

STORAGE NAME: h0783z.hcs

DATE: May 20, 1999

**\*\*FINAL ACTION\*\***

**\*\*SEE FINAL ACTION STATUS SECTION\*\***

**HOUSE OF REPRESENTATIVES  
COMMITTEE ON  
HEALTH CARE SERVICES  
FINAL ANALYSIS**

**BILL #:** HB 783 (Passed as CS/SB 2554)

**RELATING TO:** Provider Contracts

**SPONSOR(S):** Rep. Murman

**COMPANION BILL(S):** SB 2554 (s)

**ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:**

- (1) HEALTH CARE SERVICES YEAS 15 NAYS 1
- (2) INSURANCE (W/D)
- (3) HEALTH CARE LICENSING & REGULATION (W/D)
- (4) HEALTH & HUMAN SERVICES APPROPRIATION (W/D)
- (5)

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I. FINAL ACTION STATUS:

06/08/99 Approved by Governor; Chapter No. 99-275

II. SUMMARY:

HB 783 provides that part I, ch. 626, F.S., relating to insurance representatives: licensing procedures and general requirements, does not apply to a certified public accountant licensed under ch. 473 who is acting within the scope of the practice of public accounting, as defined in s. 473.302, F.S., provided certain conditions exist.

The bill requires that payments by a fiscal intermediary to a health care provider, pursuant to contracts with health maintenance organizations (HMOs), include the following information:

- For a *noncapitated* health care provider, an explanation of services being reimbursed which includes the patient's name, date of service, procedure code, amount of reimbursement and plan identification.
- For a *capitated* health care provider, a statement of services which includes the number of patients covered by the contract, rate per patient, total amount of payment, and the identification of the plan on whose behalf the payment is made.

In addition, the bill: allows HMOs to increase the copayment for any benefit, or amend benefits to which a subscriber is entitled under a group contract, subject to written notice to the contract holder at least 45 days in advance of the time of coverage renewal; requires such notice to identify deletions, limitations, or amendments to any benefits provided in the group contract which will be included in the group contract upon renewal; and requires that HMO contracts providing for massage must also cover the services of persons licensed to practice massage under certain circumstances. Such massage services are subject to the same terms, conditions, and limitations as other covered services.

The bill provides that contracts between an HMO and health care provider may not contain provisions which prohibit:

- The health care provider from entering into contract with any other HMO; or
- The HMO from entering into contract with any other health care provider.

Finally, the bill limits the right of an insurance company or HMO to retroactively cancel a group health insurance policy due to nonpayment of premium by the employer and protects the employee's right to elect a conversion health insurance policy in this event.

This legislation is not expected to have a fiscal impact on state or local government.

III. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

**Insurance Administration**

Part IV, ch. 626, F.S., relating to insurance administrators, provides that "an 'administrator' is any person who directly or indirectly solicits or effects coverage of, collects charges or premiums from, or adjusts or settles claims on residents of this state in connection with authorized commercial self-insurance funds or with insured or self-insured programs which provide life or health insurance coverage or coverage of any other expenses described in s. 624.33(1)." Several exceptions to who can be considered an administrator are listed in this section, some of which include, employers on behalf of their employees, health maintenance organizations, and insurance agents whose activities are limited to the sale of insurance.

**Health Maintenance Organizations and Provider Contracts**

Chapter 641, F.S., relates to health care services programs. Part I of this chapter, consisting of ss. 641.17-641.3923, F.S., is the "Health Maintenance Organization Act," under which the Department of Insurance regulates HMOs. Any entity that is issued a certificate of authority under part 1 of chapter 641, F.S., and that is otherwise in compliance with that part may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.

Section 641.31, F.S., sets certain requirements HMOs must meet when contracting with subscribers and provides for certain coverage that must be included in the contract. Subsection (3) of this section allows an HMO to amend any contract with its subscriber or change any rate, subject to the disapproval of the Department of Insurance. Rate changes require the HMO to provide the subscriber with at least 30 days' advance written notice of the change. There is no mention in this section of any action HMO subscribers may take once they have received notice of a contract change by their HMO. According to representatives with the Department of Insurance, HMOs may amend their contracts to change benefits, rates or co-payment provisions *only* at the time of coverage renewal [ss. 641.31074(4) and 627.6425(4), F.S., and Rule 4-191.033(1)(a)(b), F.A.C.] and the subscriber must be given 30 days' advance written notice of any rate change. Additionally, an HMO may revise its prescription drug formulary (which limits the providers choice of a drug), so long as the HMO continues to provide the drugs necessary to treat the subscriber's medical condition.

