

By Senator Diaz-Balart

37-1523-98

1                                   A bill to be entitled  
2           An act relating to health insurance; amending  
3           s. 222.22, F.S.; exempting moneys paid into a  
4           Medical Savings Account from attachment,  
5           garnishment, or legal process; amending s.  
6           627.6425, F.S.; specifying exceptions to  
7           guaranteed renewability of individual health  
8           insurance policies; amending s. 627.6487, F.S.,  
9           redefining the term "eligible individual" for  
10          purposes of guaranteed-issuance of an  
11          individual health insurance policy; amending s.  
12          627.6498, F.S.; requiring the Department of  
13          Insurance to establish standard risk rates for  
14          purposes of determining premium rates of  
15          coverage issued by the Florida Comprehensive  
16          Health Association; amending s. 627.6571, F.S.;  
17          specifying exceptions to guaranteed  
18          renewability of group health insurance  
19          policies; amending s. 627.6675, F.S.; requiring  
20          the Department of Insurance to annually  
21          establish standard risk rates for purposes of  
22          determining maximum premiums for conversion  
23          policies; revising standards for renewal of  
24          converted insurance policies; requiring the  
25          insurer to mail certain information to a person  
26          eligible for a converted policy, upon request;  
27          creating s. 627.6685, F.S.; requiring health  
28          insurers and health maintenance organizations  
29          to include in their plans that offer mental  
30          health coverage certain mental health benefits  
31          that are not less favorable than those for

1           medical or surgical benefits covered by the  
2           plan; defining terms; providing exemptions;  
3           limiting applicability of this section;  
4           amending s. 627.674, F.S.; revising the minimum  
5           standards for Medicare Supplement policies;  
6           amending s. 627.6741, F.S.; revising  
7           requirements for insurers to issue, cancel,  
8           nonrenew, and replace Medicare supplement  
9           policies; restricting preexisting-condition  
10          exclusions; authorizing the Department of  
11          Insurance to adopt rules governing guaranteed  
12          issue of Medicare supplement coverage for  
13          continuously covered individuals; amending s.  
14          627.9403, F.S.; specifying the provisions of  
15          the Long-term Care Insurance Act that apply to  
16          limited benefit policies; amending s. 627.9404,  
17          F.S.; defining the term "limited benefit  
18          policy"; amending s. 627.9407, F.S.; revising  
19          the requirements for exclusion of coverage for  
20          preexisting conditions for long-term care  
21          policies; requiring limited-benefit policies to  
22          contain a disclosure statement regarding their  
23          qualification for favorable tax treatment;  
24          amending s. 627.94073, F.S.; revising the  
25          notice requirement for long-term care policies  
26          regarding the right to designate a secondary  
27          person to receive notice of lapse of coverage;  
28          amending s. 641.31074, F.S.; revising  
29          requirements for guaranteed renewability of a  
30          health maintenance organization contract;  
31          amending s. 641.3111, F.S.; requiring health

1 maintenance organization contracts to provide  
2 for an extension of benefits upon termination  
3 of the contract; amending s. 641.3922, F.S.;  
4 revising the method for establishing the  
5 maximum premium for converted contracts issued  
6 by health maintenance organizations; revising  
7 the exceptions to guaranteed renewability of  
8 converted health maintenance organization  
9 contracts; requiring a health maintenance  
10 organization to mail certain information to a  
11 person eligible for a converted contract;  
12 amending s. 641.495, F.S.; exempting from  
13 licensure under part I of ch. 395, F.S.,  
14 certain beds of a health maintenance  
15 organization; providing an effective date.

16  
17 Be It Enacted by the Legislature of the State of Florida:

18  
19 Section 1. Section 222.22, Florida Statutes, is  
20 amended to read:

21 222.22 Exemption of moneys in the Prepaid  
22 Postsecondary Education Expense Trust Fund and in a Medical  
23 Savings Account from legal process.--

24 (1) Moneys paid into or out of the Prepaid  
25 Postsecondary Education Expense Trust Fund by or on behalf of  
26 a purchaser or qualified beneficiary pursuant to an advance  
27 payment contract made under s. 240.551, which contract has not  
28 been terminated, are not liable to attachment, garnishment, or  
29 legal process in the state in favor of any creditor of the  
30 purchaser or beneficiary of such advance payment contract.

