

SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

Date: March 31, 1998 Revised: \_\_\_\_\_

Subject: Health Insurance

	<u>Analyst</u>	<u>Staff Director</u>	<u>Reference</u>	<u>Action</u>
1.	<u>Deffenbaugh</u>	<u>Deffenbaugh</u>	<u>BI</u>	<u>Favorable/CS</u>
2.	<u>Williams</u>	<u>Wilson</u>	<u>HC</u>	<u>Favorable/CS</u>
3.	_____	_____	<u>WM</u>	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

**I. Summary:**

Committee Substitute for Committee Substitute for Senate Bill 1800 makes various changes to health insurance and HMO coverage requirements, related primarily to the 1997 legislation conforming the Florida Insurance Code to the provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The bill expands eligibility for guaranteed-issuance of an individual health insurance policy to include persons with 18 months of prior coverage under an individual plan, if the prior insurance coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO. (Current law specifies that the most recent coverage must be group coverage.)

The bill increases solvency-related requirements for HMOs, including an increase in the minimum surplus requirements, an increase in the amount that must be deposited with the Department of Insurance, and additional financial reports and other information that must be filed with the department.

The bill requires the Department of Insurance, rather than the Florida Comprehensive Health Association (FCHA), to annually establish the standard risk premium which serves as the benchmark for establishing maximum premiums for the FCHA and for individual conversion policies that must be offered by group insurers and HMOs.

Other provisions include:

Requiring insurers to mail to individuals who are eligible for a conversion policy, an election and premium notice form, including an outline of coverage, within 14 days of request or notice to the insurer that an individual is considering applying for a conversion policy;

Conforming Florida law to the federal Mental Health Parity Act of 1996, thereby authorizing the Florida Department of Insurance to enforce such provisions under state law, which would require that lifetime and annual dollar limitations on mental health benefits (if provided) under group policies be the same as for other medical and surgical benefits under the policy, subject to certain exemptions;

Providing that moneys paid into a Roth individual retirement account (IRA) or Medical Savings Account are protected from creditors;

Revising minimum standards for Medicare supplement policies, to conform to federal law;

Revising the definition of “health benefit plan” as used in the Employee Health Care Access Act, specific to supplemental coverage that may be offered by employers;

Revising the requirements for an HMO to provide a 12-month extension of benefits for persons who are totally disabled, to apply the requirement to any termination of an HMO contract, including termination by a group contract holder, but limiting such requirement to group HMO contracts;

Lowering and revising the bond requirements that must be met by fiscal intermediary organizations;

Exempting disability income and accidental death policies from certain prohibited rating practices that apply to health insurance policies; and

Making other changes to conform to HIPAA relating to grounds for non-renewal of individual policies, group policies, and HMO contracts and changes to clarify provisions in the long-term care insurance act.

This bill amends the following sections of the Florida Statutes: 222.21, 222.22, 627.410, 627.6425, 627.6487, 627.6498, 627.6571, 627.6675, 627.6699, 627.674, 627.6741, 627.9403, 627.9404, 627.9407, 627.94073, 641.225, 641.285, 641.26, 641.31074, 641.3111, 641.316, 641.3922, and 641.495; and creates section 627.6685.

