section, to read:

817.234 False and fraudulent insurance claims.—

(1)(a) A person commits insurance fraud punishable as provided in subsection (11) if that ~~Any~~ person ~~who~~, with the intent to injure, defraud, or deceive any insurer:

1. Presents or causes to be presented any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or a health maintenance organization subscriber or provider contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;

2. Prepares or makes any written or oral statement that is intended to be presented to any insurer in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy or a health maintenance organization subscriber or provider contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim; or

3.a. Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any employee or agent thereof, any false, incomplete, or misleading information or written or oral statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a health maintenance organization subscriber or provider contract; or

b. Who knowingly conceals information concerning any fact material to such application~~,~~

~~commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084~~.

(b) All claims and application forms shall contain a statement that is approved by the Department of Insurance that clearly states in substance the following: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing

any false, incomplete, or misleading information is guilty of a felony of the third degree." This paragraph shall not apply to reinsurance contracts, reinsurance agreements, or reinsurance claims transactions. ~~The changes in this paragraph relating to applications shall take effect on March 1, 1996.~~

(2) Any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, or other practitioner licensed under the laws of this state who knowingly and willfully assists, conspires with, or urges any insured party to fraudulently violate any of the provisions of this section or part XI of chapter 627, or any person who, due to such assistance, conspiracy, or urging by said physician, osteopathic physician, chiropractic physician, or practitioner, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud ~~is guilty of a felony of the third degree~~, punishable as provided in subsection (11) ~~s. 775.082, s. 775.083, or s. 775.084~~. In the event that a physician, osteopathic physician, chiropractic physician, or practitioner is adjudicated guilty of a violation of this section, the Board of Medicine as set forth in chapter 458, the Board of Osteopathic Medicine as set forth in chapter 459, the Board of Chiropractic Medicine as set forth in chapter 460, or other appropriate licensing authority shall hold an administrative hearing to consider the imposition of administrative sanctions as provided by law against said physician, osteopathic physician, chiropractic physician, or practitioner.

(3) Any attorney who knowingly and willfully assists, conspires with, or urges any claimant to fraudulently violate any of the provisions of this section or part XI of chapter 627, or any person who, due to such assistance, conspiracy, or urging on such attorney's part, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud ~~a felony of the third degree~~, punishable as provided in subsection (11) ~~s. 775.082, s. 775.083, or s. 775.084~~.

(4) Any ~~No~~ person or governmental unit licensed under chapter 395 to maintain or operate a hospital, and any ~~no~~ administrator or employee of any such hospital, who ~~shall~~ knowingly and willfully allows ~~allow~~ the use of the facilities of said hospital by an insured party in a scheme or conspiracy to fraudulently violate any of the provisions of this section or part XI of chapter 627~~. Any hospital administrator or employee who violates this subsection~~ commits insurance fraud ~~a felony of the third degree~~, punishable as provided in subsection (11) ~~s. 775.082, s. 775.083, or s. 775.084~~. Any adjudication of guilt for a violation of this subsection, or the use of business practices demonstrating a pattern indicating that the spirit of the law set forth in this section or part XI of chapter 627 is not being followed, shall be grounds for suspension or revocation of the license to operate the hospital or the imposition of an administrative penalty of up to $5,000 by the licensing agency, as set forth in chapter 395.

(10) As used in this section, the term "insurer" means any insurer, health maintenance organization, self-insurer, self-insurance fund, or other similar entity or person regulated under chapter 440 or chapter 641 or by the Department of Insurance under the Florida Insurance Code.

(11) If the value of any property involved in a violation of this section:

(a) Is less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(12) As used in this section:

(a) "Property" means property as defined in s. 812.012.

(b) "Value" means value as defined in s. 812.012.

Section 7. Subsection (4) of section 817.505, Florida Statutes, 1998 Supplement, is amended to read:

817.505 Patient brokering prohibited; exceptions; penalties.—

(4) Any person, including an officer, partner, agent, attorney, or other representative of a firm, joint venture, partnership, business trust, syndicate, corporation, or other business entity, who violates any provision of this section commits:

~~(a) A misdemeanor of the first degree for a first violation, punishable as provided in s. 775.082 or by a fine not to exceed $5,000, or both.~~

~~(b)~~ a felony of the third degree ~~for a second or subsequent violation~~, punishable as provided in s. 775.082, s. 775.083, or s. 775.084 ~~or by a fine not to exceed $10,000, or both~~.

