By the Committee on Health Care Services and Representatives Albright, Casey, Bloom, Gottlieb, Tamargo, Goode, Arnall, Peaden and Flanagan

1 A bill to be entitled
2 An act relating to health insurance; creating
3 s. 222.23, F.S.; exempting moneys paid into a
4 medical savings account from attachment,
5 garnishment, or legal process; creating the
6 "Equity in Contraceptive Coverage Act of 1998";
7 providing legislative findings and intent;
8 creating ss. 627.64061 and 627.65741, F.S., and
9 amending 641.31, F.S.; requiring certain health
10 insurance policies and health maintenance
11 contracts to provide coverage for prescription
12 oral contraceptives; amending s. 627.6515,
13 F.S.; applying certain requirements for group
14 coverage to out-of-state groups; amending s.
15 627.6571, F.S.; clarifying application;
16 amending s. 627.6675, F.S.; revising standards
17 for renewal of converted insurance policies;
18 creating s. 627.6685, F.S.; requiring health
19 insurers and health maintenance organizations
20 to include in their plans that offer mental
21 health coverage annual and lifetime mental
22 health benefits coverage restrictions that are
23 not less than annual and lifetime benefits
24 coverage restrictions for medical or surgical
25 benefits covered by the plan; providing
26 exemptions; amending s. 627.6699, F.S.;
27 revising a definition; authorizing the
28 Department of Insurance to adopt rules
29 governing guaranteed issue of Medicare
30 supplement coverage for continuously covered
31 individuals; applying certain requirements for

1 group coverage to coverage for small employers;
2 amending s. 627.674, F.S.; revising the minimum
3 standards for Medicare Supplement policies;
4 amending s. 627.6741, F.S.; revising
5 requirements for insurers to issue, cancel,
6 nonrenew, and replace Medicare supplement
7 policies; restricting preexisting condition
8 exclusions; amending s. 627.912, F.S.;
9 requiring certain self-insurers to report
10 certain information to the Department of
11 Insurance; amending s. 627.9403, F.S.;
12 clarifying application to certain types of
13 long-term care policies; amending s. 627.9404,
14 F.S.; exempting long-term care insurance
15 policies from certain requirements; providing
16 definitions; amending s. 627.9407, F.S.;
17 revising the definition of "preexisting
18 condition"; requiring certain insurance
19 policies to provide disclosure of certain
20 information; amending s. 627.94073, F.S.,
21 clarifying notice; amending s. 641.225, F.S.;
22 increasing solvency requirements for health
23 maintenance organizations; amending s. 641.285,
24 F.S.; revising requirements for insolvency
25 protection; authorizing the Department of
26 Insurance to increase insolvency protection for
27 certain health maintenance organizations;
28 amending s. 641.31074, F.S.; removing redundant
29 language and making technical corrections;
30 amending s. 641.3922, F.S.; revising standards
31 for renewal of converted health maintenance

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1 organization policies; amending s. 641.495,
2 F.S.; exempting from certain licensure
3 requirements certain beds of a health
4 maintenance organization; repealing s.
5 641.3922(7)(b), F.S., relating to cancellation
6 or nonrenewal of health maintenance contracts
7 due to eligibility for coverage under Medicare;
8 providing an effective date.
9
10 Be It Enacted by the Legislature of the State of Florida:
11
12 Section 1. Section 222.23, Florida Statutes, is
13 created to read:
14 222.23 Exemption of moneys in the medical savings
15 account from legal process.--Moneys paid into or out of a
16 medical savings account by or on behalf of a person depositing
17 money into such account or qualified beneficiary are not
18 liable to attachment, garnishment, or legal process in the
19 state in favor of any creditor of such person or beneficiary
20 of such medical savings account.
21 Section 2. Section 3, ss. 627.64061, 627.65741, and
22 641.31(34), Florida Statutes, and amendments to ss. 627.6515
23 and 627.6699, Florida Statutes, providing for application of
24 s. 627.67541, Florida Statutes, may be cited as the "Equity in
25 Prescription Insurance and Contraceptive Coverage Act of
26 1998."
27 Section 3. Legislative findings and intent.--
28 (1) The Legislature finds that:
29 (a) Each year, more than half of all pregnancies in
30 this state are unintended.
31

