

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31

A bill to be entitled  
An act relating to health insurance; amending  
s. 222.21, F.S.; exempting moneys paid into a  
Roth individual retirement account from  
creditors' claims; amending s. 222.22, F.S.;  
exempting moneys paid into a Medical Savings  
Account from attachment, garnishment, or legal  
process; amending s. 627.410, F.S.; exempting  
certain policies from rating requirements;  
amending s. 627.6425, F.S.; specifying  
exceptions to guaranteed renewability of  
individual health insurance policies; amending  
s. 627.6487, F.S.; redefining the term  
"eligible individual" for purposes of  
guaranteed-issuance of an individual health  
insurance policy; amending s. 627.6498, F.S.;  
requiring the Department of Insurance to  
annually establish standard risk rates for  
purposes of determining premium rates of  
coverage issued by the Florida Comprehensive  
Health Association; amending s. 627.6571, F.S.;  
specifying exceptions to guaranteed  
renewability of group health insurance  
policies; amending s. 627.6575, F.S.; providing  
that coverage may not be denied if specified  
notice is given; amending s. 627.6415, F.S.;  
providing that coverage may not be denied if  
specified notice is given; amending s.  
627.6578, F.S.; providing that coverage may not  
be denied if specified notice is given;  
amending s. 627.6675, F.S.; requiring the

1 Department of Insurance to annually establish  
2 standard risk rates for purposes of determining  
3 maximum premiums for conversion policies;  
4 revising standards for renewal of converted  
5 insurance policies; requiring the insurer to  
6 mail certain information to a person eligible  
7 for a converted policy, upon request; creating  
8 s. 627.6685, F.S.; requiring health insurers  
9 and health maintenance organizations to include  
10 in their plans that offer mental health  
11 coverage certain mental health benefits that  
12 are not less favorable than those for medical  
13 or surgical benefits covered by the plan;  
14 defining terms; providing exemptions; limiting  
15 applicability of this section; amending s.  
16 627.6699, F.S.; redefining the term "health  
17 benefit plan" as used in the Employee Health  
18 Care Access Act; amending s. 627.674, F.S.;  
19 revising the minimum standards for Medicare  
20 Supplement policies; amending s. 627.6741,  
21 F.S.; revising requirements for insurers to  
22 issue, cancel, nonrenew, and replace Medicare  
23 supplement policies; restricting  
24 preexisting-condition exclusions; authorizing  
25 the Department of Insurance to adopt rules  
26 governing guaranteed issue of Medicare  
27 supplement coverage for continuously covered  
28 individuals; amending s. 627.9403, F.S.;  
29 specifying the provisions of the Long-term Care  
30 Insurance Act that apply to limited benefit  
31 policies; amending s. 627.9404, F.S.; defining

1 the terms "limited benefit policy" and  
2 "qualified long-term care limited benefit  
3 insurance policy"; amending s. 627.9407, F.S.;  
4 revising the requirements for exclusion of  
5 coverage for preexisting conditions for  
6 long-term care policies; requiring  
7 limited-benefit policies to contain a  
8 disclosure statement regarding their  
9 qualification for favorable tax treatment;  
10 amending s. 627.94073, F.S.; revising the  
11 notice requirement for long-term care policies  
12 regarding the right to designate a secondary  
13 person to receive notice of lapse of coverage;  
14 amending s. 641.225, F.S.; increasing surplus  
15 requirements for health maintenance  
16 organizations; amending s. 641.285, F.S.;  
17 increasing deposit requirements for health  
18 maintenance organizations; revising exceptions;  
19 amending s. 641.26, F.S.; requiring health  
20 maintenance organizations to file certain  
21 reports with the Department of Insurance;  
22 requiring that health maintenance organizations  
23 provide additional information upon the request  
24 of the department; amending s. 641.31, F.S.;  
25 providing that coverage may not be denied if  
26 specified notice is given; amending s.  
27 641.31074, F.S.; revising requirements for  
28 guaranteed renewability of a health maintenance  
29 organization contract; amending s. 641.3111,  
30 F.S.; requiring health maintenance organization  
31 contracts to provide for an extension of

1 benefits upon termination of the contract;  
2 amending s. 641.316, F.S.; revising the amount  
3 of the bond that a fiscal intermediary services  
4 organization is required to maintain;  
5 specifying certain additional requirements and  
6 conditions for the bond and the intermediary;  
7 amending s. 641.3922, F.S.; revising the method  
8 for establishing the maximum premium for  
9 converted contracts issued by health  
10 maintenance organizations; revising the  
11 exceptions to guaranteed renewability of  
12 converted health maintenance organization  
13 contracts; requiring a health maintenance  
14 organization to mail certain information to a  
15 person eligible for a converted contract;  
16 amending s. 641.495, F.S.; exempting from  
17 licensure under part I of ch. 395, F.S.,  
18 certain beds of a health maintenance  
19 organization; providing an effective date.  
20

21 Be It Enacted by the Legislature of the State of Florida:  
22

23 Section 1. Paragraph (a) of subsection (2) of section  
24 222.21, Florida Statutes, is amended to read:

25 222.21 Exemption of pension money and retirement or  
26 profit-sharing benefits from legal processes.--

27 (2)(a) Except as provided in paragraph (b), any money  
28 or other assets payable to a participant or beneficiary from,  
29 or any interest of any participant or beneficiary in, a  
30 retirement or profit-sharing plan that is qualified under s.  
31 401(a), s. 403(a), s. 403(b), s. 408, s. 408A, or s. 409 of

1 the Internal Revenue Code of 1986, as amended, is exempt from  
2 all claims of creditors of the beneficiary or participant.

3 Section 2. Section 222.22, Florida Statutes, is  
4 amended to read:

5 222.22 Exemption of moneys in the Prepaid  
6 Postsecondary Education Expense Trust Fund and in a Medical  
7 Savings Account from legal process.--

8 (1) Moneys paid into or out of the Prepaid  
9 Postsecondary Education Expense Trust Fund by or on behalf of  
10 a purchaser or qualified beneficiary pursuant to an advance  
11 payment contract made under s. 240.551, which contract has not  
12 been terminated, are not liable to attachment, garnishment, or  
13 legal process in the state in favor of any creditor of the  
14 purchaser or beneficiary of such advance payment contract.

15 (2) Moneys paid into or out of a Medical Savings  
16 Account by or on behalf of a person depositing money into such  
17 account or a qualified beneficiary are not liable to  
18 attachment, garnishment, or legal process in the state in  
19 favor of any creditor of such person or beneficiary of such  
20 Medical Savings Account.

21 Section 3. Subsection (6) of section 627.410, Florida  
22 Statutes, is amended to read:

23 627.410 Filing, approval of forms.--

24 (6)(a) An insurer shall not deliver or issue for  
25 delivery or renew in this state any health insurance policy  
26 form until it has filed with the department a copy of every  
27 applicable rating manual, rating schedule, change in rating  
28 manual, and change in rating schedule; if rating manuals and  
29 rating schedules are not applicable, the insurer must file  
30 with the department applicable premium rates and any change in  
31 applicable premium rates.

1 (b) The department may establish by rule, for each  
2 type of health insurance form, procedures to be used in  
3 ascertaining the reasonableness of benefits in relation to  
4 premium rates and may, by rule, exempt from any requirement of  
5 paragraph (a) any health insurance policy form or type thereof  
6 (as specified in such rule) to which form or type such  
7 requirements may not be practically applied or to which form  
8 or type the application of such requirements is not desirable  
9 or necessary for the protection of the public. With respect to  
10 any health insurance policy form or type thereof which is  
11 exempted by rule from any requirement of paragraph (a),  
12 premium rates filed pursuant to ss. 627.640 and 627.662 shall  
13 be for informational purposes.

14 (c) Every filing made pursuant to this subsection  
15 shall be made within the same time period provided in, and  
16 shall be deemed to be approved under the same conditions as  
17 those provided in, subsection (2).