31

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

7           Section 2. Paragraph (a) of subsection (3) of section  
8 627.6425, Florida Statutes, is amended to read:

9           627.6425 Renewability of individual coverage.--

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

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

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

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

29           Section 3. Subsection (3) of section 627.6487, Florida  
30 Statutes, is amended to read:

31

1           627.6487 Guaranteed availability of individual health  
2 insurance coverage to eligible individuals.--

3           (3) For the purposes of this section, the term  
4 "eligible individual" means an individual:

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

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

13           (b) Who is not eligible for coverage under:

14           1. A group health plan, as defined in s. 2791 of the  
15 Public Health Service Act;

16           2. A conversion policy under s. 627.6675 or s.  
17 641.3921;

18           3. Part A or part B of Title XVIII of the Social  
19 Security Act; or

20           4. A state plan under Title XIX of such act, or any  
21 successor program, and does not have other health insurance  
22 coverage;

23           (c) With respect to whom the most recent coverage  
24 within the coverage period described in paragraph~~(1)~~(a) was  
25 not terminated based on a factor described in s.

26 627.6571(2)(a) or (b), relating to nonpayment of premiums or  
27 fraud, unless such nonpayment of premiums or fraud was due to  
28 acts of an employer or person other than the individual;

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

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

4 Section 4. Paragraph (a) of subsection (4) of section  
5 627.6498, Florida Statutes, is amended to read:

6 627.6498 Minimum benefits coverage; exclusions;  
7 premiums; deductibles.--

8 (4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.--

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

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

23 2. Rates are subject to approval by the department.

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

30 4. The board shall establish separate premium  
31 schedules for low-risk individuals, medium-risk individuals,

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

12 Section 5. Paragraphs (a) and (b) of subsection (3) of  
13 section 627.6571, Florida Statutes, are amended to read:

14 627.6571 Guaranteed renewability of coverage.--

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

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

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

29 3. In exercising the option to discontinue coverage of  
30 this form and in offering the option of coverage under  
31 subparagraph 2., the insurer acts uniformly without regard to

1 the claims experience of those policyholders or any  
2 health-status-related factor that relates to any participants  
3 or beneficiaries covered or new participants or beneficiaries  
4 who may become eligible for such coverage.

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

10 a. The insurer provides notice to the department and  
11 to each policyholder, and participants and beneficiaries  
12 covered under such coverage, of such discontinuation at least  
13 180 days prior to the date of the discontinuation of such  
14 coverage; and

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

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

24 Section 6. Subsection (3), paragraph (b) of subsection  
25 (7), and subsection (17) of section 627.6675, Florida  
26 Statutes, are amended to read:

27 627.6675 Conversion on termination of  
28 eligibility.--Subject to all of the provisions of this  
29 section, a group policy delivered or issued for delivery in  
30 this state by an insurer or nonprofit health care services  
31 plan that provides, on an expense-incurred basis, hospital,

1 surgical, or major medical expense insurance, or any  
2 combination of these coverages, shall provide that an employee  
3 or member whose insurance under the group policy has been  
4 terminated for any reason, including discontinuance of the  
5 group policy in its entirety or with respect to an insured  
6 class, and who has been continuously insured under the group  
7 policy, and under any group policy providing similar benefits  
8 that the terminated group policy replaced, for at least 3  
9 months immediately prior to termination, shall be entitled to  
10 have issued to him or her by the insurer a policy or  
11 certificate of health insurance, referred to in this section  
12 as a "converted policy." An employee or member shall not be  
13 entitled to a converted policy if termination of his or her  
14 insurance under the group policy occurred because he or she  
15 failed to pay any required contribution, or because any  
16 discontinued group coverage was replaced by similar group  
17 coverage within 31 days after discontinuance.