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1 (b) Contraceptive services are part of basic health
2 care, allowing families to both adequately space desired
3 pregnancies and avoid unintended pregnancy.
4 (c) Contraceptives are highly cost effective, yielding
5 from $4 to $14 dollars in savings for every dollar expended.
6 (d) By reducing rates of unintended pregnancy,
7 contraceptives help reduce the need for abortions.
8 (e) Unintended pregnancies lead to higher rates of
9 infant mortality, low birth weight, and maternal morbidity,
10 and threaten the economic viability of families.
11 (f) Most women in this state of childbearing age rely
12 on private employment-related insurance to cover their medical
13 expenses.
14 (g) Most private insurers cover prescription drugs,
15 but many exclude coverage for prescription contraceptives.
16 (h) The lack of contraceptive coverage in health
17 insurance policies places many effective forms of
18 contraceptives beyond the financial reach of many women,
19 leading to unintended pregnancies.
20 (2) Therefore, the Legislature determines that
21 enactment of this bill constitutes an important state
22 interest.
23 Section 4. Section 627.64061, Florida Statutes, is
24 created to read:
25 627.64061 Coverage for prescription
26 contraceptives.--Any health insurance policy that provides
27 coverage for outpatient prescription drugs shall cover
28 prescription oral contraceptives approved by the federal Food
29 and Drug Administration and prescribed by a practitioner
30 authorized by state licensure to prescribe such medication.
31 Coverage must be provided to the same extent and subject to

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1 the same contract terms, including copayments and deductibles,
2 as any other prescription drug. Nothing in this section:
3 (1) Requires an insurer regulated under this part to
4 provide coverage for any prescription oral contraceptive if
5 the insurer or policyholder objects on religious or moral
6 grounds. Failure to provide coverage for prescription oral
7 contraceptives based on religious or moral grounds shall not
8 be the basis for any claim for damages or any recriminatory or
9 discriminatory action against an insurer or policyholder.
10 (2) Applies to any prescription medications which are
11 abortifacient in nature.
12 Section 5. Paragraph (c) of subsection (2) of section
13 627.6515, Florida Statutes, is amended to read:
14 627.6515 Out-of-state groups.--
15 (2) This part does not apply to a group health
16 insurance policy issued or delivered outside this state under
17 which a resident of this state is provided coverage if:
18 (c) The policy provides the benefits specified in ss.
19 627.419, 627.6574, 627.65741,627.6575, 627.6579, 627.6612,
20 627.66121, 627.66122, 627.6613, 627.667, 627.6675, and
21 627.6691.
22 Section 6. Paragraph (b) of subsection (3) of section
23 627.6571, Florida Statutes, is amended to read:
24 627.6571 Guaranteed renewability of coverage.--
25 (3)
26 (b)1. In any case in which an insurer elects to
27 discontinue offering all health insurance coverage in the
28 small-group market or the large-group market, or both, in this
29 state, health insurance coverage may be discontinued by the
30 insurer only if:
31

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1 a. The insurer provides notice to the department and
2 to each policyholder, and participants and beneficiaries
3 covered under such coverage, of such discontinuation at least
4 180 days prior to the date of the discontinuation of such
5 coverage; and
6 b. All health insurance issued or delivered for
7 issuance in this state in such <u>market</u> ~~markets~~ is discontinued
8 and coverage under such health insurance coverage in such
9 market is not renewed.
10 2. In the case of a discontinuation under subparagraph
11 1. in a market, the insurer may not provide for the issuance
12 of any health insurance coverage in the market in this state
13 during the 5-year period beginning on the date of the
14 discontinuation of the last insurance coverage not renewed.
15 Section 7. Section 627.65741, Florida Statutes, is
16 created to read:
17 <u>627.65741 Coverage for prescription</u>
18 <u>contraceptives.--Any group, franchise, accident, or health</u>
19 <u>insurance policy that provides coverage for outpatient</u>
20 <u>prescription drugs shall cover prescription oral</u>
21 <u>contraceptives approved by the federal Food and Drug</u>
22 <u>Administration and prescribed by a practitioner authorized by</u>
23 <u>state licensure to prescribe such medication. Coverage must</u>
24 <u>be provided to the same extent and subject to the same</u>
25 <u>contract terms, including copayments and deductibles, as any</u>
26 <u>other prescription drug. Nothing in this section:</u>
27 <u>(1) Requires an insurer regulated under this part to</u>
28 <u>provide coverage for any prescription oral contraceptive if</u>
29 <u>the insurer or policyholder objects on religious or moral</u>
30 <u>grounds. Failure to provide coverage for prescription oral</u>
31 <u>contraceptives based on religious or moral grounds shall not</u>