18 (d) Every filing made pursuant to this subsection,  
19 except disability income policies and accidental death  
20 policies, shall be prohibited from applying the following  
21 rating practices:

- 22 1. Select and ultimate premium schedules.
- 23 2. Premium class definitions which classify insured  
24 based on year of issue or duration since issue.
- 25 3. Attained age premium structures on policy forms  
26 under which more than 50 percent of the policies are issued to  
27 persons age 65 or over.

28 (e) Except as provided in subparagraph 1., an insurer  
29 shall continue to make available for purchase any individual  
30 policy form issued on or after October 1, 1993. A policy form  
31 shall not be considered to be available for purchase unless

1 the insurer has actively offered it for sale in the previous  
2 12 months.

3  
4 1. An insurer may discontinue the availability of a  
5 policy form if the insurer provides to the department in  
6 writing its decision at least 30 days prior to discontinuing  
7 the availability of the form of the policy or certificate.  
8 After receipt of the notice by the department, the insurer  
9 shall no longer offer for sale the policy form or certificate  
10 form in this state.

11 2. An insurer that discontinues the availability of a  
12 policy form pursuant to subparagraph 1. shall not file for  
13 approval a new policy form providing similar benefits as the  
14 discontinued form for a period of 5 years after the insurer  
15 provides notice to the department of the discontinuance. The  
16 period of discontinuance may be reduced if the department  
17 determines that a shorter period is appropriate.

18 3. The experience of all policy forms providing  
19 similar benefits shall be combined for all rating purposes.

20 Section 4. Subsection (3) of section 627.6425, Florida  
21 Statutes, is amended to read:

22 627.6425 Renewability of individual coverage.--

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

27 1. The insurer provides notice to each covered  
28 individual provided coverage under this policy form in the  
29 individual market of such discontinuation at least 90 days  
30 prior to the date of the nonrenewal ~~discontinuation~~ of such  
31 coverage;

1           2. The insurer offers to each individual in the  
2 individual market provided coverage under this policy form the  
3 option to purchase any other individual health insurance  
4 coverage currently being offered by the insurer for  
5 individuals in such market in the state; and  
6

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

12           (b)1. Subject to subparagraph (a)3., in any case in  
13 which an insurer elects to discontinue offering all health  
14 insurance coverage in the individual market in this state,  
15 health insurance coverage may be discontinued by the insurer  
16 only if:

17           a. The insurer provides notice to the department and  
18 to each individual of such discontinuation at least 180 days  
19 prior to the date of the nonrenewal ~~expiration~~ of such  
20 coverage; and

21           b. All health insurance issued or delivered for  
22 issuance in the state in the individual market is discontinued  
23 and coverage under such health insurance coverage in such  
24 market is not renewed.

25           2. In the case of a discontinuation under subparagraph  
26 1. in the individual market, the insurer may not provide for  
27 the issuance of any individual health insurance coverage in  
28 this state during the 5-year period beginning on the date of  
29 the discontinuation of the last health insurance coverage not  
30 so renewed.

31           Section 5. Subsection (3) of section 627.6487, Florida  
Statutes, is amended to read:



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.a. 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; or

13           b. Whose most recent prior creditable coverage was  
14 under an individual plan issued by a health insurer or health  
15 maintenance organization, which coverage is terminated due to  
16 the insurer or health maintenance organization becoming  
17 insolvent or discontinuing the offering of all individual  
18 coverage in the state, or due to the insured no longer living  
19 in the service area of the insurer or health maintenance  
20 organization that provides coverage through a network plan;

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

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

24           2. A conversion policy or contract issued by an  
25 authorized insurer or health maintenance organization under s.  
26 627.6675 or s. 641.3921, respectively, offered to an  
27 individual who is no longer eligible for coverage under either  
28 an insured or self-insured employer plan;

29           3. Part A or part B of Title XVIII of the Social  
30 Security Act; or  
31

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

4           (c) With respect to whom the most recent coverage  
5 within the coverage period described in paragraph~~(1)~~(a) was  
6 not terminated based on a factor described in s.  
7 627.6571(2)(a) or (b), relating to nonpayment of premiums or  
8 fraud, unless such nonpayment of premiums or fraud was due to  
9 acts of an employer or person other than the individual;

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

13           (e) Who, if the individual elected such continuation  
14 provision, has exhausted such continuation coverage under such  
15 provision or program.

16           Section 6. Paragraph (a) of subsection (4) of section  
17 627.6498, Florida Statutes, is amended to read:

18           627.6498 Minimum benefits coverage; exclusions;  
19 premiums; deductibles.--

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

21           (a) The plan shall provide for annual deductibles for  
22 major medical expense coverage in the amount of \$1,000 or any  
23 higher amounts proposed by the board and approved by the  
24 department, plus the benefits payable under any other type of  
25 insurance coverage or workers' compensation. The schedule of  
26 premiums and deductibles shall be established by the  
27 association. With regard to any preferred provider arrangement  
28 utilized by the association, the deductibles provided in this  
29 paragraph shall be the minimum deductibles applicable to the  
30 preferred providers and higher deductibles, as approved by the  
31

1 department, may be applied to providers who are not preferred  
2 providers.

3 1. Separate schedules of premium rates based on age  
4 may apply for individual risks.

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

6 3. Standard risk rates for coverages issued by the  
7 association shall be established by the department, pursuant  
8 to s. 627.6675(3)~~association, subject to approval by the~~  
9 ~~department, using reasonable actuarial techniques, and shall~~  
10 ~~reflect anticipated experience and expenses of such coverages~~  
11 ~~for standard risks.~~

12 4. The board shall establish separate premium  
13 schedules for low-risk individuals, medium-risk individuals,  
14 and high-risk individuals and shall revise premium schedules  
15 annually pursuant to this section for each 6-month policy  
16 period beginning January 1999 ~~1992. For the calendar year 1991~~  
17 ~~and thereafter,~~ No rate shall exceed 200 percent of the  
18 standard risk rate for low-risk individuals, 225 percent of  
19 the standard risk rate for medium-risk individuals, or 250  
20 percent of the standard risk rate for high-risk individuals.  
21 For the purpose of determining what constitutes a low-risk  
22 individual, medium-risk individual, or high-risk individual,  
23 the board shall consider the anticipated claims payment for  
24 individuals based upon an individual's health condition.

25 Section 7. Paragraphs (a) and (b) of subsection (3) of  
26 section 627.6571, Florida Statutes, are amended to read:

27 627.6571 Guaranteed renewability of coverage.--

28 (3)(a) An insurer may discontinue offering a  
29 particular policy form of group health insurance coverage  
30 offered in the small-group market or large-group market only  
31 if:

1  
2 1. The insurer provides notice to each policyholder  
3 provided coverage of this form in such market, and to  
4 participants and beneficiaries covered under such coverage, of  
5 such discontinuation at least 90 days prior to the date of the  
6 nonrenewal ~~discontinuation~~ of such coverage;

7 2. The insurer offers to each policyholder provided  
8 coverage of this form in such market the option to purchase  
9 all, or in the case of the large-group market, any other  
10 health insurance coverage currently being offered by the  
11 insurer in such market; and

12 3. In exercising the option to discontinue coverage of  
13 this form and in offering the option of coverage under  
14 subparagraph 2., the insurer acts uniformly without regard to  
15 the claims experience of those policyholders or any  
16 health-status-related factor that relates to any participants  
17 or beneficiaries covered or new participants or beneficiaries  
18 who may become eligible for such coverage.

