CHAPTER 99-275

Committee Substitute for Senate Bill No. 2554

An act relating to insurance contracts; amending s. 626.022, F.S.; providing an exception from certain insurance licensing requirements for certified public accountants acting within the scope of their profession; amending s. 626.883, F.S.; requiring that certain information be included with the payments made by a fiscal intermediary to a health care provider; amending s. 641.31, F.S., relating to health maintenance contracts; requiring a health maintenance organization to provide notice prior to increasing the copayments or limiting any benefits under a group contract; requiring certain health maintenance contracts to cover persons licensed to practice massage under certain circumstances; amending s. 641.315, F.S.; providing that a contract between a health maintenance organization and a health care provider may not restrict the provider from entering into a contract with any other health maintenance organizations and may not restrict the health maintenance organization from entering into a contract with any other provider; amending s. 641.316, F.S.; requiring that certain information be included with the payments made by a fiscal intermediary to a health care provider; providing for applicability; 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. Paragraph (d) is added to subsection (1) of section 626.022, Florida Statutes, 1998 Supplement, to read:

626.022 Scope of part.—

(1) This part applies as to insurance agents, solicitors, service representatives, adjusters, and insurance agencies; as to any and all kinds of insur-

ance; and as to stock insurers, mutual insurers, reciprocal insurers, and all other types of insurers, except that:

(d) This part does not apply to a certified public accountant licensed under chapter 473 who is acting within the scope of the practice of public accounting, as defined in s. 473.302, provided that the activities of the certified public accountant are limited to advising a client of the necessity of obtaining insurance, the amount of insurance needed, or the line of coverage needed, and provided that the certified public accountant does not directly or indirectly receive or share in any commission, referral fee, or solicitor's fee.

Section 2. Subsection (6) is added to section 626.883, Florida Statutes, to read:

626.883 Administrator as intermediary; collections held in fiduciary capacity; establishment of account; disbursement; payments on behalf of insurer.—

(6) All payments to a health care provider by a fiscal intermediary for noncapitated providers must include an explanation of services being reimbursed which includes, at a minimum, the patient's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is being made. For capitated providers, the statement of services must include the number of patients covered by the contract, the rate per patient, the total amount of the payment, and the identification of the plan on whose behalf the payment is being made.

Section 3. Subsections (36) and (37) are added to section 641.31, Florida Statutes, 1998 Supplement, to read:

641.31 Health maintenance contracts.—

(36) A health maintenance organization may increase the copayment for any benefit, or delete, amend, or limit any of the benefits to which a subscriber is entitled under the group contract only, upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. The health maintenance organization may amend the contract with the contract holder, with such amendment to be effective immediately at the time of coverage renewal. The written notice to the contract holder shall specifically identify any deletions, amendments, or limitations to any of the benefits provided in the group contract during the current contract period which will be included in the group contract upon renewal. This subsection does not apply to any increases in benefits. The 45-day notice requirement shall not apply if benefits are amended, deleted, or limited at the request of the contract holder.

(37) All health maintenance contracts that provide coverage for massage must also cover the services of persons licensed to practice massage pursuant to chapter 480 if the massage is prescribed by a contracted physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 as

medically necessary and the prescription specifies the number of treatments. Such massage services are subject to the same terms, conditions, and limitations as those of other covered services.

Section 4. Subsection (9) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.—

(9) A contract between a health maintenance organization and a provider of health care services may not contain any provision that in any way prohibits or restricts:

(a) The health care provider from entering into a commercial contract with any other health maintenance organization; or

(b) The health maintenance organization from entering into a commercial contract with any other health care provider.

Section 5. Paragraph (a) of subsection (2) of section 641.316, Florida Statutes, 1998 Supplement, is amended to read:

641.316 Fiscal intermediary services.—

(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. All payments to a health care provider by a fiscal intermediary for noncapitated providers must include an explanation of services being reimbursed which includes, at a minimum, the patient's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is being made. For capitated providers, the statement of services must include the number of patients covered by the contract, the rate per patient, the total amount of the payment, and the identification of the plan on whose behalf the payment is being made.

(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).

Section 6. 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 7. 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 8. 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 9. 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 nonpayment 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 10. This act shall take effect July 1, 1999, and shall apply to all contracts renewed or entered into on or after that date.

Approved by the Governor June 8, 1999.

Filed in Office Secretary of State June 8, 1999.