1 be the basis for any claim for damages or any recriminatory or
2 discriminatory action against an insurer or policyholder.
3 (2) Applies to any prescription medications which are
4 abortifacient in nature.
5 Section 8. Paragraph (b) of subsection (7) of section
6 627.6675, Florida Statutes, is amended to read:
7 627.6675 Conversion on termination of
8 eligibility.--Subject to all of the provisions of this
9 section, a group policy delivered or issued for delivery in
10 this state by an insurer or nonprofit health care services
11 plan that provides, on an expense-incurred basis, hospital,
12 surgical, or major medical expense insurance, or any
13 combination of these coverages, shall provide that an employee
14 or member whose insurance under the group policy has been
15 terminated for any reason, including discontinuance of the
16 group policy in its entirety or with respect to an insured
17 class, and who has been continuously insured under the group
18 policy, and under any group policy providing similar benefits
19 that the terminated group policy replaced, for at least 3
20 months immediately prior to termination, shall be entitled to
21 have issued to him or her by the insurer a policy or
22 certificate of health insurance, referred to in this section
23 as a "converted policy." An employee or member shall not be
24 entitled to a converted policy if termination of his or her
25 insurance under the group policy occurred because he or she
26 failed to pay any required contribution, or because any
27 discontinued group coverage was replaced by similar group
28 coverage within 31 days after discontinuance.
29 (7) INFORMATION REQUESTED BY INSURER.--
30
31

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

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

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

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

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

4.~~5.~~ Other reasons approved by the department.

Section 9. Section 627.6685, Florida Statutes, is created to read:

627.6685 Mental health coverage.--

(1) DEFINITIONS.--As used in this section:

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

(b) "Annual limit" means, with respect to benefits under a group health plan or health insurance coverage, a

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

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

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1 (II) Not include any annual limit on mental health
2 benefits which is less than the applicable annual limit.
3 c. For any plan or coverage that is not described in
4 sub-subparagraph a. or sub-subparagraph b. and that includes
5 no or different annual limits on different categories of
6 medical and surgical benefits, the department shall establish
7 rules under which sub-subparagraph b. is applied to such plan
8 or coverage with respect to mental health benefits by
9 substituting for the applicable annual limit an average annual
10 limit that is computed taking into account the weighted
11 average of the annual limits applicable to such categories.
12 (b) Nothing in this section shall be construed:
13 1. To require a group health plan, or health insurance
14 coverage offered in connection with such a plan, to provide
15 any mental health benefits; or
16 2. In the case of a group health plan, or health
17 insurance coverage offered in connection with such a plan,
18 which provides mental health benefits, to affect the terms and
19 conditions, including cost-sharing, limits on numbers of
20 visits or days of coverage, and requirements relating to
21 medical necessity, relating to the amount, duration, or scope
22 of mental health benefits under the plan or coverage, except
23 as specifically provided in paragraph (a) with respect to
24 parity in the imposition of aggregate lifetime limits and
25 annual limits for mental health benefits.
26 (3) EXEMPTIONS.--
27 (a) This section does not apply to any group health
28 plan, or group health insurance coverage offered in connection
29 with a group health plan, for any plan year of a small
30 employer as defined in s. 627.6699.
31