18 (3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR  
19 GROUP COVERAGE.--

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

31

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

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

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

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

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

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

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

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

31 (7) INFORMATION REQUESTED BY INSURER.--

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

4 1. Either the benefits provided under the sources  
5 referred to in subparagraphs (a)1. and 2. for the person or  
6 the benefits provided or available under the sources referred  
7 to in subparagraph (a)3. for the person, together with the  
8 benefits provided by the converted policy, would result in  
9 overinsurance according to the insurer's standards on file  
10 with the department.

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

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

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

19 ~~4.5.~~ Other reasons approved by the department.

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

1 Section 7. Section 627.6685, Florida Statutes, is  
2 created to read:

3 627.6685 Mental health coverage.--

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

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

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

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

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

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

29 (2) BENEFITS.--

30 (a)1. In the case of a group health plan, or health  
31 insurance coverage offered in connection with such a plan,

1 which provides both medical and surgical benefits and mental  
2 health benefits:  
3       a. If the plan or coverage does not include an  
4 aggregate lifetime limit on substantially all medical and  
5 surgical benefits, the plan or coverage may not impose any  
6 aggregate lifetime limit on mental health benefits.  
7       b. If the plan or coverage includes an aggregate  
8 lifetime limit on substantially all medical and surgical  
9 benefits, the plan or coverage must:  
10           (I) Apply that applicable lifetime limit both to the  
11 medical and surgical benefits to which it otherwise would  
12 apply and to mental health benefits and not distinguish in the  
13 application of such limit between such medical and surgical  
14 benefits and mental health benefits; or  
15           (II) Not include any aggregate lifetime limit on  
16 mental health benefits which is less than that applicable  
17 lifetime limit.  
18       c. For any plan or coverage that is not described in  
19 sub-subparagraph a. or sub-subparagraph b. and that includes  
20 no or different aggregate lifetime limits on different  
21 categories of medical and surgical benefits, the department  
22 shall establish rules under which sub-subparagraph b. is  
23 applied to such plan or coverage with respect to mental health  
24 benefits by substituting for the applicable lifetime limit an  
25 average aggregate lifetime limit that is computed taking into  
26 account the weighted average of the aggregate lifetime limits  
27 applicable to such categories.  
28       2. In the case of a group health plan, or health  
29 insurance coverage offered in connection with such a plan,  
30 which provides both medical and surgical benefits and mental  
31 health benefits:

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

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

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

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

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

24           (b) This section may not be construed:

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

28           2. In the case of a group health plan, or health  
29 insurance coverage offered in connection with such a plan,  
30 which provides mental health benefits, as affecting the terms  
31 and conditions, including cost-sharing, limits on numbers of

1 visits or days of coverage, and requirements relating to  
2 medical necessity, relating to the amount, duration, or scope  
3 of mental health benefits under the plan or coverage, except  
4 as specifically provided in paragraph (a) with respect to  
5 parity in the imposition of aggregate lifetime limits and  
6 annual limits for mental health benefits.

7 (3) EXEMPTIONS.--

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

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

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

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

25 (6) The provisions of this section prevail over any  
26 conflicting provision of s. 627.668 occurs.

27 Section 8. Paragraphs (a) and (d) of subsection (2)  
28 and subsection (3) of section 627.674, Florida Statutes, are  
29 amended to read:

30 627.674 Minimum standards; filing requirements.--  
31

1           (2)(a) The department must adopt rules establishing  
2 minimum standards for Medicare supplement policies that, taken  
3 together with the requirements of this part, are no less  
4 comprehensive or beneficial to persons insured or covered  
5 under Medicare supplement policies issued, delivered, or  
6 issued for delivery in this state, including certificates  
7 under group or blanket policies issued, delivered, or issued  
8 for delivery in this state, than the standards provided in 42  
9 U.S.C. Section 1395ss, or the most recent version of the NAIC  
10 Model Regulation To Implement the NAIC Medicare Supplement  
11 Insurance Minimum Standards Model Act adopted by the National  
12 Association of Insurance Commissioners on July 31, 1991, or  
13 the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No.  
14 101-508).