19 (b)1. In any case in which an insurer elects to  
20 discontinue offering all health insurance coverage in the  
21 small-group market or the large-group market, or both, in this  
22 state, health insurance coverage may be discontinued by the  
23 insurer only if:

24 a. The insurer provides notice to the department and  
25 to each policyholder, and participants and beneficiaries  
26 covered under such coverage, of such discontinuation at least  
27 180 days prior to the date of the nonrenewal ~~discontinuation~~  
28 of such coverage; and

29 b. All health insurance issued or delivered for  
30 issuance in this state in such market ~~markets~~ is discontinued  
31 and coverage under such health insurance coverage in such  
market is not renewed.

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

7           Section 8. Subsection (4) of section 627.6575, Florida  
8 Statutes, is amended to read:

9           627.6575 Coverage for newborn children.--

10           (4) A policy or contract may require the insured to  
11 notify the insurer of the birth of a child within a time  
12 period, as specified in the policy, of not less than 30 days  
13 after the birth. If timely notice is given, the insurer may  
14 not charge an additional premium for coverage of the newborn  
15 child for the duration of the notice period. If timely notice  
16 is not given, the insurer may charge an additional premium  
17 from the date of birth. If notice is given within 60 days of  
18 the birth of the child,the insurer may not deny coverage for  
19 a child due to the failure of the insured to timely notify the  
20 insurer of the birth of the child.

21           Section 9. Subsection (2) of section 627.6415, Florida  
22 Statutes, is amended to read:

23           627.6415 Coverage for natural-born, adopted, and  
24 foster children; children in insured's custodial care.--

25           (2) A policy may require the insured to notify the  
26 insurer of the birth or placement of an adopted child within a  
27 specified time period of not less than 30 days after the birth  
28 or placement in the residence of a child adopted by the  
29 insured. If timely notice is given, the insurer may not  
30 charge an additional premium for coverage of the child for the  
31 notice period. If timely notice is not given, the insurer may  
charge an additional premium from the date of birth or

1 placement. If notice is given within 60 days of the birth or  
2 placement of the child, the insurer may not deny coverage for  
3 the child due to the failure of the insured to timely notify  
4 the insurer of the birth or placement of the child.

5 Section 10. Subsection (2) of section 627.6578,  
6 Florida Statutes, is amended to read:

7 627.6578 Coverage for natural-born, adopted, and  
8 foster children; children in insured's custodial care.--

9 (2) A policy or contract may require the insured to  
10 notify the insurer of the birth or placement of an adopted  
11 child within a specified time period of not less than 30 days  
12 after the birth or placement in the residence of a child  
13 adopted by the insured. If timely notice is given, the  
14 insurer may not charge an additional premium for coverage of  
15 the child for the duration of the notice period. If timely  
16 notice is not given, the insurer may charge an additional  
17 premium from the date of birth or placement. If notice is  
18 given within 60 days of the birth or placement of the child,  
19 the insurer may not deny coverage for the child due to the  
20 failure of the insured to timely notify the insurer of the  
21 birth or placement of the child.

22 Section 11. Subsection (3), paragraph (b) of  
23 subsection (7), and subsection (17) of section 627.6675,  
24 Florida Statutes, are amended to read:

25 627.6675 Conversion on termination of  
26 eligibility.--Subject to all of the provisions of this  
27 section, a group policy delivered or issued for delivery in  
28 this state by an insurer or nonprofit health care services  
29 plan that provides, on an expense-incurred basis, hospital,  
30 surgical, or major medical expense insurance, or any  
31 combination of these coverages, shall provide that an employee

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

16 (3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR  
17 GROUP COVERAGE.--

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

29 (b) Actual or expected experience under converted  
30 policies may be combined with such experience under group  
31 policies for the purposes of determining premium and loss

1 experience and establishing premium rate levels for group  
2 coverage.

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

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

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

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

20 4. The rate schedule shall be determined from analysis  
21 of the one county with the largest market share in the state  
22 of all such carriers.

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

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

28 (7) INFORMATION REQUESTED BY INSURER.--

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



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

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

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

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

17 ~~4.5.~~ Other reasons approved by the department.

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

30 Section 12. Section 627.6685, Florida Statutes, is  
31 created to read:

627.6685 Mental health coverage.--

1           (1) DEFINITIONS.--As used in this section, the term:  
2           (a) "Aggregate lifetime limit" means, with respect to  
3 benefits under a group health plan or health insurance  
4 coverage, a dollar limitation on the total amount that may be  
5 paid with respect to such benefits under the plan or health  
6 insurance coverage with respect to an individual or other  
7 coverage unit.  
8           (b) "Annual limit" means, with respect to benefits  
9 under a group health plan or health insurance coverage, a  
10 dollar limitation on the total amount of benefits that may be  
11 paid with respect to such benefits in a 12-month period under  
12 the plan or health insurance coverage with respect to an  
13 individual or other coverage unit.  
14           (c) "Medical or surgical benefits" means benefits with  
15 respect to medical or surgical services, as defined under the  
16 terms of the plan or coverage, but does not include mental  
17 health benefits.  
18           (d) "Mental health benefits" means benefits with  
19 respect to mental health services, as defined under the terms  
20 of the plan or coverage, but does not include benefits with  
21 respect to treatment of substance abuse or chemical  
22 dependency.  
23           (e) "Health insurance coverage" means coverage  
24 provided by an authorized insurer or by a health maintenance  
25 organization.  
26           (2) BENEFITS.--  
27           (a)1. In the case of a group health plan, or health  
28 insurance coverage offered in connection with such a plan,  
29 which provides both medical and surgical benefits and mental  
30 health benefits:  
31

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

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

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

13           (II) Not include any aggregate lifetime limit on  
14 mental health benefits which is less than that applicable  
15 lifetime limit.

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

26           2. In the case of a group health plan, or health  
27 insurance coverage offered in connection with such a plan,  
28 which provides both medical and surgical benefits and mental  
29 health benefits:

30           a. If the plan or coverage does not include an annual  
31 limit on substantially all medical and surgical benefits, the

1 plan or coverage may not impose any annual limit on mental  
2 health benefits.

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

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

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

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

22 (b) This section may not be construed:

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

26 2. In the case of a group health plan, or health  
27 insurance coverage offered in connection with such a plan,  
28 which provides mental health benefits, as affecting the terms  
29 and conditions, including cost-sharing, limits on numbers of  
30 visits or days of coverage, and requirements relating to  
31 medical necessity, relating to the amount, duration, or scope

1 of mental health benefits under the plan or coverage, except  
2 as specifically provided in paragraph (a) with respect to  
3 parity in the imposition of aggregate lifetime limits and  
4 annual limits for mental health benefits.

5 (3) EXEMPTIONS.--

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

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

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

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

23 (6) CONFLICTING PROVISIONS.--The provisions of this  
24 section prevail over any conflicting provision of s. 627.668.

25 Section 13. Paragraph (k) of subsection (3) of section  
26 627.6699, Florida Statutes, is amended to read:

27 627.6699 Employee Health Care Access Act.--

28 (3) DEFINITIONS.--As used in this section, the term:

29 (k) "Health benefit plan" means any hospital or  
30 medical policy or certificate, hospital or medical service  
31 plan contract, or health maintenance organization subscriber

1 contract. The term does not include accident-only, specified  
2 disease, individual hospital indemnity, credit, dental-only,  
3 vision-only, Medicare supplement, long-term care, or  
4 disability income insurance; similar supplemental plans  
5 provided under a separate policy, certificate, or contract of  
6 insurance, which cannot duplicate coverage under an underlying  
7 health plan and are specifically designed to fill gaps in the  
8 underlying health plan, coinsurance, or deductibles; coverage  
9 issued as a supplement to liability insurance; workers'  
10 compensation or similar insurance; or automobile  
11 medical-payment insurance.