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1 (b) This section does not apply with respect to a
2 group health plan, or health insurance coverage offered in
3 connection with a group health plan, if the application of
4 this section to such plan or coverage results in an increase
5 in the cost under the plan or for such coverage of at least 1
6 percent.
7 (4) SEPARATE APPLICATION.--For any group health plan
8 that offers a participant or beneficiary two or more
9 benefit-package options under the plan, the requirements of
10 this section apply separately with respect to each such
11 option.
12 (5) DURATION.--This section does not apply to benefits
13 for services furnished on or after September 30, 2001.
14 (6) APPLICATION.--The provisions of this section shall
15 control in the event to the extent of any conflict between
16 this section and s. 627.668.
17 Section 10. Paragraph (k) of subsection (3) and
18 paragraph (b) of subsection (12) of section 627.6699, Florida
19 Statutes, are amended to read:
20 627.6699 Employee Health Care Access Act.--
21 (3) DEFINITIONS.--As used in this section, the term:
22 (k) "Health benefit plan" means any hospital or
23 medical policy or certificate, hospital or medical service
24 plan contract, or health maintenance organization subscriber
25 contract. The term does not include accident-only, specified
26 disease, individual hospital indemnity, credit, dental-only,
27 vision-only, Medicare supplement, and similar supplemental
28 plans provided under a separate policy, certificate, or
29 contract of insurance, which cannot duplicate coverage under
30 an underlying health plan and are specifically designed to
31 fill gaps in the underlying health plan, coinsurance, or

1 deductibles,long-term care, or disability income insurance;
2 coverage issued as a supplement to liability insurance;
3 workers' compensation or similar insurance; or automobile
4 medical-payment insurance.
5 (12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT
6 PLANS.--
7 (b)1. Each small employer carrier issuing new health
8 benefit plans shall offer to any small employer, upon request,
9 a standard health benefit plan and a basic health benefit plan
10 that meets the criteria set forth in this section.
11 2. For purposes of this subsection, the terms
12 "standard health benefit plan" and "basic health benefit plan"
13 mean policies or contracts that a small employer carrier
14 offers to eligible small employers that contain:
15 a. An exclusion for services that are not medically
16 necessary or that are not covered preventive health services;
17 and
18 b. A procedure for preauthorization by the small
19 employer carrier, or its designees.
20 3. A small employer carrier may include the following
21 managed care provisions in the policy or contract to control
22 costs:
23 a. A preferred provider arrangement or exclusive
24 provider organization or any combination thereof, in which a
25 small employer carrier enters into a written agreement with
26 the provider to provide services at specified levels of
27 reimbursement or to provide reimbursement to specified
28 providers. Any such written agreement between a provider and a
29 small employer carrier must contain a provision under which
30 the parties agree that the insured individual or covered
31 member has no obligation to make payment for any medical

service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the department, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for handicapped children pursuant to s. 627.6615;

h. Emergency or urgent care out of the geographic service area; and

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1 i. Coverage for services provided by a hospice
2 licensed under s. 400.602 in cases where such coverage would
3 be the most appropriate and the most cost-effective method for
4 treating a covered illness.
5 5. The standard health benefit plan and the basic
6 health benefit plan may include a schedule of benefit
7 limitations for specified services and procedures. If the
8 committee develops such a schedule of benefits limitation for
9 the standard health benefit plan or the basic health benefit
10 plan, a small employer carrier offering the plan must offer
11 the employer an option for increasing the benefit schedule
12 amounts by 4 percent annually.
13 6. The basic health benefit plan shall include all of
14 the benefits specified in subparagraph 4.; however, the basic
15 health benefit plan shall place additional restrictions on the
16 benefits and utilization and may also impose additional cost
17 containment measures.
18 7. Sections 627.419(2), (3), and (4), 627.6574,
19 627.65741,627.6612, 627.66121, 627.66122, 627.6616, 627.6618,
20 and 627.668 apply to the standard health benefit plan and to
21 the basic health benefit plan. However, notwithstanding said
22 provisions, the plans may specify limits on the number of
23 authorized treatments, if such limits are reasonable and do
24 not discriminate against any type of provider.
25 8. Each small employer carrier that provides for
26 inpatient and outpatient services by allopathic hospitals may
27 provide as an option of the insured similar inpatient and
28 outpatient services by hospitals accredited by the American
29 Osteopathic Association when such services are available and
30 the osteopathic hospital agrees to provide the service.
31