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

20           (3) A policy may not be filed with the department as a  
21 Medicare supplement policy unless the policy meets or exceeds,  
22 ~~either in a single policy or, in the case of nonprofit health~~  
23 ~~care services plans, in one or more policies issued in~~  
24 ~~conjunction with one another,~~ the requirements of 42 U.S.C.  
25 Section 1395ss, or the most recent version of the NAIC  
26 Medicare Supplement Insurance Minimum Standards Model Act,  
27 adopted by the National Association of Insurance Commissioners  
28 on July 31, 1991, and the Omnibus Budget Reconciliation Act of  
29 1990 (Pub. L. No. 101-508).

30           Section 9. Section 627.6741, Florida Statutes, is  
31 amended to read:

1           627.6741 Issuance, cancellation, nonrenewal, and  
2 replacement.--

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

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

14           (b) To any individual who is 65 years of age or older  
15 and is enrolled in Medicare part B, who resides in this state,  
16 upon the request of the individual during the 2-month period  
17 following termination of coverage under a group health  
18 insurance policy.†

19  
20 A Medicare supplement policy issued to an individual under  
21 paragraph (a) or paragraph (b) may not exclude benefits based  
22 on a pre-existing condition if the individual has a continuous  
23 period of creditable coverage, as defined in s. 627.6561(5),  
24 of at least 6 months as of the date of application for  
25 coverage.

26  
27 ~~the opportunity of enrolling in a Medicare supplement policy,~~  
28 ~~without conditioning the issuance or effectiveness of the~~  
29 ~~policy on, and without discriminating in the price of the~~  
30 ~~policy based on, the medical or health status or receipt of~~  
31 ~~health care by the individual.~~

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

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

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

15           (c) If a Medicare supplement policy or certificate  
16 replaces another Medicare supplement policy or certificate or  
17 creditable coverage as defined in s. 627.6561(5)~~a group~~  
18 ~~health insurance policy or certificate~~, the replacing insurer  
19 shall waive any time periods applicable to preexisting  
20 conditions, waiting periods, elimination periods, and  
21 probationary periods in the new Medicare supplement policy for  
22 similar benefits to the extent such time was spent under the  
23 original policy, subject to the requirements of s.  
24 627.6561(6)-(11).

25           (3) For group Medicare supplement policies:

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

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

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

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

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

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

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

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

31

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

6           Section 10. Section 627.9403, Florida Statutes, is  
7 amended to read:

8           627.9403 Scope.--The provisions of this part shall  
9 apply to long-term care insurance policies delivered or issued  
10 for delivery in this state, and to policies delivered or  
11 issued for delivery outside this state to the extent provided  
12 in s. 627.9406, by an insurer, a fraternal benefit society as  
13 defined in s. 632.601, a health care services plan as defined  
14 in s. 641.01, a health maintenance organization as defined in  
15 s. 641.19, a prepaid health clinic as defined in s. 641.402,  
16 or a multiple-employer welfare arrangement as defined in s.  
17 624.437. A policy which is advertised, marketed, or offered as  
18 a long-term care policy and as a Medicare supplement policy  
19 shall meet the requirements of this part and the requirements  
20 of ss. 627.671-627.675 and, to the extent of a conflict, be  
21 subject to the requirement that is more favorable to the  
22 policyholder or certificateholder. The provisions of this  
23 part shall not apply to a continuing care contract issued  
24 pursuant to chapter 651 and shall not apply to guaranteed  
25 renewable policies issued prior to October 1, 1988. Any  
26 limited benefit policy that limits coverage to care in a  
27 nursing home or to one or more lower levels of care required  
28 or authorized to be provided by this part or by department  
29 rule must meet all requirements of this part that apply to  
30 long-term care insurance policies, except s. 627.9407(3)(c),  
31 (9), (10)(f), and (12), and s. 627.94073(2)~~s. 627.9407(3)(c)~~

1 ~~and (9)~~. If the limited benefit policy does not provide  
2 coverage for care in a nursing home, but does provide coverage  
3 for one or more lower levels of care, the policy shall also be  
4 exempt from the requirements of s. 627.9407(3)(d).