## II. Present Situation:

### Guaranteed Availability of Individual Coverage

In 1997 Florida enacted revisions to various portions of the Florida Insurance Code necessary to conform to the provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), (ch. 97-179, L.O.F.). One of the most important revisions provided for guaranteed availability of individual coverage for eligible individuals, as contained in s. 627.6487, F.S. Currently, an *eligible individual* is defined as any person with 18 months of creditable coverage (as defined), the most recent of which was under a *group health insurance plan*, governmental plan, or church plan, and who does not have access to a conversion policy or other specified types of health insurance. The law further provides that the individual may not have more than a 63-day gap in coverage. An eligible individual is entitled to the guaranteed-issuance of an individual policy from any insurer or HMO offering individual policies or contracts, which must offer their two policy forms with the largest premium volume in the state. For persons who are eligible for a conversion policy under Florida law (generally, all persons who lose eligibility for coverage under a group health insurance policy or group HMO contract), the conversion policy serves as their access to individual coverage. Under the Florida conversion policy laws, the insurer or HMO must offer the standard benefit plan required to be offered to small employers in s. 627.6699, F.S., and the premium may not exceed 200 percent of the standard risk rate. This conversion policy option was determined by the federal Health Care Financing Administration to be an acceptable alternative mechanism under HIPAA. Since the current law refers only to those persons who are eligible for a conversion policy under Florida law (s. 627.6675 or s.641.3921, F.S.), any person who is eligible for a conversion policy under another state's law or under a self-insurance plan not subject to Florida law (due to federal preemption under ERISA), is also eligible for guaranteed-issuance of an individual policy, assuming they meet all other criteria of eligibility.

The 1997 Florida legislation also created s. 627.6476, F.S., which provides a reinsurance pool for individual insurers who wish to reinsure HIPAA eligibles. The pool is administered by, and closely modeled on, the small group reinsurance pool. Reinsuring individual health insurers and all other health insurers (excluding insurers that assume the risk of insuring HIPAA eligibles) are subject to assessments to fund the reinsurance pool.

### Conversion Policies

Insurers and HMOs issuing group policies in Florida must offer individual conversion policies or contracts to an employee or member whose eligibility for the group coverage terminates, as required by s. 627.6675 F.S., for insurers and by s. 641.3922, F.S., for HMOs. The maximum premium for the policy is 200 percent of the *standard risk rate* as determined by the Florida Comprehensive Health Association, adjusted for differences in benefit levels and structure between the converted policy and the FCHA policy. (See FCHA, below.) Insurers and HMOs must offer the standard benefit plan currently required to be offered to small employers under s. 627.6699, F.S., as one of the conversion policy options.

### **Florida Comprehensive Health Association (FCHA)**

The FCHA is established in ss. 627.648-627.6498, F.S., to provide health insurance to individuals who, due to their health status, are unable to obtain health insurance coverage in the private market. However, the FCHA has been prohibited from issuing policies to new applicants since July 1, 1991 (s. 627.6484, F.S.) and currently provides coverage for approximately 1100 individuals who have renewed their coverage since that time. Premiums are set at 200 percent, 225 percent, and 250 percent of the standard risk rate for low, medium, and high risk individuals, respectively. The standard risk rate is determined by the 3-member board that governs the FCHA, and premiums are established by the board and approved by the Department of Insurance.

### **Mental Health Coverage**

In Florida there is no statutory requirement that health insurance policies or HMO contracts include mental health or substance abuse treatment benefits. However, s. 627.668, F.S., presently requires insurers and HMOs to offer the option of coverage for mental illness or nervous disorders to the group policyholder (e.g., employer), for an appropriate additional premium. The type of mental illnesses or nervous disorders that may be covered are as defined in the standard nomenclature of the American Psychiatric Association (APA). The law requires the insurer or HMO to offer coverage for inpatient hospital benefits of at least 30 days per year, and outpatient benefits may be limited to \$1,000, payable to any mental health professional licensed under chapter 491, F.S.

### **HMO Solvency Requirements**

In order to obtain a certificate of authority, an HMO in Florida must initially have a minimum surplus of the greater of: (a) \$1,500,000, (b) 10 percent of total projected liabilities, or (c) \$500,000 plus all startup losses projected to be incurred for 12 months. After obtaining a certificate of authority, an HMO must maintain a minimum surplus of \$500,000 or 10 percent of total liabilities, whichever is greater (s. 641.225, F.S.). An HMO must also deposit with the department securities equal to \$100,000 or twice its average monthly uncovered expenditures, whichever is greater (s. 641.285, F.S.). However, the department may waive the deposit requirement based on various grounds, including a determination that the assets of the HMO are reasonably sufficient to assure the performance of its obligations, or upon approval of a plan for handling insolvency. HMOs are also required to submit an annual report to the department, including audited financial statements, an actuarial certification that the HMO is actuarially sound, and other specified information.