Requirements for contracts between an HMO and its providers are established in s. 641.315, F.S. According to this section, all contracts between HMOs and providers must be in writing and must contain a provision that the subscriber shall not be liable to the provider for any services covered by the subscriber's contract with the HMO. Section 641.315, F.S., also sets out requirements for cancellation of the contract by both the provider and the HMO that must be included in the contract. Subsection (8) of this section provides that a contract between a health maintenance organization and a provider may not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options. Currently, there is no statutory provision relating to contract language that prohibits the contracting HMO and the health care provider from contracting with any other HMO or health care provider.

In general, current Florida law does not restrict the authority of an HMO from terminating the contract of a health care provider. The allowable reasons for termination of the contract by either party would be subject to the terms of the contract itself. Florida courts have long held firm to an established doctrine known as the employment-at-will doctrine. The employment-at-will doctrine provides that, absent express agreement to the contrary, either employer or employee may terminate their relationship at any time, for any reason. Such employment relationships have no specific duration, and may be terminated at will by either the employer or the employee for or without cause. However, exceptions to the employment-at-will doctrine may be made by the Legislature. For example, the current law requires that HMOs provide at least 60 days' written notice prior to canceling a contract with a health care provider, without cause, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency. The law also requires the health care provider to give the HMO at least 60 days' notice prior to canceling the contract, but allows the HMO and the

provider to agree to terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent. (s. 641.315, F.S.)

HMOs are required to allow subscribers to continue care with a terminated treating provider for a certain time period under certain conditions. Each HMO must allow a subscriber who is pregnant to continue care with a terminated treating provider until completion of postpartum care. The HMO and the provider must continue to be bound by the terms of the contract for this continuation coverage. (s. 641.51(7), F.S.)

### **Fiscal Intermediary Services**

Section 641.316, F.S., provides requirements for the use of fiscal intermediary services by contracting health care professionals and health maintenance organizations. According to this section, "fiscal intermediary services" means reimbursements received or collected on behalf of health care professionals for services rendered, patient and provider accounting, financial reporting and auditing, receipts and collections managements, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations. This section also defines "fiscal intermediary services organization" as a person or entity which performs fiscal intermediary services to health care professionals who contract with health maintenance organizations other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under ch. 395, an insurer licensed under ch. 624, a prepaid limited health service organization licensed under ch. 636, a third-party administrator licensed under ch. 626, a health maintenance organization licensed under this chapter, or physician group practices as defined in s. 455.654(3)(f).

### **Retroactive Cancellation of Group Health Insurance Contracts**

Under Florida law, group health insurers are *not* required to provide advance notice to the group policyholder (the employer) or the certificate-holder (employee) that their insurance is canceled due to nonpayment of premium (s. 627.6645, F.S.). For other reasons, however, insurers must give the policyholder at least 45 days' advance notice of cancellation, expiration, non-renewal, or a change in rates of a policy. Upon receiving such notice, the policyholder must forward the notice to each certificate-holder covered under the policy. Insurers who bill certificate-holders directly for premiums must provide the 45 days' notice described above directly to each certificate-holder. If insurers fail to provide the 45 days' notice, the coverage shall remain in effect at the existing rate until 45 days after the notice is given or until the effective date of replacement coverage is obtained by the insured, whichever occurs first.

Health maintenance organizations have similar notice provisions to group health insurers under s. 641.3108, F.S. Health maintenance organizations are *not* required to provide advance notice to either the group contract holder (employer), or the subscriber (employee) that their coverage is canceled due to nonpayment of premium or termination of eligibility. However, for cancellation due to other reasons, HMOs, who contract directly with group contract holders, must provide these entities with 45 days' advance notice in writing prior to cancellation, expiration, or non-renewal of a contract and request that the notification be forward to all subscribers. All HMO contracts must contain the 45 days' notice requirements and the notice must contain the reasons for the cancellation, expiration, or non-renewal. Pursuant to s. 641.31, F.S., HMOs must provide 30 days' notice to contract holders of a change in health insurance rates and the contract must allow a grace period of at least 10 days after the premium date, during which time the contract must stay in force. Health maintenance organizations that contract directly with subscribers must provide the notices as described above directly to each subscriber.