Section 8. For the purpose of incorporating the amendment to subsection (4) of section 817.505, Florida Statutes, 1998 Supplement, in a reference thereto, subsection (3) of section 455.657, Florida Statutes, is reenacted to read:

455.657 Kickbacks prohibited.—

(3) Violations of this section shall be considered patient brokering and shall be punishable as provided in s. 817.505.

Section 9. The sum of $250,000 is hereby appropriated from the Insurance Commissioner's Regulatory Trust Fund in a nonoperating category for state fiscal year 1999-2000 for the purpose of implementing the reward program under s. 626.9892, Florida Statutes, as created by this act.

Section 10. Section 624.6085, Florida Statutes, is created to read:

624.6085 "Collateral protection insurance" defined.—For purposes of ss. 215.555, 627.311, and 627.351, "collateral protection insurance" means commercial property insurance under which a creditor is the primary benefi-

ciary and policyholder and which protects or covers an interest of the creditor arising out of a credit transaction secured by real or personal property. Initiation of such coverage is triggered by the mortgagor's failure to maintain insurance coverage as required by the mortgage or other lending document. Collateral protection insurance is not residential coverage.

Section 11. Paragraphs (e) and (f) of subsection (1) of section 626.321, Florida Statutes, 1998 Supplement are amended to read:

626.321 Limited licenses.—

(1) The department shall issue to a qualified individual, or a qualified individual or entity under paragraphs (c), (d), and (e), a license as agent authorized to transact a limited class of business in any of the following categories:

(e) Credit life or disability insurance.—License covering only credit life or disability insurance. The license may be issued only to an individual employed by a life or health insurer as an officer or other salaried or commissioned representative, or to an individual employed by or associated with a lending or financing institution or creditor, and may authorize the sale of such insurance only with respect to borrowers or debtors of such lending or financing institution or creditor. However, only the individual or entity whose tax identification number is used in receiving or is credited with receiving the commission from the sale of such insurance shall be the licensed agent of the insurer. No individual while so licensed shall hold a license as an agent or solicitor as to any other or additional kind or class of life or health insurance coverage. An entity other than a lending or financial institution defined in s. 626.988 holding a limited license under this paragraph shall also be authorized to sell credit property insurance. An entity applying for a license under this section:

1. Is required to submit only one application for a license under s. 626.171.

2. Is required to obtain a license for each office, branch office, or place of business making use of the entity's business name by applying to the department for the license on a simplified form developed by rule of the department for this purpose.

3. Is not required to pay any additional application fees for a license issued to the offices or places of business referenced in subsection (2), but is required to pay the license fee as prescribed in s. 624.501, be appointed under s. 626.112, and pay the prescribed appointment fee under s. 624.501. The license obtained under this paragraph shall be posted at the business location for which it was issued so as to be readily visible to prospective purchasers of such coverage.

(f) Credit insurance.—License covering only credit insurance, as such insurance is defined in s. 624.605(1)(i), and no individual or entity so licensed shall, during the same period, hold a license as an agent or solicitor as to any other or additional kind of life or health insurance with the exception of credit life or disability insurance as defined in paragraph (e). The

same licensing provisions as outlined in paragraph (e) apply to entities licensed as credit insurance agents under this paragraph.

Section 12. Subsection (1) of section 627.6645, Florida Statutes, is amended and subsection (5) is added to that section to read:

627.6645 Notification of cancellation, expiration, nonrenewal, or change in rates.—

(1) Every insurer delivering or issuing for delivery a group health insurance policy under the provisions of this part shall give the policyholder at least 45 days' advance notice of cancellation, expiration, nonrenewal, or a change in rates. Such notice shall be mailed to the policyholder's last address as shown by the records of the insurer. However, if cancellation is for nonpayment of premium, only the requirements of subsection (5) ~~this section shall not~~ apply. Upon receipt of such notice, the policyholder shall forward, as soon as practicable, the notice of expiration, cancellation, or nonrenewal to each certificateholder covered under the policy.

(5) If cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due.

Section 13. Section 627.6675, Florida Statutes, 1998 Supplement, is 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." A group insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the department under s. 627.410. 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.