12 Section 14. Paragraphs (a) and (d) of subsection (2)  
13 and subsection (3) of section 627.674, Florida Statutes, are  
14 amended to read:

15 627.674 Minimum standards; filing requirements.--

16 (2)(a) The department must adopt rules establishing  
17 minimum standards for Medicare supplement policies that, taken  
18 together with the requirements of this part, are no less  
19 comprehensive or beneficial to persons insured or covered  
20 under Medicare supplement policies issued, delivered, or  
21 issued for delivery in this state, including certificates  
22 under group or blanket policies issued, delivered, or issued  
23 for delivery in this state, than the standards provided in 42  
24 U.S.C. Section 1395ss, or the most recent version of the NAIC  
25 Model Regulation To Implement the NAIC Medicare Supplement  
26 Insurance Minimum Standards Model Act adopted by the National  
27 Association of Insurance Commissioners on July 31, 1991, or  
28 the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No.  
29 101-508).

30 (d) For policies issued on or after January 1, 1991,  
31 the department may adopt rules to establish minimum policy

1 standards to authorize the types of policies specified by 42  
2 U.S.C. Section 1395ss(p)(2)(C) and any optional benefits to  
3 facilitate policy comparisons.

4 (3) A policy may not be filed with the department as a  
5 Medicare supplement policy unless the policy meets or exceeds,  
6 ~~either in a single policy or, in the case of nonprofit health~~  
7 ~~care services plans, in one or more policies issued in~~  
8 ~~conjunction with one another,~~ the requirements of 42 U.S.C.  
9 Section 1395ss, or the most recent version of the NAIC  
10 Medicare Supplement Insurance Minimum Standards Model Act,  
11 adopted by the National Association of Insurance Commissioners  
12 on July 31, 1991, and the Omnibus Budget Reconciliation Act of  
13 1990 (Pub. L. No. 101-508).

14 Section 15. Section 627.6741, Florida Statutes, is  
15 amended to read:

16 627.6741 Issuance, cancellation, nonrenewal, and  
17 replacement.--

18 (1) An insurer issuing Medicare supplement policies in  
19 this state shall offer the opportunity of enrolling in a  
20 Medicare supplement policy, without conditioning the issuance  
21 or effectiveness of the policy on, and without discriminating  
22 in the price of the policy based on, the medical or health  
23 status or receipt of health care by the individual:

24 (a) To any individual who is 65 years of age or older  
25 and who resides in this state, upon the request of the  
26 individual during the 6-month period beginning with the first  
27 month in which the individual has attained 65 years of age and  
28 is enrolled in Medicare part B; or

29 (b) To any individual who is 65 years of age or older  
30 and is enrolled in Medicare part B, who resides in this state,  
31 upon the request of the individual during the 2-month period

1 following termination of coverage under a group health  
2 insurance policy.<sup>7</sup>  
3

4 A Medicare supplement policy issued to an individual under  
5 paragraph (a) or paragraph (b) may not exclude benefits based  
6 on a pre-existing condition if the individual has a continuous  
7 period of creditable coverage, as defined in s. 627.6561(5),  
8 of at least 6 months as of the date of application for  
9 coverage.  
10

11 ~~the opportunity of enrolling in a Medicare supplement policy,~~  
12 ~~without conditioning the issuance or effectiveness of the~~  
13 ~~policy on, and without discriminating in the price of the~~  
14 ~~policy based on, the medical or health status or receipt of~~  
15 ~~health care by the individual.~~  
16

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

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

22 (b) If it is not replacing an existing policy, a  
23 Medicare supplement policy shall not limit or preclude  
24 liability under the policy for a period longer than 6 months  
25 because of a health condition existing before the policy is  
26 effective. The policy may not define a preexisting condition  
27 more restrictively than a condition for which medical advice  
28 was given or treatment was recommended by or received from a  
29 physician within 6 months before the effective date of  
30 coverage.

31 (c) If a Medicare supplement policy or certificate  
replaces another Medicare supplement policy or certificate or



1 creditable coverage as defined in s. 627.6561(5)~~a group~~  
2 ~~health insurance policy or certificate~~, the replacing insurer  
3 shall waive any time periods applicable to preexisting  
4 conditions, waiting periods, elimination periods, and  
5 probationary periods in the new Medicare supplement policy for  
6 similar benefits to the extent such time was spent under the  
7 original policy, subject to the requirements of s.  
8 627.6561(6)-(11).  
9

10 (3) For group Medicare supplement policies:

11 (a) If a group Medicare supplement insurance policy is  
12 terminated by the group policyholder and not replaced as  
13 provided in paragraph (c), the insurer shall offer  
14 certificateholders an individual Medicare supplement policy.  
15 The insurer shall offer the certificateholder at least the  
16 following choices:

17 1. An individual Medicare supplement policy that  
18 provides for continuation of the benefits contained in the  
19 group policy.

20 2. An individual Medicare supplement policy that  
21 provides only the benefits required to meet the minimum  
22 standards.

23 (b) If membership in a group is terminated, the  
24 insurer shall:

25 1. Offer the certificateholder conversion  
26 opportunities specified in paragraph (a); or

27 2. At the option of the group policyholder, offer the  
28 certificateholder continuation of coverage under the group  
29 policy.

30 (c) If a group Medicare supplement policy is replaced  
31 by another group Medicare supplement policy purchased by the  
same policyholder, the succeeding insurer shall offer coverage

1 to all persons covered under the old group policy on its date  
2 of termination. Coverage under the new group policy may not  
3 result in any exclusion for preexisting conditions that would  
4 have been covered under the group policy being replaced.

5 (4) If a policy is canceled, the insurer must return  
6 promptly the unearned portion of any premium paid. If the  
7 insured cancels the policy, the earned premium shall be  
8 computed by the use of the short-rate table last filed with  
9 the state official having supervision of insurance in the  
10 state where the insured resided when the policy was issued.  
11 If the insurer cancels, the earned premium shall be computed  
12 pro rata. Cancellation shall be without prejudice to any  
13 claim originating prior to the effective date of the  
14 cancellation.

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

20 Section 16. Section 627.9403, Florida Statutes, is  
21 amended to read:

22 627.9403 Scope.--The provisions of this part shall  
23 apply to long-term care insurance policies delivered or issued  
24 for delivery in this state, and to policies delivered or  
25 issued for delivery outside this state to the extent provided  
26 in s. 627.9406, by an insurer, a fraternal benefit society as  
27 defined in s. 632.601, a health care services plan as defined  
28 in s. 641.01, a health maintenance organization as defined in  
29 s. 641.19, a prepaid health clinic as defined in s. 641.402,  
30 or a multiple-employer welfare arrangement as defined in s.  
31 624.437. A policy which is advertised, marketed, or offered as

1 a long-term care policy and as a Medicare supplement policy  
2 shall meet the requirements of this part and the requirements  
3 of ss. 627.671-627.675 and, to the extent of a conflict, be  
4 subject to the requirement that is more favorable to the  
5 policyholder or certificateholder. The provisions of this  
6 part shall not apply to a continuing care contract issued  
7 pursuant to chapter 651 and shall not apply to guaranteed  
8 renewable policies issued prior to October 1, 1988. Any  
9 limited benefit policy that limits coverage to care in a  
10 nursing home or to one or more lower levels of care required  
11 or authorized to be provided by this part or by department  
12 rule must meet all requirements of this part that apply to  
13 long-term care insurance policies, except s. 627.9407(3)(c),  
14 (9), (10)(f), and (12), and s. 627.94073(2)~~s. 627.9407(3)(c)~~  
15 ~~and (9)~~. If the limited benefit policy does not provide  
16 coverage for care in a nursing home, but does provide coverage  
17 for one or more lower levels of care, the policy shall also be  
18 exempt from the requirements of s. 627.9407(3)(d).

