STORAGE NAME: h2071z.hcs ****FINAL ACTION****
DATE: June 8, 1999 ****SEE FINAL ACTION STATUS SECTION****

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
FINAL ANALYSIS

BILL #: HB 2071 (PCB HCS 99-07) (Passed as CS/SB 312)

RELATING TO: Health Insurance

SPONSOR(S): Committee on Health Care Services and Rep. Peaden

COMPANION BILL(S): CS/SB 312 (s), SB 1832 (c), CS/HB's 1927 & 961 (c), CS/HB 1743 (c), CS/SB 2472 (c), CS/SB 2516 (c), and CS/SB 2554 (c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 17 NAYS 0
(2)
(3)
(4)
(5)

I. FINAL ACTION STATUS:

05/26/99 Approved by Governor; Chapter No. 99-204

II. SUMMARY:

HB 2071 addresses several insurance issues. The bill facilitates the licensing and appointment procedures for entities offering credit property, credit life, credit disability, and credit insurance.

The bill addresses some of the concerns raised in three reports released by the Fourteenth Statewide Grand Jury in December 1998, related to insurance fraud. Specific insurance fraud provisions addressed in the bill include:

- Criminal penalties for insurance fraud are increased;
- Statutes of limitations for prosecuting insurance fraud are extended;
- An Anti-Fraud Reward Program is established, and $250,000 is appropriated from the Insurance Commissioner's Regulatory Trust Fund to implement the program;
- HMOs are required to file anti-fraud plans or establish special investigative units;
- HMOs and HMO contracts are included under the law prohibiting false and fraudulent insurance claims and applications; and
- The criminal penalty for first offenses of "patient brokering" provisions are increased.

The bill defines "collateral protection insurance" in the context of the Florida Hurricane Catastrophe Fund, joint underwriters and joint reinsurers, and insurance risk apportionment plans. Such insurance is not residential coverage.

The bill also addresses health insurance issues relating to the cancellation of coverage as a result of the non-payment of premiums by an employer. The bill:

- Limits the right of an insurance company or health maintenance organization (HMO) to retroactively cancel a group health insurance policy due to nonpayment of premium by the employer, and imposes certain notice requirements for enrollees prior to coverage cancellation.

- Protects the employee's right to elect a conversion health insurance policy in the event of such a cancellation.

- Clarifies current law to allow group insurers to contract with another insurer to issue conversion contracts on its behalf, provided that the other insurer is authorized in Florida and the policy has been approved by the Department of Insurance.

The bill is effective on, and applies to policies and contracts issued or renewed after, October 1, 1999.

III. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Retroactive Cancellation of Group Health Insurance Contracts

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

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

In January 1998, the Department of Insurance filed an administrative action against AvMed Health Plan (an HMO) for *retroactively* canceling the group health insurance coverage of employees who worked for a company which failed to pay its group HMO premiums. According to the petition filed by the department, the employer had fallen behind on paying the HMO for its group health contract, but during a 2 to 3 month period, the HMO continued to authorize doctors and hospitals to treat the employees. In August 1997, the HMO terminated the group coverage retroactively to May when the last premiums were paid. Employees were not provided written notification by the HMO prior to the contract being canceled. The HMO has billed employees for medical care provided after the May cancellation date. The Department of Insurance alleges that because the HMO failed to provide any of the employees with written notice of termination of their health insurance coverage as specified in their member handbook, the employees were illegally denied the opportunity to request continued health insurance coverage through a converted contract under s. 641.3922, F.S. Additionally, due to the fact that the HMO continued to authorize and preauthorize medical visits, the department contends that employees were misled into believing that they had health insurance.

Health Insurance Policies and Contracts--Conversion

Presently, insurers and HMOs issuing group policies in Florida must offer individual conversion policies or contracts to an employee or member whose eligibility for the group coverage terminates, as required by s. 627.6675, F.S., for insurers, and by s. 641.3922, F.S., for HMOs. The maximum premium for the policy is 200 percent of the *standard risk rate* as determined by the department.