Other aspects of current law affected by the bill are addressed in the section-by-section analysis, below.

### III. Effect of Proposed Changes:

**Section 1.** Amends s. 222.21, F.S., relating to the exemption of pension money and retirement or profit-sharing benefits from legal processes, to specifically exempt Roth IRA resources from creditors' claims. This revision is necessary because federal Internal Revenue Code revisions which created the Roth IRA did so as a new section of IRS law.

**Section 2.** Amends s. 222.22, F.S., to provide that moneys paid into a Medical Savings Account are not subject to attachment, garnishment, or legal process in favor of any creditor. The bill does not define *Medical Savings Accounts*, but the term would apparently refer to the medical savings accounts provided tax-exempt status by HIPAA for a limited number of small employers. Either the employer or employee can contribute to a medical savings account (MSA) to pay for medical expenses up to certain limits, in conjunction with a high-deductible health insurance policy. Earnings accumulated and withdrawals from qualified MSAs are tax-free. Maximum contribution limits are set at 65 percent of the policy's deductible (75 percent for family coverage), which equates to maximum annual contributions of \$1,462 for individuals and \$1,950 for family coverage. (The bill provides the same protection from creditors for MSA accounts as currently provided for moneys paid into or out of a Florida pre-paid college tuition plan [the Prepaid Postsecondary Education Expense Trust Fund].)

**Section 3.** Amends s. 627.410, F.S., to provide an exception to certain health insurance rating requirements for disability income policies and accidental death policies. Currently, certain rating practices are prohibited for health insurance policies issued in Florida, including: (1) select and ultimate premium schedules, (2) premium class definitions which classify the insured based on year of issue or duration since issue, and (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. The statute does not further define these terms but, in general, these rating prohibitions are designed to require insurers to account in the initial, first-year premium for cost increases that are expected as a policyholder ages, rather than a rating plan that schedules premium increases as a policyholder ages. The bill specifies that these prohibited rating practices do not apply to disability income policies or accidental death policies.

**Section 4.** Amends s. 627.6425, F.S., relating to exceptions to guaranteed renewability of individual health insurance policies, to clarify that if an insurer discontinues offering a particular policy form, the insurer must provide current policyholders with at least 90 days notice prior to *non-renewal* (and offer the option to purchase any other individual coverage currently being offered). This is intended to eliminate a possible interpretation that an insurer may cancel policies mid-term, with 90-days notice.

**Section 5.** Amends s. 627.6487, F.S., to expand the definition of "eligible individual" for purposes of entitlement to guaranteed-issuance of an individual health insurance policy. The current law, enacted in 1997 to conform to HIPAA, guarantees availability of individual coverage to persons with 18 months of prior creditable coverage, if their most recent coverage was under a *group* health plan, governmental plan, or church plan. The bill expands eligibility for guaranteed-issuance

of individual coverage to include persons with 18 months of prior coverage, whose most recent coverage was under an *individual* plan, if the prior insurance coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO.

**Section 6.** Amends s. 627.6498, F.S. to require the Department of Insurance, rather than the FCHA, to annually establish the *standard risk rates* that serve as the basis for determining premiums established for the FCHA. As currently provided, the maximum rates for the FCHA would be 200 percent, 225 percent, and 250 percent of the standard risk rate for low, medium, and high risk individuals, respectively. See Section 8, below, which provides standards for this determination and for use of the standard risk rate in establishing maximum premiums for conversion policies.

**Section 7.** Amends s. 627.6571, F.S., relating to exceptions to guaranteed renewability of group policies, to clarify that if an insurer discontinues offering a particular policy form, the insurer must provide current policyholders with at least 90 days notice prior to *non-renewal*. This is intended to eliminate a possible interpretation that an insurer may cancel policies mid-term with 90-days' notice. Also, a technical change clarifies that an insurer may elect to discontinue offering all coverage in either the small group or large group market, or both.