In January 1998, the Department of Insurance filed an administrative action against AvMed Health Plan (an HMO) for *retroactively* canceling the group health insurance coverage of employees who worked for a company which failed to pay its group HMO premiums. According to the petition filed by the department, the employer had fallen behind on paying the HMO for its group health contract, but during a 2 to 3 month period, the HMO continued to authorize doctors and hospitals to treat the employees. In August 1997, the HMO terminated the group coverage retroactively to May when the last premiums were paid. Employees were not provided written notification by the HMO prior to the contract being canceled. The HMO has billed employees for medical care provided after the May cancellation date. The Department of Insurance alleges that because the HMO failed to provide any of the employees with written notice of termination of their health insurance coverage as specified in

their member handbook, the employees were illegally denied the opportunity to request continued health insurance coverage through a converted contract under s. 641.3922, F.S. Additionally, due to the fact that the HMO continued to authorize and preauthorize medical visits, the department contends that employees were misled into believing that they had health insurance.

Presently, 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 department.

Failure of an employee to obtain notice of cancellation of a group policy may result in the employee incurring medical bills that are not covered. It may also compromise the employee's ability to obtain an individual conversion policy or other replacement coverage, due to the fact that an employee has only 63 days after the date of termination of eligibility for group coverage to apply for an individual conversion policy (s. 627.6675, F.S., for group health insurance, and s. 641.3922, F.S., for group HMO contracts).

**B. EFFECT OF PROPOSED CHANGES:**

Florida law will clearly state that part 1 of chapter 626, F.S., relating to insurance representatives: licensing procedures and general requirements, does not apply to a certified public accountant licensed under ch. 473 who is acting within the scope of the practice of public accounting, as defined in s. 473.302, F.S., provided that certain conditions exist.

Pursuant to contracts with HMOs, a fiscal intermediary will be required to include in its payments to a health care provider, the following information:

- For a *noncapitated* health care provider, an explanation of services being reimbursed which includes the patient's name, date of service, procedure code, amount of reimbursement and plan identification.
- For a *capitated* health care provider, a statement of services which includes the number of patients covered by the contract, rate per patient, total amount of payment, and the identification of the plan on whose behalf the payment is made.

HMOs will be permitted to increase the copayment for any benefit, or amend benefits to which a subscriber is entitled under a group contract, subject to written notice to the contract holder at least 45 days in advance of the time of coverage renewal. Such notice must identify any deletions, limitations, or amendments to any benefits provided in the group contract which will be included in the group contract upon renewal. HMO contracts providing for massage will also be required to cover the services of persons licensed to practice massage under certain circumstances. Such massage services will be subject to the same terms, conditions, and limitations as other covered services.

It will be prohibited for contracts between an HMO and health care provider to contain provisions which prohibit:

- The health care provider from entering into contract with any other HMO; or
- The HMO from entering into contract with any other health care provider.

The right of an insurance company or health maintenance organization to retroactively cancel a group health insurance policy due to nonpayment of premium by the employer will be limited and the employee's right to elect a conversion health insurance policy in this event will be protected.

**C. APPLICATION OF PRINCIPLES:**

1. Less Government:

- a. Does the bill create, increase or reduce, either directly or indirectly:

- (1) any authority to make rules or adjudicate disputes?

No.

- (2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes. HMOs will be required to provide written notice to the contract holder at least 45 days in advance of the time of coverage renewal in order to increase the copayment for any benefit or amend benefits to which a subscriber is entitled under a group contract.

- (3) any entitlement to a government service or benefit?

No.

- b. If an agency or program is eliminated or reduced:

- (1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

- (2) what is the cost of such responsibility at the new level/agency?

N/A

- (3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

- a. Does the bill increase anyone's taxes?

No.

- b. Does the bill require or authorize an increase in any fees?

No.

- c. Does the bill reduce total taxes, both rates and revenues?

No.

- d. Does the bill reduce total fees, both rates and revenues?

No.

- e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

- a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

- b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

No.

4. Individual Freedom:

- a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

No.

- b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

- a. If the bill purports to provide services to families or children:

- (1) Who evaluates the family's needs?

No.

- (2) Who makes the decisions?

No.

- (3) Are private alternatives permitted?

No.

- (4) Are families required to participate in a program?

No.

- (5) Are families penalized for not participating in a program?

No.

- b. Does the bill directly affect the legal rights and obligations between family members?

No.

- c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

- (1) parents and guardians?

N/A

- (2) service providers?

N/A

(3) government employees/agencies?

N/A

**D. STATUTE(S) AFFECTED:**

Sections 626.022, 626.883, 627.6645, 627.6675, 641.31, 641.3108, 641.315, 641.316, and 641.3922, F.S.