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

Insurance Fraud

According to *Black's Law Dictionary*, "fraud" is an "intentional perversion of the truth for the purpose of inducing another in reliance upon it to part with some valuable thing belonging to him or surrender a legal right." The concept of insurance fraud is not specifically addressed in a single section of Florida Statutes. Rather, insurance fraud is addressed in a variety of different sections relating to violations of the Florida Insurance Code.

For example, Florida has enacted laws relating to "fraudulent insurance acts" (s. 626,989(1), F.S.), "false and fraudulent insurance claims" (s. 817.234, F.S.), and "unfair insurance trade practices" (Part X, Chapter 626, F.S.). In addition, there are statutes prohibiting theft, forgery, and bribery and statutes relating to unlawful financial transactions, unlawful business solicitation, and misrepresentations.

Division of Insurance Fraud

The Division of Insurance Fraud (division) is a law enforcement agency within the Department of Insurance. The division has the statutory duty to investigate "fraudulent insurance acts" (s. 626.989(1), F.S.), unfair insurance trade practices (s. 626.9541, F.S.), "false and fraudulent insurance claims" (s. 817.234, F.S.), workers' compensation fraud (s. 440.105(4), F.S.), and acts punishable under s. 624.15, F.S. (the general penalty that makes any violation of the Insurance Code at least a second degree misdemeanor).

Insurer Anti-Fraud Units

Since 1996, each insurer has been required under s. 626.9891, F.,S., to establish an anti-fraud unit to investigate potential fraudulent claims, contract with a vendor to provide the services of an anti-fraud unit, or, in the case of an insurer that writes less than $10 million in premiums in a year, establish and file with the Department an anti-fraud plan. The requirements do not apply to a health maintenance organization (HMO), because an HMO is not included within the definition of an "insurer." Section 626.9891, F.S., does not give the department the authority to approve or disapprove an insurer's anti-fraud unit, contract, or plan.

Criminal Penalties and Statute of Limitations

The criminal penalty for false and fraudulent insurance claims and applications (s. 817.234, F.S.) is a third-degree felony, punishable by up to 5 years in prison and a fine of up to $5,000. By virtue of the general penalty provision, s. 624.15, F.S., second degree misdemeanor penalties (up to 60 days in county jail and a fine of up to $500) apply to any violation of the Insurance Code for which no other criminal penalty is specified.

Under s. 775.15, F.S., a prosecution for a third-degree felony must be commenced within 3 years after it was committed, and a prosecution for a misdemeanor must be commenced within 1 year after it was committed. If the limitation period has expired and fraud is a material element of the crime, the prosecution may be commenced within 1 year after the fraud is discovered, but this exception cannot be used more than 3 years after the end of the original limitation period.

Workers' compensation fraud is punishable based on a sliding scale which depends on the amount involved in fraudulent activity. See s. 440.105(4)(f), F.S. (1998 Supplement). Furthermore, prosecutions of workers' compensation fraud must be commenced within 5 years after the fraud is discovered. See s. 775.15(2)(h), F.S. (1998 Supplement).

Rewards

There is no statutory authorization for the Department of Insurance to provide cash rewards to persons who provide information leading to insurance fraud convictions. Various other state agencies have statutory authorization for reward programs.

Statewide Grand Jury Reports on Insurance Fraud

The Fourteenth Statewide Grand Jury was impaneled on August 19, 1997, and was seated in the Second Judicial Circuit, Leon County. The panel was drawn from around the state. The Grand Jury met on 13 occasions to investigate allegations of multi-circuit, organized criminal activity. The Grand Jury's original term expired after twelve months, but was extended to February 19, 1999.

The Grand Jury primarily investigated cases involving insurance fraud, with an emphasis on workers' compensation premium fraud, health care claim fraud, insolvency fraud and consumer fraud. The Grand Jury issued 13 indictments charging 78 defendants and 5 businesses with a total of 508 crimes. The indictments allege the following criminal offenses: racketeering; conspiracy to racketeer; grand theft; insurance fraud; organized fraud; insurance solicitation; workers' compensation fraud; failure to secure workers' compensation; securities fraud; sale of unregistered securities; sale of securities by an unlicensed dealer; unauthorized transaction of insurance; false evidence of compliance; and false entry in books of corporation.