**Section 8.** Amends s. 627.6675, F.S. relating to conversion policies required to be offered by group insurers to persons who lose eligibility for group coverage, to make the following changes related to maximum premiums for conversion policies, grounds for non-renewal, and information that must be provided about conversion policy premiums to prospective applicants:

Subsection (3): Currently, the maximum premium for conversion policies is set at 200 percent of the standard risk rate, as determined by the FCHA. The bill requires the Department of Insurance, rather than the FCHA, to annually establish the standard risk rate, using reasonable actuarial techniques and standards adopted by rule of the department. The standard risk rate must be determined separately for indemnity policies, preferred provider/exclusive provider policies, and HMO contracts, based on a survey of insurers and HMOs representing 80 percent of the statewide market share for each type of policy. Standard risk rate schedules are to be computed as the average rates charged by the insurers surveyed, giving appropriate weight to each carrier's statewide market share, broken down by county, age brackets, and family-size.

Subsection (7): Revising the grounds for non-renewal of a conversion policy to be consistent with HIPAA, by: (1) changing "fraud or *material* misrepresentation" to "fraud or *intentional* misrepresentation" in applying for benefits under the policy, and (2) deleting as a ground, eligibility of the insured for Medicare or any other state or federal law providing similar benefits to the conversion policy.

Subsection (17): Requiring insurers to mail to individuals who are eligible for a conversion policy, an election and premium notice form, including an outline of coverage, within 14 days

of request or notice to the insurer that an individual is considering applying for a conversion policy.

**Section 9.** Creates s. 627.6685, F.S., to conform Florida law to the federal Mental Health Parity Act of 1996. By doing so, the bill authorizes the Florida Department of Insurance to enforce, under state law, the provisions of the federal law. The provisions are substantively identical to the federal law and apply to group health plans offered by insurers or HMOs.

The section requires a plan that provides both medical and surgical benefits and mental health benefits to establish the same *annual and lifetime dollar limits* on mental health benefits, as provided for non-mental health benefits. Mental health benefits are defined to mean, with respect to mental health services, those benefits as defined under the terms of the plan or coverage, but not benefits with respect to treatment of substance abuse or chemical dependency.

Small employers (2-50 employees) are exempted from the provisions of this section. Moreover, the provisions do not apply if the implementation would result in an increase in the cost of the plan of 1 percent or more. The section is silent as to how this exemption would be determined, i.e., projected or actual claims' experience.

The section specifically states that the provisions do not require a group health plan, or health insurance coverage offered in connection with such a plan, to provide any mental health benefits. In addition, it does not affect 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 in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits. The section does not apply to benefits for services provided on or after September 30, 2001.

The bill does not amend the current Florida law, s. 627.668, F.S., requiring group insurers to offer mental health coverage, at specified minimum coverage amounts. The current law requires the insurer or HMO to offer mental health coverage for inpatient hospital benefits of at least 30 days per year, and outpatient benefits which may be limited to \$1,000 annually, payable to any mental health professional licensed under chapter 491. The bill provides that the new provision (conforming to the federal law) controls to the extent of any conflict. Therefore, the \$1,000 annual limit for outpatient visits could not be imposed only on mental health benefits, since this is an annual dollar limitation. However, the 30-day limit for in-patient treatment is apparently permissible since this is not a dollar limitation.

See Related Issues, below, for other mental health parity legislation currently under consideration and its relationship to this section.

**Section 10.** Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act, to incorporate into the definition of "health benefit plan" an exception for employer-provided supplemental plans that may be provided as part of an enhanced employee benefit package.

**Section 11.** Amends s. 627.674, F.S., relating to minimum standards for Medicare supplement policies, to conform to federal law. The bill provides that the rules adopted by the department must be no less comprehensive or beneficial to insureds than provided in federal law, 42 U.S.C. sec. 1395ss and the most recent version of the model act adopted by the National Association of Insurance Commissioners. Conforming changes are made to cite the federal law and the most recent version of the model act.