**E. SECTION-BY-SECTION ANALYSIS:**

**Section 1.** Amends s. 626.022, F.S., 1998 Supplement, to provide that part 1 of chapter 626, F.S., relating to insurance representatives; licensing procedures and general requirements, does not apply to a certified public accountant licensed under ch. 473 who is acting within the scope of the practice of public accounting, as defined in s. 473.302, F.S., provided that the activities of the certified public accountant are limited to advising a client of the necessity of obtaining insurance, the amount of insurance needed, or the line of coverage needed, and provided that the certified public accountant does not directly or indirectly receive or share in any commission, referral fee, or solicitor's fee.

**Section 2.** Amends s. 626.883, F.S., relating to insurance administrators, to require that payments by a fiscal intermediary to a health care provider include the following information:

- For a *noncapitated* health care provider, an explanation of services being reimbursed which includes specific information such as the patient's name, date of service, procedure code, amount of reimbursement and plan identification.
- For a *capitated* health care provider, a statement of services which must include the number of patients covered by the contract, the rate per patient, the total amount of payment, and the identification of the plan on whose behalf the payment is made.

**Section 3.** Amends s. 641.31, F.S., relating to health maintenance organization contracts. The following subsections are created:

Subsection (36) is created to allow an HMO to increase the copayment for any benefit, or delete, limit, or amend any of the benefits to which a subscriber is entitled under a group contract only, upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. The HMO may amend the contract with the contract holder, with such amendment effective at the time of renewal. Such written notice must identify deletions, limitations, or amendments to any benefits provided in the group contract which will be included in the group contract upon renewal. This provision does not apply to increases in benefits provided by the HMO. The 45-day notice requirement shall not apply if benefits are amended, deleted, or limited at the request of the contract holder.

Subsection (37) is created to require that HMO contracts providing for massage must also cover the services of persons licensed to practice massage pursuant to chapter 480 (regulating massage practice), if the massage is prescribed by a contracted licensed physician as medically necessary and the prescription specifies the number of treatments. The reference to physicians are those licensed under certain provisions of Florida law which are the following: chapter 458-practice of medicine, chapter 459-practice of osteopathic medicine, chapter 460-practice of chiropractic, and chapter 461-practice of podiatric medicine. Such massage services are subject to the same terms, conditions, and limitations as other covered services.

**Section 4.** Amends s. 641.315, F.S., relating to health maintenance organization provider contracts, to provide that a contract renewed or entered into between a health maintenance organization and a provider of health care services may not contain any provision which prohibits or restricts:

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

**Section 5.** Amends s. 641.316, F.S., 1998 Supplement, relating to fiscal intermediary services, to require that payments by a fiscal intermediary to a health care provider include the following information:

- For a *noncapitated* health care provider, an explanation of services being reimbursed which includes specific information such as the patient's name, date of service, procedure code, amount of reimbursement and plan identification.
- For a *capitated* health care provider, a statement of services which must include the number of patients covered by the contract, the rate per patient, the total amount of payment, and the identification of the plan on whose behalf the payment is made.

**Section 6.** Amends s. 627.6645(1), F.S., relating to notification of cancellation or non-renewal of group health insurance policies and time limits thereof, to prohibit a group health insurer from retroactively canceling a group contract, due to nonpayment of premium, *prior* to the date the notice of cancellation is mailed by the insurer to the employer, *unless* the notice is mailed within 45 days after the date the premium was due. Such notice must be mailed to the policyholder's (employer's) last address as a shown by the records of the insurer.

**Section 7.** Amends s. 627.6675, F.S., 1998 Supplement, relating to conversion of group health insurance policies. If termination of an employee's health insurance coverage under a group policy is due to nonpayment of premium by the employer (policyholder) and written notice of cancellation from the insurer was not provided to the employee (certificate-holder) by the employer, the following requirements apply:

- The 63-day time period within which the employee must apply for an individual conversion policy would *not* begin to run until the date the insurer or employer mails notice of cancellation to the employee or certificate-holder at the employee's or certificate-holder's last address as a shown by the record of the insurer.
- The premium for the conversion policy would be at the previous group rate for the time period prior to the date the insurer mails notice to the employee. For the period of coverage after such date, the premium for the converted policy would be subject to the requirements of current law which provide that such premium may not exceed 200 percent of the standard risk rate as established by the Department of Insurance.

The bill also clarifies current law to allow group insurers to contract with another insurer to issue conversion contracts on its behalf, provided that the other insurer is authorized in Florida and the policy has been approved by the Department of Insurance pursuant to s. 627.410, F.S.

**Section 8.** Amends s. 641.3108, F.S., relating to notification of cancellation of health maintenance contracts, to prohibit an HMO from retroactively canceling a group contract, due to nonpayment of premium, *prior* to the date the notice of cancellation is mailed by the HMO to the subscriber, *unless* the notice is mailed within 45 days after the date the premium was due. Such notice must be mailed to the subscriber's last address as a shown by the records of the HMO. For group contracts issued to an employer, the notice requirements of this section are satisfied by providing notice to the employer [subsection (3)].

