A bill to be entitled

An act relating to health insurance; creating s. 222.23, F.S.; exempting moneys paid into a medical savings account from attachment, garnishment, or legal process; amending s. 627.6571, F.S.; clarifying application; amending s. 627.6675, F.S.; revising standards for renewal of converted insurance policies; creating s. 627.6685, F.S.; requiring 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; providing exemptions; amending s. 627.6699, F.S.; revising a definition; authorizing the Department of Insurance to adopt rules governing guaranteed issue of Medicare supplement coverage for continuously covered individuals; amending s. 627.674, F.S.; revising the minimum standards for Medicare Supplement policies; amending s. 627.6741, F.S.; revising requirements for insurers to issue, cancel, nonrenew, and replace Medicare supplement policies; restricting preexisting condition exclusions; amending s. 627.912, F.S.; requiring certain self-insurers to report certain information to the Department of Insurance; amending s. 627.9403, F.S.;

clarifying application to certain types of long-term care policies; amending s. 627.9404, F.S.; exempting long-term care insurance policies from certain requirements; providing definitions; amending s. 627.9407, F.S.; revising the definition of "preexisting condition"; requiring certain insurance policies to provide disclosure of certain information; amending s. 627.94073, F.S., clarifying notice; amending s. 641.225, F.S.; increasing solvency requirements for health maintenance organizations; amending s. 641.285, F.S.; revising requirements for insolvency protection; authorizing the Department of Insurance to increase insolvency protection for certain health maintenance organizations; amending s. 641.31074, F.S.; removing redundant language and making technical corrections; amending s. 641.3922, F.S.; revising standards for renewal of converted health maintenance organization policies; amending s. 641.495, F.S.; exempting from certain licensure requirements certain beds of a health maintenance organization; repealing s. 641.3922(7)(b), F.S., relating to cancellation or nonrenewal of health maintenance contracts due to eligibility for coverage under Medicare; providing an effective date.

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

Section 1. Section 222.23, Florida Statutes, is created to read:

222.23 Exemption of moneys in the medical savings account from legal process.--Moneys paid into or out of a medical savings account by or on behalf of a person depositing money into such account or qualified beneficiary are not liable to attachment, garnishment, or legal process in the state in favor of any creditor of such person or beneficiary of such medical savings account.

Section 2. Paragraph (b) of subsection (3) of section 627.6571, Florida Statutes, is amended to read:

627.6571 Guaranteed renewability of coverage.--

(3)

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

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

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

2. In the case of a discontinuation under subparagraph 1. in a market, the insurer may not provide for the issuance of any health insurance coverage in the market in this state

during the 5-year period beginning on the date of the discontinuation of the last insurance coverage not renewed.

Section 3. Paragraph (b) of subsection (7) of section 627.6675, Florida Statutes, is amended to read:

627.6675 Conversion on termination of eligibility.--Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(7) INFORMATION REQUESTED BY INSURER.--

(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 4. 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 dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under

the plan or health insurance coverage with respect to an individual or other coverage unit.

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

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

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

(2) BENEFITS.--

(a)1. In the case of a group health plan, or health insurance coverage offered in connection with such a plan, which provides both medical and surgical benefits and mental health benefits:

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

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

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

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

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

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

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

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

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

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

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

(b) Nothing in this section shall be construed:

1. To require a group health plan, or health insurance coverage offered in connection with such a plan, to provide any mental health benefits; or

2. In the case of a group health plan, or health insurance coverage offered in connection with such a plan, which provides mental health benefits, to affect the terms and conditions, including cost-sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity, relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in paragraph (a) with respect to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

(3) EXEMPTIONS.--

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

(b) This section does not apply with respect to a group health plan, or health insurance coverage offered in connection with a group health plan, if the application of

this section to such plan or coverage results in an increase in the cost under the plan or for such coverage of at least 1 percent.

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

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

(6) APPLICATION.--The provisions of this section shall control in the event to the extent of any conflict between this section and s. 627.668.

Section 5. Paragraph (k) of subsection (3) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.--

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

(k) "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, and similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

Section 6. Paragraphs (a) and (d) of subsection (2) and subsection (3) of section 627.674, Florida Statutes, are amended to read:

627.674 Minimum standards; filing requirements.--

(2)(a) The department must adopt rules establishing minimum standards for Medicare supplement policies that, taken together with the requirements of this part, are no less 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 7. 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 creditable coverage as defined in s. 627.6561(5)~~group health insurance policy or certificate~~, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original policy, subject to the requirements of s. 627.6561(6)-(11).