**Section 12.** Amends s. 627.6741, F.S., relating to issuance, cancellation, nonrenewal, and replacement of Medicare supplement policies, to conform to the federal law cited in the section, above. Current Florida law requires insurers to guarantee-issue coverage to any individual during the first 6 months after they reach age 65 and who enrolls in part B, and to any individual who is 65 or older during the 2-month period following termination of coverage under a group plan. The bill provides that if any such individual has at least 6 months of prior creditable coverage, the Medicare supplement policy may not exclude benefits based on a pre-existing condition. The department would be required to adopt rules relating to the guaranteed issuance of coverage, without preexisting condition exclusions, for continuously covered individuals, consistent with the federal law cited above.

The bill also amends the current law that requires Medicare supplement policies to provide credit towards a preexisting condition exclusion for time covered under a previous Medicare supplement policy or a group policy. As amended, such credit would have to be given for any previous “creditable coverage” as defined in s. 627.6561, F.S., which is consistent with the HIPAA requirements and current Florida law for group health insurance policies adopted in 1997.

**Section 13.** Amends s. 627.9403, F.S., related to the scope of the Long-Term Care Insurance Act, to clarify which provisions of the act apply to “limited benefit policies,” as defined in the following section.

**Section 14.** Amends s. 627.9404, F.S., related to definitions used in the Long-Term Care Insurance Act, to add a definition of “limited benefit policy” as meaning 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 the Act or by department rule; and to add a definition of “qualified long-term care limited benefit insurance policy” as meaning an accident and health insurance contract as defined in s. 7702B of the Internal Revenue Code and all applicable sections of this part. (In order to be marketed as a “long-term care” policy, a policy must cover care in a nursing home and at least one or more lower levels of care, such as home health care, which are specified by department rule. However, a policy may limit coverage to care in a nursing home or to one or more lower levels of care as long as it is marketed as a “limited benefit policy” or a “qualified long-term care limited benefit insurance policy.”)

**Section 15.** Amends s. 627.9407, F.S., related to minimum standards for long-term care insurance policies, to revise the definition of “preexisting condition” that must be used in long-term care policies. The revision is consistent with the definition used in HIPAA (which provides tax benefits to persons who buy qualified long-term care policies). The amendment deletes the “ordinarily

prudent person standard,” so that in order to be considered a preexisting condition, medical advice or treatment must have been recommended or received within the previous 6 months, whether or not an ordinarily prudent person would have sought advice or treatment.

New subsection (13) requires a specific disclosure statement in policies and outlines of coverage for those limited benefit policies that do not qualify for favorable federal tax treatment, to inform the policyholder of this fact. The language is modeled on the current law in subsection (12), added by the 1997 Florida law to conform to HIPAA, that requires a similar disclosure statement for long-term care policies that do not qualify for favorable tax treatment.

**Section 16.** Amends s. 627.94073, F.S., related to notice of cancellation and grace periods for long-term care policies. Currently, insurers must notify policyholders of their right to designate an additional person to receive notice of termination of a long-term care policy due to nonpayment of premium. This requirement also applies to limited benefit policies, but the specific notice language refers only to a “long-term care policy.” The bill adds a reference in the notice to a long-term care limited benefit insurance policy, to be used for such policies.

**Section 17.** Amends s. 641.225, F.S., related to surplus requirements for HMOs. The bill increases the minimum surplus requirements for both new and existing HMOs. In order to obtain a certificate of authority as an HMO, an applicant must currently have a minimum surplus equal to the greater of: (a) \$1,500,000, (b) 10 percent of total projected liabilities, or (c) \$500,000 plus all startup losses projected to be incurred for 12 months. The bill increases the minimum requirement for certificates issued after October 1, 1998, to the greater of: (a) 10 percent of total projected liabilities, (b) 2 percent of total projected premiums, or (c) \$1.5 million plus all startup losses projected to be incurred for 12 months.