In December of 1998, the Grand Jury released its final three reports on insurance fraud -- (1) Insurance Insolvency Fraud, (2) Health Care Claims Fraud, and (3) Non-Standard Insurance Industry Fraud. These reports, cited as Supreme Court Case No. 90,703, are summarized below.

Insurance Insolvency Fraud

The Grand Jury report considered an insurance company insolvent when its financial condition falls below certain minimum state requirements. The Grand Jury defined insurance insolvency fraud as criminal activity by company insiders which causes an insurance company to become insolvent; or fraudulent activity designed to hide a company's true financial condition from state regulators.

According to the Grand Jury, insurance company insolvencies not only impact the companies' policyholders, they impact everyone. Since 1993, a total of 21 insurance companies doing business in the state of Florida have become insolvent. Of these insolvencies, the Grand Jury suspected criminal activity in 14 of the cases. According to the Grand Jury, insolvencies of insurance companies doing business in Florida where crime has either caused or contributed to their condition have cost insurance guaranty associations approximately $435,945,000 over the past five years -- which costs are ultimately passed on to policy holders.

Based on the work involved in investigating and prosecuting these cases, the Grand Jury believed the current statutes addressing insurance fraud do not specifically address insolvency fraud as forcefully or as specifically as they should. The Grand Jury noted that the Legislature has always relied upon general criminal statutes to combat insolvency fraud. The Grand Jury reported that these statutes were not designed with insolvency fraud in mind and do not carry sufficiently stiff penalties.

Health Care Claims Fraud

In this report, the Grand Jury focused on fraudulent practices in the area of health care claims submitted to private insurance companies and self-insurance programs.

Citing the Department of Insurance, the Grand Jury reported that fraudulent health insurance claims amount to $4.8 billion each year. Based on this figure, the Grand Jury stated "every insurance consumer family in the state pays over $1,066 in additional health insurance premiums annually."

The Grand Jury found that a variety of health care fraud scams are presently being perpetrated in Florida. According to the Grand Jury, these scams include:

- Submitting medical bills from actual clinics for services that were never performed or that were unnecessary;
- Submitting false medical bills from fictitious clinics either by using information from real patients and physicians or fictitious physicians;
- Recruiting and paying insured persons to go to storefront clinics for routine physicals;
- Forcing patients to undergo tests and procedures they do not need; and
- Using runners to solicit accident victims to visit chiropractors.

Fraud in the Non-Standard Insurance Industry

The third report released by the Grand Jury in December of 1998 dealt with insurance fraud in the non-standard insurance industry. According to the Grand Jury report, "non-standard" insurance agencies provide automobile insurance and other related products to consumers not able to secure insurance from standard insurance companies because of their driving history, age, and costs.

The Grand Jury learned through the course of its investigation that, in addition to selling insurance, "many of these agencies offer optional non-insurance related products (i.e. towing clubs, legal plans, and life insurance) to their customers as an added means of profit for the agency. Unfortunately [the Grand Jury has] learned that deception, misrepresentation and other fraudulent means are often used in order to insure these ancillary products are sold."

The Grand Jury's investigation revealed several different schemes used by non-standard agencies to cause consumers to purchase ancillary products that they may not want or need. One scheme involves agencies including the cost of the ancillary product in the base quote for insurance. For example, assume the base cost of insurance is $100 and the cost of the ancillary product is $50. Under this scheme, the agency would quote the base cost for insurance as $150 and tell the consumer that this price includes the additional product. However, the agency would not tell the consumer that the product is optional. Another related scheme involved agencies advising consumers that if optional products were refused, the cost of insurance would be higher or that the consumer could not be insured.

Yet another scheme discovered by the Grand Jury involved agencies selling ancillary products to consumers who did not even know that they had purchased an ancillary product. The Grand Jury found that some agencies would provide a series of forms for the consumer to sign without explaining the product's benefits. Through what the Grand Jury referred to as a "sign here, sign here, sign here" approach, the consumer would unknowingly purchase ancillary products.