1 Section 11. Subsection (34) is added to section
2 641.31, Florida Statutes, to read:
3 641.31 Health maintenance contracts.--
4 (34) Health maintenance contracts that provide
5 coverage for outpatient prescription drugs shall cover
6 prescription oral contraceptives approved by the federal Food
7 and Drug Administration and prescribed by a practitioner
8 authorized by state licensure to prescribe such medication
9 when such practitioner is under the organization's direct
10 employ or under contract or other arrangement with the
11 organization to provide health care services to subscribers.
12 Coverage must be provided to the same extent and subject to
13 the same contract terms, including copayments, as any other
14 prescription medication. Nothing in this section:
15 (a) Requires an insurer regulated under this part to
16 provide coverage for any prescription oral contraceptive if
17 the insurer or policyholder objects on religious or moral
18 grounds. Failure to provide coverage for prescription oral
19 contraceptives based on religious or moral grounds shall not
20 be the basis for any claim for damages or any recriminatory or
21 discriminatory action against an insurer or policyholder.
22 (b) Applies to any prescription medications which are
23 abortifacient in nature.
24 Section 12. Paragraphs (a) and (d) of subsection (2)
25 and subsection (3) of section 627.674, Florida Statutes, are
26 amended to read:
27 627.674 Minimum standards; filing requirements.--
28 (2)(a) The department must adopt rules establishing
29 minimum standards for Medicare supplement policies that, taken
30 together with the requirements of this part, are no less
31 comprehensive or beneficial to persons insured or covered

under Medicare supplement policies issued, delivered, or issued for delivery in this state, including certificates under group or blanket policies issued, delivered, or issued for delivery in this state, than the standards provided in 42 U.S.C., s. 1395ss, or the most recent version of the NAIC Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act adopted by the National Association of Insurance Commissioners ~~on July 31, 1991, or the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508)~~.

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

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

Section 13. Subsection (1) and paragraph (c) of subsection (2) of section 627.6741, Florida Statutes, are amended, and subsection (5) is added to said section, to read:

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

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

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

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

A Medicare supplement policy issued to an individual under paragraph (a) or paragraph (b) may not exclude benefits based on a preexisting condition if the individual has a continuous period of creditable coverage, as defined in s. 627.6561(5), of at least 6 months as of the date of application for coverage ~~the opportunity of enrolling in a Medicare supplement policy, without conditioning the issuance or effectiveness of the policy on, and without discriminating in the price of the policy based on, the medical or health status or receipt of health care by the individual~~.

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

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

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1 creditable coverage as defined in s. 627.6561(5)group health
2 insurance policy or certificate, the replacing insurer shall
3 waive any time periods applicable to preexisting conditions,
4 waiting periods, elimination periods, and probationary periods
5 in the new Medicare supplement policy for similar benefits to
6 the extent such time was spent under the original policy,
7 subject to the requirements of s. 627.6561(6)-(11).
8 (5) The department, by rule, shall prescribe standards
9 relating to the guaranteed issue of coverage, without
10 exclusions for preexisting conditions, for continuously
11 covered individuals consistent with the provisions of 42
12 U.S.C., s. 1395ss(s)(3).
13 Section 14. Subsection (5) is added to section
14 627.912, Florida Statutes, to read:
15 627.912 Professional liability claims and actions;
16 reports by insurers.--
17 (5) Any self-insurance program established under s.
18 240.213 shall report in duplicate to the Department of
19 Insurance any claim or action for damages for personal
20 injuries claimed to have been caused by error, omission, or
21 negligence in the performance of professional services
22 provided by the Board of Regents through an employee or agent
23 of the Board of Regents, including practitioners of medicine
24 licensed under chapter 458, practitioners of osteopathic
25 medicine licensed under chapter 459, podiatrists licensed
26 under chapter 461, and dentists licensed under chapter 466, or
27 based on a claimed performance of professional services
28 without consent if the claim resulted in a final judgment in
29 any amount, a settlement in any amount, or a final disposition
30 not resulting in payment on behalf of the insured. The reports
31 required by this subsection shall contain the information

required by subsection (3) and the name, address, and specialty of the employee or agent of the Board of Regents whose performance or professional services is alleged in the claim or action to have caused personal injury.