After an HMO obtains a certificate of authority, the current law requires the HMO to maintain a minimum surplus equal to \$500,000 or 10 percent of total liabilities, whichever is greater. For HMOs obtaining a certificate of authority on or after October 1, 1998, the bill increases the minimum surplus requirement to the greater of \$1.5 million, 10 percent of total liabilities, or 2 percent of total annualized premium. For HMOs that already have a certificate of authority as of October 1, 1998, the bill requires a scheduled increase in the minimum surplus requirement, as follows: by September 30, 1998, \$800,000, 10 percent of liabilities, or 1 percent of annualized premium, whichever is greatest; by September 30, 1999, \$1.15 million, 10 percent of liabilities, or 1.25 percent of annualized premium, whichever is greatest; and by September 30, 2000, the full requirement of \$1.5 million, 10 percent of total liabilities, or 2 percent of annualized premium, whichever is greatest.

**Section 18.** Amends s. 641.285, F.S., relating to the minimum deposit of cash or securities that HMOs must file with the Department of Insurance. The bill increases the minimum deposit from the current \$100,000 or twice the HMO’s estimated average monthly uncovered expenditures, whichever is greater, to a flat \$300,000 deposit requirement. The bill eliminates all of the various exceptions to the deposit requirement that may currently be approved by the department and authorizes the department to require additional deposits ranging from \$100,000 to a maximum of

\$2 million, if the department determines that the financial condition of an HMO has deteriorated to the point that the policyholders' or subscribers' best interests are not being preserved by the activities of the HMO.

**Section 19.** Amends s. 641.26, F.S., relating to annual reports that must be filed by HMOs. Current law requires audited financial statements to be filed annually, certified by an independent certified public accountant (CPA). The bill requires that the report filed by the CPA must include any material weaknesses in the HMO's internal control structure as noted by the CPA during the audit, and that the HMO must provide a description of remedial actions taken that are not otherwise described in the CPA's report. Current law also requires the annual filing of a certification by an actuary as to the actuarial soundness of the HMO. The bill authorizes the department to require updates of the actuarial certification if the department has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the HMO. Work papers in support of the statement of the updated actuarial certification must be provided to the department upon request. The bill further authorizes the department to require an HMO, upon written request, to furnish such additional information as to its transactions or affairs which, in the department's opinion, may have a material effect on the HMO's financial condition. Each HMO would also be required to file a copy of its annual statement in electronic form along with such additional filings as prescribed by the department for the preceding year, with the National Association of Insurance Commissioners (NAIA), and to pay a reasonable fee to the department to cover the cost associated with the filing of an analysis of the documents by the NAIA.

**Section 20.** Amends s. 627.31074, F.S., related to guaranteed renewability of HMO contracts. The bill makes changes to this section to be consistent with the guaranteed renewability provisions of s. 627.6571, F.S., which apply to group health insurance policies. The bill clarifies that if an HMO discontinues offering a particular policy form, the HMO must provide current contract holders with at least 90 days notice prior to *non-renewal*, eliminating a possible interpretation that an HMO may cancel policies mid-term with 90-days notice. Also, if an HMO discontinues offering a contract form, the bill requires the HMO to offer a large employer (with more than 50 employees) *any* rather than *all* other health insurance coverage offered by the HMO in the large group market. This is consistent with HIPAA law and the current group health insurance statute, s. 627.6571, F.S. The bill also clarifies that an HMO may elect to discontinue offering all coverage in either the small group or large group market, or both, and deletes a reference to acting in accordance with *applicable state law* in such circumstances, since there appears to be no other statutory requirement that applies.

**Section 21.** Amends s. 641.3111, F.S., related to extension of benefits under HMO contracts. Currently, if an HMO contract is terminated *by the HMO*, the contract must continue to provide benefits for at least 12 months for a person who is totally disabled, for the treatment of a specific accident or illness incurred while the subscriber was a member. This current statute has a very limited effect, because the extension of benefit's requirement does not apply if a group HMO contract is terminated by the contract holder, as compared to the extension of benefits requirement for group health insurance policies in s. 627.667, F.S., which applies whenever a