The Grand Jury recognized that s. 626.9541(1)(z), F.S., relating to the practice of "sliding," encompasses many of the activities discovered by the Grand Jury. This section, which carries a penalty of a second degree misdemeanor, currently provides:

> Sliding is the act or practice of:
>
> 1. Representing to the applicant that a specific ancillary coverage or product is required by law in conjunction with the purchase of motor vehicle insurance when such coverage or product is not required;
>
> 2. Representing to the applicant that a specific ancillary coverage or product is included in the motor vehicle policy applied for without an additional charge when such charge is required; or
>
> 3. Charging an applicant for a specific ancillary coverage or product, in addition to the cost of the motor vehicle insurance coverage applied for, without the informed consent of the applicant.

However, the Grand Jury believed that this section does not cover all the fraudulent activity it discovered.

Grand Jury Recommendations

Based on its investigations, the Grand Jury concluded that Florida was a "fraud friendly" state. In order to make Florida less "fraud friendly," the Grand Jury made many recommendations for statutory change. These recommendations include:

- Increasing criminal penalties for insurance fraud;
- Increasing criminal penalties for patient brokering;
- Increasing statutes of limitations for insurance fraud prosecutions;
- Creating incentive programs for the reporting of insurance fraud;

- Requiring insurers to demonstrate they have allocated sufficient resources and implemented policies and procedures to identify fraud as a condition of receiving rate increases;
- Requiring all medical facilities, including non-physician owned clinics, to be licensed by the state;
- Requiring insurance companies and HMOs to verify the existence of medical facilities prior to paying bills;
- Requiring HMOs to implement special investigative units (SIUs) like other insurers; and
- Establishing specialized prohibitions against fraudulent activities by persons engaged in the business of insurance.

Credit Insurance

Currently, financial institutions such as banks, loan finance companies, and credit card companies offer credit insurance that pays for the credit holder's debt in case of disability or death. Credit disability pays if the person becomes disabled while credit life insurance pays if the person dies. Credit property insurance provides coverage on personal property used as collateral for a loan. Licenses to sell such insurance are issued to entities, such as finance companies or auto dealerships, enabling any employee of the entity to sell the coverage. Such entities are licensed by the Department of Insurance.

B. EFFECT OF PROPOSED CHANGES:

The bill would address the licensure and appointment issues relating to the sale of various types of credit insurance.

The bill would address many of the issues raised in three reports from the Statewide Grand Jury relating to health insurance fraud.

The bill would define "collateral coverage insurance" in the context of specified commercial, but not residential, coverage.

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

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

C. APPLICATION OF PRINCIPLES:

1. <u>Less Government:</u>

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

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

The Department of Insurance is granted rule-making authority specific to the new anti-fraud activities.

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

The Department of Insurance is required to establish enhanced fraud avoidance and eradication mechanisms.

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

No.

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

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

N/A

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

N/A

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

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

N/A

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

N/A

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

N/A

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

N/A

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

N/A

3. Personal Responsibility:

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

No.

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

No.

4. Individual Freedom:

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

N/A

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

N/A

5. Family Empowerment:

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

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

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

N/A

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

N/A

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

N/A

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

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 455.657(3), 624.6085, 626.321(1) (e) and (f), 626.989(1), 626.9892, 627.6645, 627.6675, 641.3108, 641.3922(1), 641.3915, 775.15(2)(h), 817.234, 817.505(4), F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 626.321, F.S., 1998 Supplement, relating to limited (credit life or disability insurance) licenses, to permit entities, other than lending or financial institutions as defined in s. 626.988, F.S., to be licensed to market credit life insurance, including credit disability, credit property, and credit insurance. The bill allows entities applying for licensure under this provision to submit only one application, obtain a license for each branch office, and apply for licensure using an abbreviated or simplified application form. Additionally, such entities are not required to pay any additional application fees for a license issued to a branch office, but are required to pay certain appointment fees. The bill further requires posting of the license at the business location.