19 Section 17. Section 627.9404, Florida Statutes, is  
20 amended to read:

21 627.9404 Definitions.--For the purposes of this part:

22 (1) "Long-term care insurance policy" means any  
23 insurance policy or rider advertised, marketed, offered, or  
24 designed to provide coverage on an expense-incurred,  
25 indemnity, prepaid, or other basis for one or more necessary  
26 or medically necessary diagnostic, preventive, therapeutic,  
27 curing, treating, mitigating, rehabilitative, maintenance, or  
28 personal care services provided in a setting other than an  
29 acute care unit of a hospital. Long-term care insurance shall  
30 not include any insurance policy which is offered primarily to  
31 provide basic Medicare supplement coverage, basic hospital

1 expense coverage, basic medical-surgical expense coverage,  
2 hospital confinement indemnity coverage, major medical expense  
3 coverage, disability income protection coverage, accident only  
4 coverage, specified disease or specified accident coverage, or  
5 limited benefit health coverage.

6 (2) "Applicant" means:

7 (a) In the case of an individual long-term care  
8 insurance policy, the person who seeks to contract for  
9 benefits.

10 (b) In the case of a group long-term care insurance  
11 policy, the proposed certificateholder.

12 (3) "Certificate" means any certificate issued under a  
13 group long-term care insurance policy, which policy has been  
14 delivered or issued for delivery in this state.

15 (4) "Chronically ill" means certified by a licensed  
16 health care practitioner as:

17 (a) Being unable to perform, without substantial  
18 assistance from another individual, at least two activities of  
19 daily living for a period of at least 90 days due to a loss of  
20 functional capacity; or

21 (b) Requiring substantial supervision for protection  
22 from threats to health and safety due to severe cognitive  
23 impairment.

24 (5) "Cognitive impairment" means a deficiency in a  
25 person's short-term or long-term memory, orientation as to  
26 person, place, and time, deductive or abstract reasoning, or  
27 judgment as it relates to safety awareness.

28 (6) "Licensed health care practitioner" means any  
29 physician, nurse licensed under chapter 464, or  
30 psychotherapist licensed under chapter 490 or chapter 491, or  
31

1 any individual who meets any requirements prescribed by rule  
2 by the department.

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

7 (8)(7) "Maintenance or personal care services" means  
8 any care the primary purpose of which is the provision of  
9 needed assistance with any of the disabilities as a result of  
10 which the individual is a chronically ill individual,  
11 including the protection from threats to health and safety due  
12 to severe cognitive impairment.

13 (9)(8) "Policy" means any policy, contract, subscriber  
14 agreement, rider, or endorsement delivered or issued for  
15 delivery in this state by any of the entities specified in s.  
16 627.9403.

17 (10) "Qualified limited benefit insurance policy"  
18 means an accident and health insurance contract as defined in  
19 s. 7702B of the Internal Revenue Code and all applicable  
20 sections of this part.

21 (11)(9) "Qualified long-term care services" means  
22 necessary diagnostic, preventive, curing, treating,  
23 mitigating, and rehabilitative services, and maintenance or  
24 personal care services which are required by a chronically ill  
25 individual and are provided pursuant to a plan of care  
26 prescribed by a licensed health care practitioner.

27 (12)(10) "Qualified long-term care insurance policy"  
28 means an accident and health insurance contract as defined in  
29 s. 7702B of the Internal Revenue Code and all applicable  
30 sections of this part.

1           Section 18. 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 19. 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 or 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 20. Subsections (1) and (2) of section  
7 641.225, Florida Statutes, are amended to read:

8 641.225 Surplus requirements.--

9 (1) Each health maintenance organization shall at all  
10 times maintain a minimum surplus in an amount that ~~which~~ is  
11 the greater of \$1,500,000, ~~\$500,000~~ or 10 percent of total  
12 liabilities, or 2 percent of total annualized premium. All  
13 health maintenance organizations that ~~which~~ have a valid  
14 certificate of authority before October 1, 1998 ~~1988~~, or an  
15 entity described in subsection (3), and that ~~which~~ do not meet  
16 the minimum surplus requirement, shall increase their surplus  
17 as follows:

18 Date	19 Amount
20 September 30, <u>1998</u> <del>1989</del>	21 <u>\$800,000</u> , <del>\$200,000</del> or <u>10</u> <del>6</del> percent 22 of total liabilities, <u>or 1 percent</u> 23 <u>of annualized premium</u> , whichever is 24 greater
25 September 30, <u>1999</u> <del>1990</del>	26 <u>\$1,150,000</u> , <del>\$350,000</del> or <u>10</u> <del>8</del> 27 percent of total liabilities, <u>or</u> 28 <u>1.25 percent of annualized premium</u> , 29 whichever is greater 30 31



1 September 30, 2000 ~~1991~~ \$1,500,000,~~\$500,000~~ or 10 percent  
2 of total liabilities, or 2 percent  
3 of annualized premium, whichever is  
4 greater  
5

6 (2) The department shall not issue a certificate of  
7 authority, except as provided in subsection (3), unless the  
8 health maintenance organization has a minimum surplus in an  
9 amount which is the greater of:

10 ~~(a) \$1,500,000;~~

11 (a) ~~(b)~~ Ten percent of their total liabilities based on  
12 their startup ~~actuarial~~ projection as set forth in this part;  
13 ~~or~~

14 (b) Two percent of their total projected premiums  
15 based on their startup projection as set forth in this part;

16 or

17 (c) \$1,500,000,~~\$500,000~~ plus all startup losses,  
18 excluding profits, projected to be incurred on their startup  
19 ~~actuarial~~ projection until the projection reflects statutory  
20 net profits for 12 consecutive months.

21 Section 21. Section 641.285, Florida Statutes, is  
22 amended to read:

23 641.285 Insolvency protection.--

24 (1) ~~Unless otherwise provided in this section,~~ Each  
25 health maintenance organization shall deposit with the  
26 department cash or securities of the type eligible under s.  
27 625.52, which shall have at all times a market value in the  
28 amount set forth in this subsection. The amount of the  
29 deposit shall be reviewed annually, or more often, as the  
30 department deems necessary. The market value of the deposit  
31 shall be a minimum of \$300,000. ~~the greater of:~~

1           ~~(a) Twice its reasonably estimated average monthly~~  
2 ~~uncovered expenditures; or~~

3           ~~(b) \$100,000.~~

4           (2) If securities or assets deposited by a health  
5 maintenance organization under this part are subject to  
6 material fluctuations in market value, the department may, in  
7 its discretion, require the organization to deposit and  
8 maintain on deposit additional securities or assets in an  
9 amount as may be reasonably necessary to assure that the  
10 deposit will at all times have a market value of not less than  
11 the amount specified under this section.

12           ~~(a)~~ If for any reason the market value of assets and  
13 securities of a health maintenance organization held on  
14 deposit in this state under this code falls below the amount  
15 required, the organization shall promptly deposit other or  
16 additional assets or securities eligible for deposit  
17 sufficient to cure the deficiency. If the health maintenance  
18 organization has failed to cure the deficiency within 30 days  
19 after receipt of notice thereof by registered or certified  
20 mail from the department, the department may revoke the  
21 certificate of authority of the health maintenance  
22 organization.