group policy is terminated, including termination by the group policyholder (e.g., employer). There is no extension of benefits requirement, currently, for individual health insurance policies. The current HMO statute also provides, in subsection (4), that the extension of benefits is not required if termination of the contract by the HMO is based upon any event referred to in s. 641.3922(7)(a)-(g), F.S., which are all but one of the allowable reasons for an HMO to non-renew a conversion contract. (The one not referenced is paragraph (h), which is a change in marital status that makes a person ineligible.) No reference is made to s. 641.31074, F.S., created in 1997, which requires group HMO contracts to be guaranteed renewable, subject to exceptions listed in subsection (2), but the exceptions would appear to include all of the events listed in s. 641.3922(7)(a)-(g), F.S. In comparison, the extension of benefits law for group health insurance policies in s. 627.667, F.S., provides no similar exceptions.

The bill strikes the phrase “by the HMO” to apply the extension of benefits requirement to any termination of an HMO contract, including termination by a group contract holder. However, the bill limits the extension of benefits requirement to *group* HMO contracts, because there is no extension of benefits law for individual health insurance policies and also due to the current exceptions in subsection (4) which effectively makes the law non-applicable to individual policies. The exceptions to providing an extension of benefits are stricken, to be consistent with the group health insurance law in s. 627.667, F.S., which provides no similar exceptions.

**Section 22.** Amends s. 641.316, F.S., related to fiscal intermediary services. This section was created in 1997 to require a \$10 million fidelity bond to all persons or entities engaged in the business of providing fiduciary or fiscal intermediary services to any contracted health care provider or provider panel. The term “fiscal intermediary services” is defined to include 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 HMOs. Organizations owned, operated, or controlled by a hospital, authorized insurer, licensed third-party administrator, prepaid limited health organization, HMO, or physician group practice is exempt from the statute’s requirements. The \$10 million fidelity bond must provide coverage against misappropriation of funds by the fiscal intermediary or its officers, agents, or employees, and must be posted with the department for the benefit of managed care plans, subscribers, and providers. It appears that surety insurers do not generally make available the \$10 million fidelity bond currently required for fiscal intermediary service organizations.

The bill deletes the \$10 million fidelity bond requirement and replaces it with two separate, but lower, bond requirements. The fiscal intermediary service organization would be required to obtain a fidelity bond in the minimum amount of 10 percent of the funds handled by the intermediary in connection with its fiscal services during the prior year, or \$1 million, whichever is less, subject to a minimum bond amount of \$50,000. This fidelity bond must protect the intermediary from loss caused by the dishonesty of its employees. The organization would also be required to maintain a surety bond on file with the department, with a penal sum of not less than 5 percent of the funds handled by the intermediary in connection with its fiscal services during the prior year, or \$250,000, whichever is less, subject to a minimum bond amount of \$10,000. The

condition of the bond must be that the intermediary register with the department and not misappropriate funds within its control or custody. The bond may be terminated by the surety upon its giving 30 days' written notice to the department.

The bill also incorporates technical revisions regarding reference to prepaid limited health *service* organizations licensed under ch. 636, F.S., and physician group practices licensed under s. 455.654(3)(f), F.S.

**Section 23.** Amends s. 641.3922, F.S., relating to HMO conversion contracts. The bill makes the same changes to the HMO conversion law as made to the group health conversion law in Section 7, above, as follows:

Subsection (3): Currently, the maximum premium for HMO conversion contracts is set at 200 percent of the standard risk rate, as determined by the FCHA. The bill requires the Department of Insurance, rather than the FCHA, to annually establish the standard risk rate, pursuant to s. 627.6675, F.S. (See Section 7, above.)

Subsection (7): Revising the grounds for non-renewal of a conversion contract to be consistent with HIPAA law, by: (1) changing “fraud or material misrepresentation” to “fraud or intentional misrepresentation” in applying for benefits under the contract, and (2) deleting as a ground, eligibility of the insured for Medicare or any other state or federal law providing similar benefits to the conversion contract.