**Section 9.** Amends s. 641.3922(1), F.S., 1998 Supplement, relating to HMO conversion contracts and time limits thereof, to specify that if termination of an employee's health insurance coverage is due to nonpayment of premium by the employer (group contract holder) and written notice of cancellation from the HMO was not provided to the employee by the employer, the following requirements apply:

- The 63-day time period within which the employee must apply for an individual conversion contract would *not* begin to run until the date the HMO mails notice of cancellation to the employee at the employee's last address as a shown by the records of the HMO.
- The premium for the conversion contract would be at the previous group rate for the time period prior to the date the HMO mails notice to the employee. For the period of coverage after such date, the premium for the converted policy would be subject to the requirements of current law

which provide that such premium may not exceed 200 percent of the standard risk rate as established by the Department of Insurance.

**Section 10.** Provides for an effective date of July 1, 1999, and stipulates that the provisions apply to all contracts renewed or entered into on or after that date.

IV. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

The Department of Insurance will need to update its filing review process to ensure insurance and HMO compliance with the provisions of this act.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

It is anticipated that there would be a fiscal impact on health insurance companies and HMOs. Insurers and HMOs would be required to expend funds and allocate administrative resources to meet the notice requirements imposed under the bill. These entities would need to continually maintain a current listing of all employees under the group plan with their addresses should employee notification of contract cancellation become necessary.

2. Direct Private Sector Benefits:

Employees who are members of group health plans may benefit from the provision that protects their right to elect a conversion insurance policy under certain circumstances. Additionally, employees will be protected by the provision that limits the right of insurers and HMOs to retroactively cancel a group health insurance policy due to nonpayment of premium by an employer.

Group contract holders will likely benefit from the provision which requires their HMO to provide advance notice of specific contract changes prior to contract renewal.

Persons licensed to practice massage therapy may also benefit by the requirement that their services be specifically covered by HMOs if such services are prescribed by HMO-contracted physicians as medically necessary.

Health care providers may benefit by being able to contract with multiple managed care plans.

3. Effects on Competition, Private Enterprise and Employment Markets:

None.

D. **FISCAL COMMENTS:**

None.

V. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. **APPLICABILITY OF THE MANDATES PROVISION:**

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. **REDUCTION OF REVENUE RAISING AUTHORITY:**

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. **REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:**

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

VI. COMMENTS:

None.

VII. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 12, 1999, the Committee on Health Care Services passed a strike-everything amendment sponsored by Representative Murman. This amendment did the following:

- Prohibited certain restrictive contractual arrangements between HMOs and health care providers. A contract between an HMO and health care provider may not contain provisions which prohibit or restrict: the health care provider from entering into a contract with any other HMO to provide services for the HMO's commercial subscriber; or the HMO from entering into a contract with any other health care provider to provide services for the HMO's commercial subscribers.
- Required all health care provider fiscal intermediaries and all HMO fiscal intermediaries to include a detailed explanation of benefits for payments to a health care provider.
- Provided that a health maintenance organization may increase the copayment for any benefit, or delete, amend, or limit any of the benefits to which a subscriber is entitled under the group contract only, upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. The health maintenance organization may amend the contract with the contract holder with such amendment to be effective immediately at the time of coverage renewal. The written notice to the contract holder shall specifically identify any deletions, amendments, or limitations to any of the benefits provided in the group contract during the current contract period that will be included in the group contract upon renewal.
- Provided that all health maintenance contracts that provide coverage for massage shall also cover the services of persons licensed to practice massage pursuant to chapter 480, F.S., if the massage is prescribed by an HMO-contracted physician licensed under chapter 458, 459, 460 or 461, F.S., as medically necessary and the prescription specified the number of treatments.

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The Senate Banking and Insurance Committee passed a committee substitute to the Senate version of HB 783, SB 2554, which contained provisions similar to the provisions passed in the above amendment by the House Health Care Services Committee. CS/SB 2554 was then adopted by the Senate and House with additional amendments relating to: exceptions from certain insurance licensing requirements for specified services; notice requirements for cancellation or non-renewal for employer failures to pay appropriate premiums; conversion coverage options; and contract renewal notice requirements.

VIII. SIGNATURES:

**COMMITTEE ON HEALTH CARE SERVICES:**

Prepared by:

Amy K. Guinan

Staff Director:

Phil E. Williams

**FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:**

Prepared by:

Amy K. Guinan

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Phil E. Williams