23           ~~(b) A health maintenance organization may, at its~~  
24 ~~option, deposit assets or securities in an amount exceeding~~  
25 ~~its deposit required or otherwise permitted under this code by~~  
26 ~~not more than 20 percent of the required or permitted deposit,~~  
27 ~~or \$20,000, whichever is the larger amount, for the purpose of~~  
28 ~~absorbing fluctuations in the value of securities and assets~~  
29 ~~deposited and to facilitate the exchange and substitution of~~  
30 ~~securities and assets. During the solvency of the health~~  
31 ~~maintenance organization, any excess shall be released to the~~

1 ~~organization upon its request. During the insolvency of the~~  
2 ~~health maintenance organization, any excess deposit shall be~~  
3 ~~released only as provided in s. 625.62.~~

4       (3) Whenever the department determines that the  
5 financial condition of a health maintenance organization has  
6 deteriorated to the point that the policyholders' or  
7 subscribers' best interests are not being preserved by the  
8 activities of a health maintenance organization, the  
9 department may require such health maintenance organization to  
10 deposit and maintain deposited in trust with the department  
11 for the protection of the health maintenance organization's  
12 policyholders, subscribers, and creditors, for such time as  
13 the department deems necessary, securities eligible for such  
14 deposit under s. 625.52 having a market value of not less than  
15 the amount that the department determines is necessary, which  
16 amount must not be less than \$100,000 or greater than \$2  
17 million. The deposit required under this subsection is in  
18 addition to any other deposits required of a health  
19 maintenance organization pursuant to subsections (1) and (2).  
20 ~~The department shall waive the deposit requirements set forth~~  
21 ~~in subsection (1) whenever it is satisfied that:~~

22       ~~(a) The health maintenance organization has sufficient~~  
23 ~~surplus and an adequate history of generating net income to~~  
24 ~~assure its financial viability for the next year;~~

25       ~~(b) The performance and obligations of the health~~  
26 ~~maintenance organization are guaranteed by a guaranteeing~~  
27 ~~organization of the type and subject to the same provisions as~~  
28 ~~outlined in s. 641.225; or~~

29       ~~(c) The assets of the health maintenance organization~~  
30 ~~or its contracts with any insurer, health care provider,~~  
31 ~~governmental entity, or other person are reasonably sufficient~~

1 ~~to assure the performance of the obligations of the~~  
2 ~~organization.~~

3 (4) All income from deposits shall belong to the  
4 depositing health maintenance organization and shall be paid  
5 to it as it becomes available. A health maintenance  
6 organization that has made a securities deposit may withdraw  
7 that deposit, or any part thereof, after making a substitute  
8 deposit of cash or eligible securities or any combination of  
9 these or other acceptable measures of equal amount and value.

10 ~~(5)(a) The requirements of this section do not apply~~  
11 ~~to an applying or licensed health maintenance organization~~  
12 ~~which has a plan, approved by the department, for handling~~  
13 ~~insolvency which provides for continuation of benefits and~~  
14 ~~payments to unaffiliated providers for services rendered both~~  
15 ~~prior to and after insolvency for the duration of the contract~~  
16 ~~period for which payment has been made, except that benefits~~  
17 ~~to members who are confined on the date of insolvency in an~~  
18 ~~inpatient facility shall be continued until their discharge.~~  
19 ~~This plan shall include at least one of the following:~~

20 1. ~~Contracts of insurance or reinsurance on file with~~  
21 ~~the department that will protect subscribers in the event the~~  
22 ~~health maintenance organization is unable to meet its~~  
23 ~~obligations. Each agreement between the organization and an~~  
24 ~~insurer shall be subject to the laws of this state regarding~~  
25 ~~reinsurance. Each agreement and any modification thereto~~  
26 ~~shall be filed with and approved by the department. Each~~  
27 ~~agreement shall remain in full force and in effect until~~  
28 ~~replaced or for at least 90 days following written~~  
29 ~~notification to the department by registered mail of~~  
30 ~~cancellation or termination by either party. The department~~  
31

1 ~~shall be endorsed on the agreement as an additional insured~~  
2 ~~party.~~

3           2. ~~Contractual arrangements with health care providers~~  
4 ~~that include a guarantee by the provider to continue providing~~  
5 ~~health care services to any subscriber of the health~~  
6 ~~maintenance organization, upon insolvency of the organization,~~  
7 ~~until the end of the contract period for which payment by or~~  
8 ~~on behalf of the subscriber has been made or the discharge of~~  
9 ~~the subscriber from an inpatient facility, whichever occurs~~  
10 ~~later; or~~

11           3. ~~Other measures acceptable to the department.~~

12           ~~(b) The department shall reduce the deposit~~  
13 ~~requirements specified in subsection (1) whenever the~~  
14 ~~department has determined that the health maintenance~~  
15 ~~organization has a plan for handling insolvency which~~  
16 ~~partially meets the requirements of this section. The amount~~  
17 ~~of the deposit reduction shall be based on the extent to which~~  
18 ~~the organization meets the requirements of this section.~~

19           Section 22. Section 641.26, Florida Statutes, is  
20 amended to read:

21           641.26 Annual report.--

22           (1) Every health maintenance organization shall,  
23 annually within 3 months after the end of its fiscal year, or  
24 within an extension of time therefor as the department, for  
25 good cause, may grant, in a form prescribed by the department,  
26 file a report with the department, verified by the oath of two  
27 officers of the organization or, if not a corporation, of two  
28 persons who are principal managing directors of the affairs of  
29 the organization, properly notarized, showing its condition on  
30 the last day of the immediately preceding reporting period.

31 Such report shall include:

1 (a) A financial statement of the health maintenance  
2 organization filed on a computer diskette using a format  
3 acceptable to the department.~~†~~

4 (b) A financial statement of the health maintenance  
5 organization filed on forms acceptable to the department.~~†~~

6 (c) An audited financial statement of the health  
7 maintenance organization, including its balance sheet and a  
8 statement of operations for the preceding year certified by an  
9 independent certified public accountant, prepared in  
10 accordance with statutory accounting principles.~~†~~

11 (d) The number of health maintenance contracts issued  
12 and outstanding and the number of health maintenance contracts  
13 terminated.~~†~~

14 (e) The number and amount of damage claims for medical  
15 injury initiated against the health maintenance organization  
16 and any of the providers engaged by it during the reporting  
17 year, broken down into claims with and without formal legal  
18 process, and the disposition, if any, of each such claim.~~†~~

19 (f) An actuarial certification that:

20 1. The health maintenance organization is actuarially  
21 sound, which certification shall consider the rates, benefits,  
22 and expenses of, and any other funds available for the payment  
23 of obligations of, the organization.~~†~~

24 2. The rates being charged or to be charged are  
25 actuarially adequate to the end of the period for which rates  
26 have been guaranteed.~~†~~

27 3. Incurred but not reported claims and claims  
28 reported but not fully paid have been adequately provided  
29 for.~~†~~~~and~~

30 (g) A report prepared by the Certified Public  
31 Accountant and filed with the department describing material

1 weaknesses in the health maintenance organization's internal  
2 control structure as noted by the Certified Public Accountant  
3 during the audit. The report must be filed with the annual  
4 audited financial report as required in paragraph (c). The  
5 health maintenance organization shall provide a description of  
6 remedial actions taken or proposed to correct material  
7 weaknesses, if the actions are not described in the  
8 independent certified public accountant's report.

9 (h)(g) Such other information relating to the  
10 performance of health maintenance organizations as is required  
11 by the department.

12 (2) The department may require updates of the  
13 actuarial certification as to a particular health maintenance  
14 organization if the department has reasonable cause to believe  
15 that such reserves are understated to the extent of materially  
16 misstating the financial position of the health maintenance  
17 organization. Workpapers in support of the statement of the  
18 updated actuarial certification must be provided to the  
19 department upon request.

20 (3)(2) Every health maintenance organization shall  
21 file quarterly, within 45 days after each of its quarterly  
22 reporting periods, an unaudited financial statement of the  
23 organization as described in paragraphs (1)(a) and (b). The  
24 quarterly report shall be verified by the oath of two officers  
25 of the organization, properly notarized.

26 (4)(3) Any health maintenance organization that ~~which~~  
27 neglects to file an annual report or quarterly report in the  
28 form and within the time required by this section shall  
29 forfeit up to \$1,000 for each day for the first 10 days during  
30 which the neglect continues and shall forfeit up to \$2,000 for  
31 each day after the first 10 days during which the neglect

1 continues; and, upon notice by the department to that effect,  
2 the organization's authority to enroll new subscribers or to  
3 do business in this state shall cease while such default  
4 continues. The department shall deposit all sums collected by  
5 it under this section to the credit of the Insurance  
6 Commissioner's Regulatory Trust Fund. The department shall not  
7 collect more than \$100,000 for each report.