Section 15. Section 627.9403, Florida Statutes, is amended to read:

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

nursing home, but does provide coverage for one or more lower levels of care, the policy shall also be exempt from the requirements of s. 627.9407(3)(d).

Section 16. Subsection (1) of section 627.9404, Florida Statutes, is amended, subsections (7), (8), (9), and (10) of said section are renumbered as subsections (8), (9), (10), and (11), respectively, and new subsection (7) is added to said section, to read:

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

(1) "Long-term care insurance policy" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. A long-term care insurance policy must meet all the requirements of this part except s. 627.9407(12).

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

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1 Section 17. Paragraph (a) of subsection (4) and
2 subsection (12) of section 627.9407, Florida Statutes, are
3 amended 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 (12) DISCLOSURE.--
18 (a) A qualified long-term care insurance policy 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 long-term contract. A long-term care insurance
22 policy that is not intended to be a qualified long-term care
23 insurance contract must include a disclosure statement within
24 the policy and within the outline of coverage that the policy
25 is not intended to be a qualified long-term care insurance
26 contract. The disclosure shall be prominently displayed and
27 shall read as follows: "This long-term care insurance policy
28 is not intended to be a qualified long-term care insurance
29 contract. You need to be aware that benefits received under
30 this policy may create unintended, adverse income tax
31 consequences to you. You may want to consult with a

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1 knowledgeable individual about such potential income tax
2 consequences."
3 (b) A limited benefit policy qualified under s. 7702B
4 of the Internal Revenue Code must include a disclosure
5 statement within the policy and within the outline of coverage
6 that the policy is intended to be a qualified limited benefit
7 insurance contract. A limited benefit policy that is not
8 intended to be a qualified limited benefit insurance contract
9 must include a disclosure statement within the policy and
10 within the outline of coverage that the policy is not intended
11 to be a qualified limited benefit insurance contract. The
12 disclosure shall be prominently displayed and shall read as
13 follows: "This limited benefit insurance policy is not
14 intended to be a qualified limited benefit insurance contract.
15 You need to be aware that benefits received under this policy
16 may create unintended, adverse income tax consequences to you.
17 You may want to consult with a knowledgeable individual about
18 such potential income tax consequences."
19 Section 18. Subsection (2) of section 627.94073,
20 Florida Statutes, is amended to read:
21 627.94073 Notice of cancellation; grace period.--
22 (2) A long-term care policy may not be canceled for
23 nonpayment of premium unless, after expiration of the grace
24 period in subsection (1), and at least 30 days prior to the
25 effective date of such cancellation, the insurer has mailed a
26 notification of possible lapse in coverage to the policyholder
27 and to a specified secondary addressee if such addressee has
28 been designated in writing by name and address by the
29 policyholder. For policies issued or renewed on or after
30 October 1, 1996, the insurer shall notify the policyholder, at
31 least once every 2 years, of the right to designate a

secondary addressee. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse.--I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this [long-term care/limited benefit] insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice." Notice shall be given by first class United States mail, postage prepaid, and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

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

641.225 Surplus requirements.--

(1) Each health maintenance organization shall at all times maintain a minimum surplus in an amount which is the greater of $1,500,000, ~~$500,000 or~~ 10 percent of total liabilities, or 2 percent of total annualized premium. All health maintenance organizations which have a valid certificate of authority before October 1, 1998 ~~1988~~, or an entity described in subsection (3), and which do not meet the