(1) TIME LIMIT.—Written application for the converted policy shall be made and the first premium must be paid to the insurer, not later than 63 days after termination of the group policy. However, if termination was the result of failure to pay any required premium or contribution and such nonpayment of premium was due to acts of an employer or policyholder other than the employee or certificateholder, written application for the converted policy must be made and the first premium must be paid to the insurer not later than 63 days after notice of termination is mailed by the insurer or the employer, whichever is earlier, to the employee's or certificateholder's last address as shown by the record of the insurer or the employer, whichever is applicable. In such case of termination due to nonpayment of premium by the employer or policyholder, the premium for the converted policy may not exceed the rate for the prior group coverage for the period of coverage under the converted policy prior to the date notice of termination is mailed to the employee or certificateholder. For the period of coverage after such date, the premium for the converted policy is subject to the requirements of subsection (3).

(2) EVIDENCE OF INSURABILITY.—The converted policy shall be issued without evidence of insurability.

(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.

(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.

(4) EFFECTIVE DATE OF COVERAGE.—The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) SCOPE OF COVERAGE.—The converted policy shall cover the employee or member and his or her dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(6) OPTIONAL COVERAGE.—The insurer shall not be required to issue a converted policy covering any person who is or could be covered by Medicare. The insurer shall not be required to issue a converted policy covering a person if paragraphs (a) and (b) apply to the person:

(a) If any of the following apply to the person:

1. The person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by any other plan or program.

2. The person is eligible for similar benefits, whether or not actually provided coverage, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

3. Similar benefits are provided for or are available to the person under any state or federal law.

(b) If the benefits provided under the sources referred to in subparagraph (a)1. or the benefits provided or available under the sources referred to in subparagraphs (a)2. and 3., together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the department prior to their use in denying coverage.

(7) INFORMATION REQUESTED BY INSURER.—

(a) A converted policy may include a provision under which the insurer may request information, in advance of any premium due date, of any person covered thereunder as to whether:

1. The person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program.

2. The person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

3. Similar benefits are provided for or are available to the person under any state or federal law.

(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 misrepresentation in applying for any benefits under the converted policy.

4. Other reasons approved by the department.

(8) BENEFITS OFFERED.—

(a) An insurer shall not be required to issue a converted policy that provides benefits in excess of those provided under the group policy from which conversion is made.

(b) An insurer shall offer the benefits specified in s. 627.668 and the benefits specified in s. 627.669 if those benefits were provided in the group plan.

(c) An insurer shall offer maternity benefits and dental benefits if those benefits were provided in the group plan.

(9) PREEXISTING CONDITION PROVISION.—The converted policy shall not exclude a preexisting condition not excluded by the group policy. However, the converted policy may provide that any hospital, surgical, or medical benefits payable under the converted policy may be reduced by the amount of any such benefits payable under the group policy after the termination of covered under the group policy. The converted policy may also provide that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force.

(10) REQUIRED OPTION FOR MAJOR MEDICAL COVERAGE.—Subject to the provisions and conditions of this part, the employee or member shall be entitled to obtain a converted policy providing major medical coverage under a plan meeting the following requirements:

(a) A maximum benefit equal to the lesser of the policy limit of the group policy from which the individual converted or $500,000 per covered person for all covered medical expenses incurred during the covered person's lifetime.

(b) Payment of benefits at the rate of 80 percent of covered medical expenses which are in excess of the deductible, until 20 percent of such expenses in a benefit period reaches $2,000, after which benefits will be paid at the rate of 90 percent during the remainder of the contract year unless the insured is in the insurer's case management program, in which case benefits shall be paid at the rate of 100 percent during the remainder of the contract year. For the purposes of this paragraph, "case management program" means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the insurer. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50 percent.

(c) A deductible for each calendar year that must be $500, $1,000, or $2,000, at the option of the policyholder.

(d) The term "covered medical expenses," as used in this subsection, shall be consistent with those customarily offered by the insurer under group or individual health insurance policies but is not required to be identical to the covered medical expenses provided in the group policy from which the individual converted.

(11) ALTERNATIVE PLANS.—The insurer shall, in addition to the option required by subsection (10), offer the standard health benefit plan, as established pursuant to s. 627.6699(12). The insurer may, at its option, also offer alternative plans for group health conversion in addition to the plans required by this section.