8 (5)~~(4)~~ Each authorized health maintenance organization  
9 shall retain an independent certified public accountant,  
10 ~~hereinafter~~ referred to in this section as "CPA," who agrees  
11 by written contract with the health maintenance organization  
12 to comply with the provisions of this part. ~~The contract~~  
13 ~~shall state:~~

14 (a) The CPA shall provide to the HMO audited financial  
15 statements consistent with this part.

16 (b) Any determination by the CPA that the health  
17 maintenance organization does not meet minimum surplus  
18 requirements as set forth in this part shall be stated by the  
19 CPA, in writing, in the audited financial statement.

20 (c) The completed work papers and any written  
21 communications between the CPA firm and the health maintenance  
22 organization relating to the audit of the health maintenance  
23 organization shall be made available for review on a  
24 visual-inspection-only basis by the department at the offices  
25 of the health maintenance organization, at the department, or  
26 at any other reasonable place as mutually agreed between the  
27 department and the health maintenance organization. The CPA  
28 must retain for review the work papers and written  
29 communications for a period of not less than 6 years.

30 (d) The CPA shall provide to the department a written  
31 report describing material weaknesses in the health



1 maintenance organizations's internal control structure as  
2 noted during the audit.

3 (6)~~(5)~~ To facilitate uniformity in financial  
4 statements and to facilitate department analysis, the  
5 department may by rule adopt the form for financial statements  
6 of a health maintenance organization, including supplements as  
7 approved by the National Association of Insurance  
8 Commissioners in 1995, and may adopt subsequent amendments  
9 thereto if the methodology remains substantially consistent,  
10 and may by rule require each health maintenance organization  
11 to submit to the department all or part of the information  
12 contained in the annual statement in a computer-readable form  
13 compatible with the electronic data processing system  
14 specified by the department.

15 (7) In addition to information called for and  
16 furnished in connection with its annual or quarterly  
17 statements, the health maintenance organization shall furnish  
18 to the department as soon as reasonably possible such  
19 information as to its material transactions which, in the  
20 department's opinion, may have a material adverse effect on  
21 the health maintenance organizations financial condition, as  
22 the department may request in writing. All such information  
23 furnished pursuant to the department's request must be  
24 verified by the oath of two executive officers of the health  
25 maintenance organization.

26 (8) Each health maintenance organization shall file  
27 one copy of its annual statement convention blank in  
28 electronic form, along with such additional filings as  
29 prescribed by the department for the preceding year, with the  
30 National Association of Insurance Commissioners. Each health  
31 maintenance organization shall pay to the department a

1 reasonable fee to cover costs associated with the filing and  
2 analysis of the documents by the National Association of  
3 Insurance Commissioners.

4           Section 23. Paragraph (a) of subsection (9) of section  
5 641.31, is amended to read:

6           641.31 Health maintenance contracts.--

7           (9) All health maintenance contracts that provide  
8 coverage, benefits, or services for a member of the family of  
9 the subscriber must, as to such family member's coverage,  
10 benefits, or services, provide also that the coverage,  
11 benefits, or services applicable for children must be provided  
12 with respect to a newborn child of the subscriber, or covered  
13 family member of the subscriber, from the moment of birth.  
14 However, with respect to a newborn child of a covered family  
15 member other than the spouse of the insured or subscriber, the  
16 coverage for the newborn child terminates 18 months after the  
17 birth of the newborn child. The coverage, benefits, or  
18 services for newborn children must consist of coverage for  
19 injury or sickness, including the necessary care or treatment  
20 of medically diagnosed congenital defects, birth  
21 abnormalities, or prematurity, and transportation costs of the  
22 newborn to and from the nearest appropriate facility  
23 appropriately staffed and equipped to treat the newborn's  
24 condition, when such transportation is certified by the  
25 attending physician as medically necessary to protect the  
26 health and safety of the newborn child.

27           (a) A contract may require the subscriber to notify  
28 the plan of the birth of a child within a time period, as  
29 specified in the contract, of not less than 30 days after the  
30 birth, or a contract may require the preenrollment of a  
31 newborn prior to birth. However, if timely notice is given, a

1 plan may not charge an additional premium for additional  
2 coverage of the newborn child for not less than 30 days after  
3 the birth of the child. If timely notice is not given, the  
4 plan may charge an additional premium from the date of birth.  
5 If notice is given within 60 days of the birth of the child,  
6 the contract may not deny coverage of the child due to failure  
7 of the subscriber to timely notify the plan of the birth of  
8 the child or to preenroll the child.

9 Section 24. Paragraph (d) of subsection (2), and  
10 paragraphs (a) and (b) of subsection (3) of section 641.31074,  
11 Florida Statutes, are amended to read:

12 641.31074 Guaranteed renewability of coverage.--

13 (2) A health maintenance organization may nonrenew or  
14 discontinue a contract based only on one or more of the  
15 following conditions:

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

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

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

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

1 offered by the health maintenance organization in such market;  
2 and

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

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

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

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

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

1           Section 25. Section 641.3111, Florida Statutes, is  
2 amended to read:

3           641.3111 Extension of benefits.--

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

15           (a) The expiration of 12 months.

16           (b) Such time as the member is no longer totally  
17 disabled.

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

20           (d) The maximum benefits payable under the contract  
21 have been paid.

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

29           (3) In the case of maternity coverage, when not  
30 covered by the succeeding carrier, a reasonable extension of  
31 benefits or accrued liability provision is required, which

1 provision provides for continuation of the contract benefits  
2 in connection with maternity expenses for a pregnancy that  
3 commenced while the policy was in effect. The extension shall  
4 be for the period of that pregnancy and shall not be based  
5 upon total disability.

6 (4) Except as provided in subsection (1), no  
7 subscriber is entitled to an extension of benefits if the  
8 termination of the contract by the health maintenance  
9 organization is based upon any event referred to in s.  
10 641.3922(7)(a), (b), or (e)~~(a)-(g)~~.

11 Section 26. Section 641.316, Florida Statutes, is  
12 amended to read:

13 641.316 Fiscal intermediary services.--

14 (1) It is the intent of the Legislature, through the  
15 adoption of this section, to ensure the financial soundness of  
16 fiscal intermediary services organizations established to  
17 develop, manage, and administer the business affairs of health  
18 care professional providers such as medical doctors, doctors  
19 of osteopathy, doctors of chiropractic, doctors of podiatric  
20 medicine, doctors of dentistry, or other health professionals  
21 regulated by the Department of Health.

22 (2)(a) The term "fiduciary" or "fiscal intermediary  
23 services" means reimbursements received or collected on behalf  
24 of health care professionals for services rendered, patient  
25 and provider accounting, financial reporting and auditing,  
26 receipts and collections management, compensation and  
27 reimbursement disbursement services, or other related  
28 fiduciary services pursuant to health care professional  
29 contracts with health maintenance organizations.

30 (b) The term "fiscal intermediary services  
31 organization" means a person or entity which performs

1 fiduciary or fiscal intermediary services to health care  
2 professionals who contract with health maintenance  
3 organizations other than a fiscal intermediary services  
4 organization owned, operated, or controlled by a hospital  
5 licensed under chapter 395, an insurer licensed under chapter  
6 624, a third-party administrator licensed under chapter 626, a  
7 prepaid limited health service organization licensed under  
8 chapter 636, a health maintenance organization licensed under  
9 this chapter, or physician group practices as defined in s.  
10 455.654(3)(f)~~s. 455.236(3)(f)~~.