5 Section 11. Subsection (1) of section 627.9404,  
6 Florida Statutes, is amended, present subsections (7), (8),  
7 (9), and (10) of that section are renumbered as subsections  
8 (8), (9), (10), and (11), respectively, and a new subsection  
9 (7) is added to that section, to read:

10 627.9404 Definitions.--For the purposes of this part:

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

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

1           Section 12. Paragraph (a) of subsection (4) of section  
2 627.9407, Florida Statutes, is amended, and subsection (13) is  
3 added to that section, to read:

4           627.9407 Disclosure, advertising, and performance  
5 standards for long-term care insurance.--

6           (4) PREEXISTING CONDITION.--

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

17           (13) ADDITIONAL DISCLOSURE.--A limited benefit policy  
18 qualified under s. 7702B of the Internal Revenue Code must  
19 include a disclosure statement within the policy and within  
20 the outline of coverage that the policy is intended to be a  
21 qualified limited benefit insurance contract. A limited  
22 benefit policy that is not intended to be a qualified limited  
23 benefit insurance contract must include a disclosure statement  
24 within the policy and within the outline of coverage that the  
25 policy is not intended to be a qualified limited benefit  
26 insurance contract. The disclosure must be prominently  
27 displayed and must read as follows: "This limited benefit  
28 insurance policy is not intended to be a qualified limited  
29 benefit insurance contract. You need to be aware that benefits  
30 received under this policy may create unintended, adverse  
31 income tax consequences to you. You may want to consult with a

1 knowledgeable individual about such potential income tax  
2 consequences."

3 Section 13. Subsection (2) of section 627.94073,  
4 Florida Statutes, is amended to read:

5 627.94073 Notice of cancellation; grace period.--

6 (2) A long-term care policy may not be canceled for  
7 nonpayment of premium unless, after expiration of the grace  
8 period in subsection (1), and at least 30 days prior to the  
9 effective date of such cancellation, the insurer has mailed a  
10 notification of possible lapse in coverage to the policyholder  
11 and to a specified secondary addressee if such addressee has  
12 been designated in writing by name and address by the  
13 policyholder. For policies issued or renewed on or after  
14 October 1, 1996, the insurer shall notify the policyholder, at  
15 least once every 2 years, of the right to designate a  
16 secondary addressee. The applicant has the right to designate  
17 at least one person who is to receive the notice of  
18 termination, in addition to the insured. Designation shall not  
19 constitute acceptance of any liability on the third party for  
20 services provided to the insured. The form used for the  
21 written designation must provide space clearly designated for  
22 listing at least one person. The designation shall include  
23 each person's full name and home address. In the case of an  
24 applicant who elects not to designate an additional person,  
25 the waiver shall state: "Protection against unintended  
26 lapse.--I understand that I have the right to designate at  
27 least one person other than myself to receive notice of lapse  
28 or termination of this long-term care/limited benefit  
29 ~~long-term care~~ insurance policy for nonpayment of premium. I  
30 understand that notice will not be given until 30 days after a  
31 premium is due and unpaid. I elect NOT to designate any person

1 to receive such notice." Notice shall be given by first class  
2 United States mail, postage prepaid, and notice may not be  
3 given until 30 days after a premium is due and unpaid. Notice  
4 shall be deemed to have been given as of 5 days after the date  
5 of mailing.

6 Section 14. Paragraph (d) of subsection (2), and  
7 paragraphs (a) and (b) of subsection (3) of section 641.31074,  
8 Florida Statutes, are amended to read:

9 641.31074 Guaranteed renewability of coverage.--

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

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

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

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

25 2. The health maintenance organization offers to each  
26 contract holder provided coverage of this form in such market  
27 the option to purchase all, or in the case of the large-group  
28 market, any other health insurance coverage currently being  
29 offered by the health maintenance organization in such market;  
30 and

31

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

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

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

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

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

29           Section 15. Section 641.3111, Florida Statutes, is  
30 amended to read:

31           641.3111 Extension of benefits.--

1           (1) Every group health maintenance contract shall  
2 provide that termination of the contract ~~by the health~~  
3 ~~maintenance organization~~ shall be without prejudice to any  
4 continuous loss which commenced while the contract was in  
5 force, but any extension of benefits beyond the period the  
6 contract was in force may be predicated upon the continuous  
7 total disability of the subscriber and may be limited to  
8 payment for the treatment of a specific accident or illness  
9 incurred while the subscriber was a member. Such extension of  
10 benefits may be limited to the occurrence of the earliest of  
11 the following events:

12           (a) The expiration of 12 months.