(12) RETIREMENT COVERAGE.—If coverage would be continued under the group policy on an employee following the employee's retirement prior to the time he or she is or could be covered by Medicare, the employee may elect, instead of such continuation of group insurance, to have the same conversion rights as would apply had his or her insurance terminated at retirement by reason or termination of employment or membership.

(13) REDUCTION OF COVERAGE DUE TO MEDICARE.—The converted policy may provide for reduction of coverage on any person upon his or her eligibility for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.

(14) CONVERSION PRIVILEGE ALLOWED.—The conversion privilege shall also be available to any of the following:

(a) The surviving spouse, if any, at the death of the employee or member, with respect to the spouse and the children whose coverages under the group policy terminate by reason of the death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents' coverages following the employee's or member's death, at the end of such continuation.

(b) The former spouse whose coverage would otherwise terminate because of annulment or dissolution of marriage, if the former spouse is dependent for financial support.

(c) The spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and the children whose coverages under the group policy terminate at the same time.

(d) A child solely with respect to himself or herself upon termination of his or her coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided in this subsection with respect to such termination.

(15) BENEFIT LEVELS.—If the benefit levels required in subsection (10) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in subsection (10).

(16) GROUP COVERAGE INSTEAD OF INDIVIDUAL COVERAGE.—The insurer may elect to provide group insurance coverage instead of issuing a converted individual policy.

(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.

(18) OUTSIDE CONVERSIONS.—A converted policy that is delivered outside of this state must be on a form that could be delivered in the other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

(19) APPLICABILITY.—This section does not require conversion on termination of eligibility for a policy or contract that provides benefits for specified diseases, or for accidental injuries only, disability income, Medicare supplement, hospital indemnity, limited benefit, nonconventional, or excess policies.

(20) Nothing in this section or in the incorporation of it into insurance policies shall be construed to require insurers to provide benefits equal to

those provided in the group policy from which the individual converted, provided, however, that comprehensive benefits are offered which shall be subject to approval by the Insurance Commissioner.

Section 14. Section 641.3108, Florida Statutes, is amended to read:

641.3108 Notice of cancellation of contract.—

(1) Except for nonpayment of premium or termination of eligibility, no health maintenance organization may cancel or otherwise terminate or fail to renew a health maintenance contract without giving the subscriber at least 45 days' notice in writing of the cancellation, termination, or nonrenewal of the contract. The written notice shall state the reason or reasons for the cancellation, termination, or nonrenewal. All health maintenance contracts shall contain a clause which requires that this notice be given.

(2) If cancellation is due to nonpayment of premium, the health maintenance organization may not retroactively cancel the contract to a date prior to the date that notice of cancellation was provided to the subscriber unless the organization mails notice of cancellation to the subscriber prior to 45 days after the date the premium was due. Such notice must be mailed to the subscriber's last address as shown by the records of the organization and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due.

(3) In the case of a health maintenance contract issued to an employer or person holding the contract on behalf of the subscriber group, the health maintenance organization may make the notification through the employer or group contract holder, and, if the health maintenance organization elects to take this action through the employer or group contract holder, the organization shall be deemed to have complied with the provisions of this section upon notifying the employer or group contract holder of the requirements of this section and requesting the employer or group contract holder to forward to all subscribers the notice required herein.

Section 15. Subsection (1) of section 641.3922, Florida Statutes, 1998 Supplement, is amended to read:

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

(1) TIME LIMIT.—Written application for the converted contract shall be made and the first premium paid to the health maintenance organization not later than 63 days after such termination. However, if termination was the result of failure to pay any required premium or contribution and such nonpayment of premium was due to acts of an employer or group contract holder other than the employee or individual subscriber, written application for the contract must be made and the first premium must be paid not later than 63 days after notice of termination is mailed by the organization or the employer, whichever is earlier, to the employee's or individual's last address as shown by the record of the organization or the employer, whichever is applicable. In such case of termination due to non-payment of premium by

the employer or group contract holder, the premium for the converted contract may not exceed the rate for the prior group coverage for the period of coverage under the converted contract prior to the date notice of termination is mailed to the employee or individual subscriber. For the period of coverage after such date, the premium for the converted contract is subject to the requirements of subsection (3).

Section 16. This act shall take effect October 1, 1999, and shall apply to policies and contracts issued or renewed on or after that date.

Approved by the Governor May 26, 1999.

Filed in Office Secretary of State May 26, 1999.