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

Section 8. Subsection (5) is added to section 627.912, Florida Statutes, to read:

627.912 Professional liability claims and actions; reports by insurers.--

(5) Any self-insurance program established under s. 240.213 shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of professional services provided by the Board of Regents through an employee or agent of the Board of Regents, including practitioners of medicine licensed under chapter 458, practitioners of osteopathic

medicine licensed under chapter 459, podiatrists licensed under chapter 461, and dentists licensed under chapter 466, or based on a claimed performance of professional services without consent if the claim resulted in a final judgment in any amount, a settlement in any amount, or a final disposition not resulting in payment on behalf of the insured. The reports 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 9. 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 10. 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.

Section 11. Paragraph (a) of subsection (4) and subsection (12) of section 627.9407, Florida Statutes, are amended to read:

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

(4) PREEXISTING CONDITION.--

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

(12) DISCLOSURE.--

(a) A qualified long-term care insurance policy must include a disclosure statement within the policy and within the outline of coverage that the policy is intended to be a qualified long-term contract. A long-term care insurance policy that is not intended to be a qualified long-term care insurance contract must include a disclosure statement within the policy and within the outline of coverage that the policy is not intended to be a qualified long-term care insurance

contract. The disclosure shall be prominently displayed and shall read as follows: "This long-term care insurance policy is not intended to be a qualified long-term care insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about such potential income tax consequences."

(b) A limited benefit policy qualified under s. 7702B of the Internal Revenue Code must include a disclosure statement within the policy and within the outline of coverage that the policy is intended to be a qualified limited benefit insurance contract. A limited benefit policy that is not intended to be a qualified limited benefit insurance contract must include a disclosure statement within the policy and within the outline of coverage that the policy is not intended to be a qualified limited benefit insurance contract. The disclosure shall be prominently displayed and shall read as follows: "This limited benefit insurance policy is not intended to be a qualified limited benefit insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about such potential income tax consequences."

Section 12. Subsection (2) of section 627.94073, Florida Statutes, is amended to read:

627.94073 Notice of cancellation; grace period.--

(2) A long-term care policy may not be canceled for nonpayment of premium unless, after expiration of the grace period in subsection (1), and at least 30 days prior to the effective date of such cancellation, the insurer has mailed a

notification of possible lapse in coverage to the policyholder and to a specified secondary addressee if such addressee has been designated in writing by name and address by the policyholder. For policies issued or renewed on or after October 1, 1996, the insurer shall notify the policyholder, at 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 13. 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 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

(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 14. 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 sufficient to cure the deficiency. If the health maintenance organization has failed to cure the deficiency within 30 days after receipt of notice thereof by registered or certified mail from the department, the department may revoke the certificate of authority of the health maintenance organization.

~~(b) A health maintenance organization may, at its option, deposit assets or securities in an amount exceeding its deposit required or otherwise permitted under this code by not more than 20 percent of the required or permitted deposit, or $20,000, whichever is the larger amount, for the purpose of absorbing fluctuations in the value of securities and assets deposited and to facilitate the exchange and substitution of securities and assets. During the solvency of the health maintenance organization, any excess shall be released to the organization upon its request. During the insolvency of the health maintenance organization, any excess deposit shall be released only as provided in s. 625.62.~~

(3) Whenever the department determines that the financial condition of a health maintenance organization has deteriorated to the point that the policyholders' or subscribers' best interests are not being preserved by the activities of a health maintenance organization, the department may require such health maintenance organization to

deposit and maintain deposited in trust with the department for the protection of the health maintenance organization's policyholders, subscribers and/or creditors, for such time as the department deems necessary, securities eligible for such deposit under s. 625.52, having a market value of not less than the amount which the department determines is necessary, 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 of the deposit reduction shall be based on the extent to which the organization meets the requirements of this section.~~

Section 15. Paragraph (d) of subsection (2) and paragraphs (a) and (b) of subsection (3) of section 641.31074, Florida Statutes, are amended to read:

641.31074 Guaranteed renewability of coverage.--

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

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

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

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

2. The health maintenance organization offers to each contract holder provided coverage of this form in such market the option to purchase all<u>, or in the case of the large group market, any</u> other health insurance coverage currently being

offered by the health maintenance organization in such market; and

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

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

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

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

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

Section 16. Paragraph (a) of subsection (7) of section 641.3922, Florida Statutes, is amended to read:

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

(7) REASONS FOR CANCELLATION; TERMINATION.--The 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 17. 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 18. This act shall take effect on July 1, 1998.