Subsection (14): Requiring HMOs to mail to individuals who are eligible for a conversion contract, an election and premium notice form, including an outline of coverage, within 14 days of request or notice to the HMO that an individual is considering applying for a conversion contract.

**Section 24.** Amends s. 641.495, F.S., relating to requirements for the issuance and maintenance of certificates of authority for HMOs, to reinsert language that was apparently inadvertently repealed in 1996. (See the history note following this section in the Florida Statutes for a discussion of ch. 96-199, L.O.F.) The language provides that the provisions of part I of ch. 395, F.S. (relating to licensure of health care facilities) do not apply to an accredited HMO if, on or before January 1, 1991, the HMO provided no more than 10 outpatient holding beds for short-term and hospice patients in an ambulatory care facility for its members and met certain accreditation standards.

**Section 25.** Provides an effective date of January 1, 1999.

**IV. Constitutional Issues:**

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, subsection 19(f) of the Florida Constitution.

**V. Economic Impact and Fiscal Note:**

A. Tax/Fee Issues:

The bill requires HMOs to pay a reasonable fee to the Department of Insurance to cover the cost associated with the filing and analysis of documents that the bill requires HMOs to file with the National Association of Insurance Commissioners. (Section 20)

B. Private Sector Impact:

The expansion of eligibility for guaranteed issuance of individual coverage would benefit those persons who have been covered for at least 18 months by prior individual coverage and who lose eligibility for coverage due to the reasons specified in the bill. Individual insurers that are required to issue policies to such persons may experience increased costs that would impact premiums. Insurers would be permitted to charge nonstandard rates for persons with identified health conditions, as permitted under current health insurance rating laws. (Section 5)

Currently licenced HMOs must meet increased surplus requirements and deposit requirements, as specified in the bill. Although precise information is not available as to the number of HMOs affected by this change and the financial impact on such HMOs, DOI suggests that 6 to 8 HMOs will be impacted by the increased solvency requirements. (Section 17) Policyholders of HMOs would be provided additional protections against insolvency, but those HMOs unable to meet the new requirements may be determined to be insolvent as a result of the changes.

Policyholders who purchase disability income policies may experience relatively low premiums in the first few years after initial issuance of the policy, followed by significant premium increases in later years, due to the exemption for disability income policies from specified prohibited rating practices. (Section 4)

Persons who establish Roth IRAs and Medical Savings Accounts would have deposits to, and withdrawals from, such accounts protected from creditors. (Sections 1 and 2)

**C. Government Sector Impact:**

To comply with the federal Mental Health Parity Act, the state self-insurance plan was required to eliminate the \$2,000 annual cap on mental health benefits. Consequently, as of January 1, 1998, in compliance with MHPA, the self-insurance plan no longer has a separate \$2,000 limit for mental health benefits. (Section 9)

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

In the interim project entitled *Access to Health Insurance Coverage* prepared by the Committee on Banking and Insurance, recommendations related to the provisions in this bill included: (1) that the Insurance Code be amended to require the Department of Insurance to establish the “standard risk rate” charged in the individual health insurance market on an annual basis, and that a more specific definition be provided in law; (2) that in the event the FCHA continues to renew policies, the Insurance Code be amended to require the FCHA board to adopt and file annual rate filings with the Department of Insurance set at 200, 225, and 250 percent of the standard risk rate for low, moderate, and high-risk policyholders, respectively, to ensure that FCHA premiums are adequate and reflect the actual and anticipated loss experiences of such coverage; and (3) at a minimum, that the Insurance Code be amended to incorporate the mental health parity provisions of federal HIPAA, to authorize the Florida Department of Insurance to enforce such provisions.

CS/SB 236 (by the Banking and Insurance Committee and Senator Grant) requires group insurers and health maintenance organizations to provide coverage for serious mental illnesses, as defined, generally at the same level provided for physical illness, except that coverage may be limited, annually, to 45 inpatient days and 60 outpatient visits, and subject to other exceptions. Any such requirements, if enacted, would be in addition to the requirements of Section 8 of CS/SB 1800.

**VIII. Amendments:**

None.