11 (3) A fiscal intermediary services organization that  
12 ~~which~~ is operated for the purpose of acquiring and  
13 administering provider contracts with managed care plans for  
14 professional health care services, including, but not limited  
15 to, medical, surgical, chiropractic, dental, and podiatric  
16 care, and which performs fiduciary or fiscal intermediary  
17 services shall be required to secure and maintain a fidelity  
18 bond in the minimum amount of 10 percent of the funds handled  
19 by the intermediary in connection with its fiscal and  
20 fiduciary services during the prior year or \$1 million,  
21 whichever is less. The minimum bond amount shall be \$50,000.  
22 The fidelity bond shall protect the fiscal intermediary from  
23 loss caused by the dishonesty of its employees and must remain  
24 unimpaired for as long as the intermediary continues in  
25 business in the state.~~\$10 million. This requirement shall~~  
26 ~~apply to all persons or entities engaged in the business of~~  
27 ~~providing fiduciary or fiscal intermediary services to any~~  
28 ~~contracted provider or provider panel. The fidelity bond shall~~  
29 ~~provide coverage against misappropriation of funds by the~~  
30 ~~fiscal intermediary or its officers, agents, or employees;~~  
31 ~~must be posted with the department for the benefit of managed~~

1 ~~care plans, subscribers, and providers; and must be on a form~~  
2 ~~approved by the department. The fidelity bond must be~~  
3 ~~maintained and remain unimpaired as long as the fiscal~~  
4 ~~intermediary services organization continues in business in~~  
5 ~~this state and until the termination of its registration.~~

6 (4) A fiscal intermediary services organization, as  
7 described in subsection (3), shall secure and maintain a  
8 surety bond on file with the department, naming the  
9 intermediary as principal. The bond must be obtained from a  
10 company authorized to write surety insurance in the state, and  
11 the department shall be obligee on behalf of itself and third  
12 parties. The penal sum of the bond may not be less than 5  
13 percent of the funds handled by the intermediary in connection  
14 with its fiscal and fiduciary services during the prior year  
15 or \$250,000, whichever is less. The minimum bond amount must  
16 be \$10,000. The condition of the bond must be that the  
17 intermediary shall register with the department and shall not  
18 misappropriate funds within its control or custody as a fiscal  
19 intermediary or fiduciary. The aggregate liability of the  
20 surety for any and all breaches of the conditions of the bond  
21 may not exceed the penal sum of the bond. The bond must be  
22 continuous in form, must be renewed annually by a continuation  
23 certificate, and may be terminated by the surety upon its  
24 giving 30 days' written notice of termination to the  
25 department.

26 ~~(5)~~(4) A fiscal intermediary services organization may  
27 not collect from the subscriber any payment other than the  
28 copayment or deductible specified in the subscriber agreement.

29 ~~(6)~~(5) Any fiscal intermediary services organization,  
30 other than a fiscal intermediary services organization owned,  
31 operated, or controlled by a hospital licensed under chapter



1 395, an insurer licensed under chapter 624, a third-party  
2 administrator licensed under chapter 626, a prepaid limited  
3 health service organization licensed under chapter 636, a  
4 health maintenance organization licensed under this chapter,  
5 or physician group practices as defined in s. 455.654(3)(f)~~s.~~  
6 ~~455.236(3)(f)~~, must register with the department and meet the  
7 requirements of this section. In order to register as a fiscal  
8 intermediary services organization, the organization must  
9 comply with ss. 641.21(1)(c) and (d) and 641.22(6). Should the  
10 department determine that the fiscal intermediary services  
11 organization does not meet the requirements of this section,  
12 the registration shall be denied. In the event that the  
13 registrant fails to maintain compliance with the provisions of  
14 this section, the department may revoke or suspend the  
15 registration. In lieu of revocation or suspension of the  
16 registration, the department may levy an administrative  
17 penalty in accordance with s. 641.25.

18 ~~(7)(6)~~ The department shall adopt ~~promulgate~~ rules  
19 necessary to administer ~~implement the provisions of~~ this  
20 section.

21 Section 27. Subsections (3), (7), and (14) of section  
22 641.3922, Florida Statutes, are amended to read:

23 641.3922 Conversion contracts; conditions.--Issuance  
24 of a converted contract shall be subject to the following  
25 conditions:

26 (3) CONVERSION PREMIUM.--The premium for the converted  
27 contract shall be determined in accordance with premium rates  
28 applicable to the age and class of risk of each person to be  
29 covered under the converted contract and to the type and  
30 amount of coverage provided. However, the premium for the  
31 converted contract may not exceed 200 percent of the standard

1 risk rate, as established by the department under s.  
2 ~~627.6675(3) Florida Comprehensive Health Association and~~  
3 ~~adjusted for differences in benefit levels and structure~~  
4 ~~between the converted policy and the policy offered by the~~  
5 ~~Florida Comprehensive Health Association.~~ The mode of payment  
6 for the converted contract shall be quarterly or more  
7 frequently at the option of the organization, unless otherwise  
8 mutually agreed upon between the subscriber and the  
9 organization.

10 (7) REASONS FOR CANCELLATION; TERMINATION.--The  
11 converted health maintenance contract must contain a  
12 cancellation or nonrenewability clause providing that the  
13 health maintenance organization may refuse to renew the  
14 contract of any person covered thereunder, but cancellation or  
15 nonrenewal must be limited to one or more of the following  
16 reasons:

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

20 ~~(b) Eligibility of the covered person for coverage~~  
21 ~~under Medicare, Title XVIII of the Social Security Act, as~~  
22 ~~added by the Social Security Amendments of 1965, or as later~~  
23 ~~amended or superseded, or under any other state or federal law~~  
24 ~~providing for benefits similar to those provided by the~~  
25 ~~converted health maintenance contract, except for Medicaid,~~  
26 ~~Title XIX of the Social Security Act, as amended by the Social~~  
27 ~~Security Amendments of 1965, or as later amended or~~  
28 ~~superseded.~~

29 ~~(b)(c)~~ (b) Disenrollment for cause, after following the  
30 procedures outlined in s. 641.3921(4).  
31

1           ~~(c)(d)~~ Willful and knowing misuse of the health  
2 maintenance organization identification membership card by the  
3 subscriber or the willful and knowing furnishing to the  
4 organization by the subscriber of incorrect or incomplete  
5 information for the purpose of fraudulently obtaining coverage  
6 or benefits from the organization.

7           ~~(d)(e)~~ Failure, after notice, to pay required  
8 premiums.

9           ~~(e)(f)~~ The subscriber has left the geographic area of  
10 the health maintenance organization with the intent to  
11 relocate or establish a new residence outside the  
12 organization's geographic area.

13           ~~(f)(g)~~ A dependent of the subscriber has reached the  
14 limiting age under the converted contract, subject to  
15 subsection (12); but the refusal to renew coverage shall apply  
16 only to coverage of the dependent, except in the case of  
17 handicapped children.

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

21           (14) NOTIFICATION.--A notification of the conversion  
22 privilege shall be included in each health maintenance  
23 contract and in any certificate or member's handbook. The  
24 organization shall mail an election and premium notice form,  
25 including an outline of coverage, on a form approved by the  
26 department, within 14 days after any individual who is  
27 eligible for a converted health maintenance contract gives  
28 notice to the organization that the individual is considering  
29 applying for the converted contract or otherwise requests such  
30 information. The outline of coverage must contain a  
31 description of the principal benefits and coverage provided by

1 the contract and its principal exclusions and limitations,  
2 including, but not limited to, deductibles and coinsurance.

3           Section 28. Subsection (12) is added to section  
4 641.495, Florida Statutes, to read:

5           641.495 Requirements for issuance and maintenance of  
6 certificate.--

7           (12) The provisions of part I of chapter 395 do not  
8 apply to a health maintenance organization that, on or before  
9 January 1, 1991, provides not more than 10 outpatient holding  
10 beds for short-term and hospice-type patients in an ambulatory  
11 care facility for its members, provided that such health  
12 maintenance organization maintains current accreditation by  
13 the Joint Commission on Accreditation of Health Care  
14 Organizations, the Accreditation Association for Ambulatory  
15 Health Care, or the National Committee for Quality Assurance.

16           Section 29. This act shall take effect January 1,  
17 1999.