Section 2. Amends s. 626.989(1), F.S., 1998 Supplement, relating to the authority of the Division of Insurance Fraud, to provide that for purposes of the jurisdiction of the division, a health maintenance organization (HMO) is to be considered an "insurer," and an HMO subscriber contract is to be considered an "insurance policy." This provision extends to HMOs the limited civil immunity contained in s. 626.989(4), F.S. That limited immunity from civil liability provision applies to persons who provide confidential information to the division relating to insurance fraud and to persons within special investigative units (SIUs) who share information with other persons relating to insurance fraud.

Section 3. Creates s. 626.9892, F.S., relating to the Anti-Fraud Reward Program and the reporting of insurance fraud. Under this section, the Department of Insurance is authorized to pay rewards of up to $25,000 from the Insurance Commissioner's Regulatory Trust Fund to persons responsible for providing information leading to the arrest and conviction of persons committing complex or organized crimes investigated by the Division of Insurance Fraud arising under s. 440.105, F.S. (workers' compensation fraud) or s. 817.234, F.S. (false and fraudulent claims). This section provides that only a single reward (which may be disbursed to more than one person) may be paid for claims arising out of the same transaction and occurrence, regardless of the number of persons arrested and convicted and regardless of the number of persons submitting claims for the reward. This section also authorizes the department to adopt rules which set forth the application and approval process, including the criteria for evaluating claims, the basis for determining award amounts, and the manner in which rewards will be disbursed. (Under current law, persons are authorized to report information relating to insurance fraud to the division without fear of civil liability for libel, slander, or another relevant tort. However, current law does not provide any incentives for the reporting of information relating to insurance fraud.)

This section also provides that determinations by the department to grant or deny a reward are not considered agency action for purposes of review under the Administrative Procedure Act, ch. 120, F.S.

Section 4. Creates s. 641.3915, F.S., to require HMOs to comply with the requirements of ss. 626.989 and 626.9891, F.S., relating to the powers and duties of the Division of Insurance Fraud and anti-fraud plans and investigative units, respectively, the same as any other insurer. Provision is made as to applicable time frames for compliance.

Section 5. Amends s. 775.15, F.S., 1998 Supplement, relating to the statute of limitations for prosecution of certain offenses, to extend the statute of limitations from 3 to 5 years for prosecutions of violations of s. 817.234, F.S., relating to false and fraudulent insurance claims. (Presently, the statute of limitations for prosecuting insurance fraud is established by the general statute of limitations for felonies other than first degree felonies -- which is 3 years. The statute of limitations for workers' compensation fraud (violations of s. 440.105, F.S.) was changed by the Legislature in 1998 from 3 years to 5 years.)

Section 6. Amends s. 817.234, F.S., 1998 Supplement, relating to fraudulent insurance claims and applications, to reclassify the various offenses contained in this section as "insurance fraud" and provide a sliding scale of penalties based on the amount involved instead of the third-degree felony penalties that currently apply to these offenses. When the amount involved in the violation is less than $20,000, the act would remain a third degree felony, as under current law; when the amount involved is $20,000 or more, but less than $100,000, the act would be a second degree felony; and when the amount involved is $100,000 or more, the act would be a first degree felony. (A second degree felony is punishable by up to 15 years in prison and a fine of up to $10,000, and a first degree felony is punishable by up to 30 years in prison and a fine of up to $10,000.)

An exception is provided from an existing fraud notice requirement for reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

This section also expands the definition of "insurer" to include HMOs and HMO subscriber and provider contracts, and defines "property" and "value" for purposes of this section.

Section 7. Amends s. 817.505(4), F.S., 1998 Supplement, relating to penalties for patient brokering, to revise the law such that all violations of this section, including first violations, are third degree felonies. (The current penalty for violations of this section are: a first degree misdemeanor for the first violation and a third degree felony for subsequent violations.)

Section 8. Reenacts s. 455.657(3), F.S., relating to prohibited kickbacks, for the purpose of incorporating the revision to s. 817.505, F.S., as contained in section 7, above.

Section 9. Appropriates $250,000 from the Insurance Commissioner's Regulatory Trust Fund to the Department of Insurance "for the purpose of implementing" the Anti-Fraud Reward Program in section 3, above.