13           (b) Such time as the member is no longer totally  
14 disabled.

15           (c) A succeeding carrier elects to provide replacement  
16 coverage without limitation as to the disability condition.

17           (d) The maximum benefits payable under the contract  
18 have been paid.

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

26           (3) In the case of maternity coverage, when not  
27 covered by the succeeding carrier, a reasonable extension of  
28 benefits or accrued liability provision is required, which  
29 provision provides for continuation of the contract benefits  
30 in connection with maternity expenses for a pregnancy that  
31 commenced while the policy was in effect. The extension shall

1 be for the period of that pregnancy and shall not be based  
2 upon total disability.

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

8 Section 16. Subsections (3), (7), and (14) of section  
9 641.3922, Florida Statutes, are amended to read:

10 641.3922 Conversion contracts; conditions.--Issuance  
11 of a converted contract shall be subject to the following  
12 conditions:

13 (3) CONVERSION PREMIUM.--The premium for the converted  
14 contract shall be determined in accordance with premium rates  
15 applicable to the age and class of risk of each person to be  
16 covered under the converted contract and to the type and  
17 amount of coverage provided. However, the premium for the  
18 converted contract may not exceed 200 percent of the standard  
19 risk rate, as established by the department under s.  
20 627.6675(3)~~Florida Comprehensive Health Association and~~  
21 ~~adjusted for differences in benefit levels and structure~~  
22 ~~between the converted policy and the policy offered by the~~  
23 ~~Florida Comprehensive Health Association.~~ The mode of payment  
24 for the converted contract shall be quarterly or more  
25 frequently at the option of the organization, unless otherwise  
26 mutually agreed upon between the subscriber and the  
27 organization.

28 (7) REASONS FOR CANCELLATION; TERMINATION.--The  
29 converted health maintenance contract must contain a  
30 cancellation or nonrenewability clause providing that the  
31 health maintenance organization may refuse to renew the

1 contract of any person covered thereunder, but cancellation or  
2 nonrenewal must be limited to one or more of the following  
3 reasons:

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

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

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

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

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

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

30 ~~(f)(g)~~ A dependent of the subscriber has reached the  
31 limiting age under the converted contract, subject to

1 subsection (12); but the refusal to renew coverage shall apply  
2 only to coverage of the dependent, except in the case of  
3 handicapped children.

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

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

20 Section 17. Subsection (12) is added to section  
21 641.495, Florida Statutes, to read:

22 641.495 Requirements for issuance and maintenance of  
23 certificate.--

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

31

1 Organizations, the Accreditation Association for Ambulatory  
2 Health Care, or the National Committee for Quality Assurance.

3 Section 18. This act shall take effect January 1,  
4 1999.

5  
6 \*\*\*\*\*

7 SENATE SUMMARY

8 Revises various sections of the Insurance Code relating  
9 to health insurance. Specifies exceptions to guaranteed  
10 renewability of individual and group health insurance  
11 policies. Requires the Department of Insurance to  
12 establish standard risk rates to determine premium rates  
13 of coverage issued by the Florida Comprehensive Health  
14 Association. Revises standards for renewal of converted  
15 insurance policies. Requires health insurers and health  
16 maintenance organizations to include in their plans that  
17 offer mental health coverage certain mental health  
18 benefits that are not less favorable than for medical or  
19 surgical benefits covered by the plan. Revises minimum  
20 standards for Medicare supplement policies. Revises  
21 requirements for insurers to issue, cancel, nonrenew, and  
22 replace Medicare supplement policies. Authorizes the  
23 department to adopt rules governing guaranteed issue of  
24 Medicare supplement coverage for continuously covered  
25 individuals. Modifies provisions of the Long-term Care  
26 Insurance Act. Authorizes rulemaking power for the  
27 department. Revises provisions of health maintenance  
28 contracts relating to renewability and extension of  
29 benefits. (See bill for details.)  
30  
31