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minimum surplus requirement, shall increase their surplus as follows:

Date	Amount
September 30, 1998 ~~1989~~	$800,000, ~~$200,000 or~~ 10 ~~6~~ percent of total liabilities, or 1 percent of annualized premium, whichever is greater
September 30, 1999 ~~1990~~	$1,150,000, ~~$350,000 or~~ 8 percent of total liabilities, or 1.25 percent of annualized premium, whichever is greater
September 30, 2000 ~~1991~~	$1,500,000, ~~$500,000 or~~ 10 percent of total liabilities, or 2 percent of annualized premium, whichever is greater

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

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

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

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

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(c) $1,150,000~~$500,000~~ plus all startup losses, excluding profits, projected to be incurred on their startup ~~actuarial~~ projection until the projection reflects statutory net profits for 12 consecutive months.

Section 20. Section 641.285, Florida Statutes, is amended to read:

641.285 Insolvency protection.--

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

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

~~(b) $100,000~~.

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

~~(a)~~ If for any reason the market value of assets and securities of a health maintenance organization held on deposit in this state under this code falls below the amount required, the organization shall promptly deposit other or additional assets or securities eligible for deposit

1 sufficient to cure the deficiency. If the health maintenance
2 organization has failed to cure the deficiency within 30 days
3 after receipt of notice thereof by registered or certified
4 mail from the department, the department may revoke the
5 certificate of authority of the health maintenance
6 organization.
7 ~~(b) A health maintenance organization may, at its~~
8 ~~option, deposit assets or securities in an amount exceeding~~
9 ~~its deposit required or otherwise permitted under this code by~~
10 ~~not more than 20 percent of the required or permitted deposit,~~
11 ~~or $20,000, whichever is the larger amount, for the purpose of~~
12 ~~absorbing fluctuations in the value of securities and assets~~
13 ~~deposited and to facilitate the exchange and substitution of~~
14 ~~securities and assets. During the solvency of the health~~
15 ~~maintenance organization, any excess shall be released to the~~
16 ~~organization upon its request. During the insolvency of the~~
17 ~~health maintenance organization, any excess deposit shall be~~
18 ~~released only as provided in s. 625.62.~~
19 (3) Whenever the department determines that the
20 financial condition of a health maintenance organization has
21 deteriorated to the point that the policyholders' or
22 subscribers' best interests are not being preserved by the
23 activities of a health maintenance organization, the
24 department may require such health maintenance organization to
25 deposit and maintain deposited in trust with the department
26 for the protection of the health maintenance organization's
27 policyholders, subscribers and/or creditors, for such time as
28 the department deems necessary, securities eligible for such
29 deposit under s. 625.52, having a market value of not less
30 than the amount which the department determines is necessary,
31 which amount shall be not less than $100,000 or greater than

$2,000,000. The deposit required under this subsection is in addition to any other deposits required of a health maintenance organization pursuant to subsections (1) and (2). ~~The department shall waive the deposit requirements set forth in subsection (1) whenever it is satisfied that:~~

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

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

~~(c) The assets of the health maintenance organization or its contracts with any insurer, health care provider, governmental entity, or other person are reasonably sufficient to assure the performance of the obligations of the organization.~~

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

~~(5)(a) The requirements of this section do not apply to an applying or licensed health maintenance organization which has a plan, approved by the department, for handling insolvency which provides for continuation of benefits and payments to unaffiliated providers for services rendered both prior to and after insolvency for the duration of the contract period for which payment has been made, except that benefits~~

~~to members who are confined on the date of insolvency in an inpatient facility shall be continued until their discharge. This plan shall include at least one of the following:~~

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

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

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

~~(b) The department shall reduce the deposit requirements specified in subsection (1) whenever the department has determined that the health maintenance organization has a plan for handling insolvency which partially meets the requirements of this section. The amount~~

1 ~~of the deposit reduction shall be based on the extent to which~~
2 ~~the organization meets the requirements of this section.~~
3 Section 21. Paragraph (d) of subsection (2) and
4 paragraphs (a) and (b) of subsection (3) of section 641.31074,
5 Florida Statutes, are amended to read:
6 641.31074 Guaranteed renewability of coverage.--
7 (2) A health maintenance organization may nonrenew or
8 discontinue a contract based only on one or more of the
9 following conditions:
10 (d) The health maintenance organization is ceasing to
11 offer coverage in such a market in accordance with subsection
12 (3) ~~and applicable state law~~.
13 (3)(a) A health maintenance organization may
14 discontinue offering a particular contract form for group
15 coverage offered in the small group market or large group
16 market only if:
17 1. The health maintenance organization provides notice
18 to each contract holder provided coverage of this form in such
19 market, and participants and beneficiaries covered under such
20 coverage, of such discontinuation at least 90 days prior to
21 the date of the discontinuation of such coverage;
22 2. The health maintenance organization offers to each
23 contract holder provided coverage of this form in such market
24 the option to purchase all, or in the case of the large group
25 market, any other health insurance coverage currently being
26 offered by the health maintenance organization in such market;
27 and
28 3. In exercising the option to discontinue coverage of
29 this form and in offering the option of coverage under
30 subparagraph 2., the health maintenance organization acts
31 uniformly without regard to the claims experience of those

1 contract holders or any health-status-related factor that
2 relates to any participants or beneficiaries covered or new
3 participants or beneficiaries who may become eligible for such
4 coverage.
5 (b)1. In any case in which a health maintenance
6 organization elects to discontinue offering all coverage in
7 the small group market or the large group market, or both, in
8 this state, coverage may be discontinued by the insurer only
9 if:
10 a. The health maintenance organization provides notice
11 to the department and to each contract holder, and
12 participants and beneficiaries covered under such coverage, of
13 such discontinuation at least 180 days prior to the date of
14 the discontinuation of such coverage; and
15 b. All health insurance issued or delivered for
16 issuance in this state in such market is ~~markets are~~
17 discontinued and coverage under such health insurance coverage
18 in such market is not renewed.
19 2. In the case of a discontinuation under subparagraph
20 1. in a market, the health maintenance organization may not
21 provide for the issuance of any health maintenance
22 organization contract coverage in the market in this state
23 during the 5-year period beginning on the date of the
24 discontinuation of the last insurance contract not renewed.
25 Section 22. Paragraph (a) of subsection (7) of section
26 641.3922, Florida Statutes, is amended to read:
27 641.3922 Conversion contracts; conditions.--Issuance
28 of a converted contract shall be subject to the following
29 conditions:
30 (7) REASONS FOR CANCELLATION; TERMINATION.--The
31 converted health maintenance contract must contain a

cancellation or nonrenewability clause providing that the health maintenance organization may refuse to renew the contract of any person covered thereunder, but cancellation or nonrenewal must be limited to one or more of the following reasons:

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

Section 23. Subsection (12) is added to section 641.495, Florida Statutes, to read:

641.495 Requirements for issuance and maintenance of certificate.--

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

Section 24. This act shall take effect on July 1, 1998.

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HOUSE SUMMARY

Exempts moneys paid into a medical savings account from attachment, garnishment, or legal process.

Creates the "Equity in Contraceptive Coverage Act of 1998" to require health insurance policies and health maintenance contracts to provide coverage for prescription oral contraceptives.

Revises standards for renewal of converted insurance policies.

Requires health insurers and health maintenance organizations to include in their plans that offer mental health coverage annual and lifetime mental health benefits coverage restrictions that are not less than annual and lifetime benefits coverage restrictions for medical or surgical benefits covered by the plan.

Authorizes the Department of Insurance to adopt rules governing guaranteed issue of Medicare supplement coverage for continuously covered individuals. Revises the minimum standards for Medicare supplement policies and revises requirements for insurers to issue, cancel, nonrenew, and replace Medicare supplement policies.

Increases insolvency requirements for health maintenance organizations, revises requirements for insolvency protection, and authorizes the Department of Insurance to increase insolvency protection for health maintenance organizations.

Revises standards for renewal of converted health maintenance organization policies. See bill for details.