Section 10. Creates s. 624.6085, F.S., to define "collateral protection insurance" for purposes of the Florida Insurance Code as "commercial insurance of which a creditor is the primary beneficiary and policyholder and which protects or covers an interest of the creditor arising out of a credit transaction secured by real or personal property. Initiation of such coverage is triggered by the mortgagor's failure to maintain insurance coverage as required by the mortgage or other lending document." This definition is specifically applicable in the context of the Florida Hurricane Catastrophe Fund (s. 215.555, F.S.), joint underwriters and joint reinsurers (s. 627.311, F.S.), and insurance risk apportionment plans (s. 627.351, F.S.). The bill further specifies that collateral protection insurance is "commercial property insurance" and not "residential coverage."

Section 11. Amends s. 626.321, F.S., 1998 Supplement, relating to limited (credit life or disability insurance) licenses, to permit entities, other than financial institutions as defined in s. 626.988, F.S., to be licensed to market credit life insurance, including credit disability, credit property, and credit insurance. The bill allows entities applying for licensure under this provision to submit only one application, obtain a license for each branch office, and apply for licensure using an abbreviated or simplified application form. Additionally, such entities are not required to pay any additional application fees for a license issued to a branch office, but are required to pay certain appointment fees. The bill further requires posting of the license at the business location. (NOTE: This is an exact replication of section 1, above.)

Section 12. Amends s. 627.6645(1), F.S., relating to notification of cancellation or non-renewal of group health insurance policies and time limits thereof, to prohibit a group health insurer from retroactively canceling a group contract, due to nonpayment of premium, *prior* to the date the notice of cancellation is mailed by the insurer to the employer, *unless* the notice is mailed within 45 days after the date the premium was due. Such notice must be mailed to the policyholder's (employer's) last address as a shown by the records of the insurer.

Section 13. Amends s. 627.6675, F.S., 1998 Supplement, relating to conversion of group health insurance policies. If termination of an employee's health insurance coverage under a group policy is due to nonpayment of premium by the employer (policyholder) and written notice of cancellation from the insurer was not provided to the employee (certificate-holder) by the employer, the following requirements apply:

-The 63-day time period within which the employee must apply for an individual conversion policy would *not* begin to run until the date the insurer or employer mails notice of cancellation to the employee or certificate-holder at the employee's or certificate-holder's last address as a shown by the record of the insurer.

-The premium for the conversion policy would be at the previous group rate for the time period prior to the date the insurer mails notice to the employee. For the period of coverage after such date, the premium for the converted policy would be subject to the requirements of current law which provide that such premium may not exceed 200 percent of the standard risk rate as established by the Department of Insurance.

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

Section 14. Amends s. 641.3108, F.S., relating to notification of cancellation of health maintenance contracts, to prohibit an HMO from retroactively canceling a group contract, due to nonpayment of premium, *prior* to the date the notice of cancellation is mailed by the HMO to the subscriber, *unless* the notice is mailed within 45 days after the date the premium was due. Such notice must be mailed to the subscriber's last address as a shown by the records of the HMO. For group contracts issued to an employer, the notice requirements of this section are satisfied by providing notice to the employer [subsection (3)].

Section 15. Amends s. 641.3922(1), F.S., 1998 Supplement, relating to HMO conversion contracts and time limits thereof, to specify that if termination of an employee's health insurance coverage is due to nonpayment of premium by the employer (group contract holder) and written notice of cancellation from the HMO was not provided to the employee by the employer, the following requirements apply:

-The 63-day time period within which the employee must apply for an individual conversion contract would *not* begin to run until the date the HMO mails notice of cancellation to the employee at the employee's last address as a shown by the records of the HMO.

-The premium for the conversion contract would be at the previous group rate for the time period prior to the date the HMO mails notice to the employee. For the period of coverage after such date, the premium for the converted policy would be subject to the requirements of current law which provide that such premium may not exceed 200 percent of the standard risk rate as established by the Department of Insurance.

Section 16. Provides for an effective date of October 1, 1999, and provides that the provisions of the bill apply to policies and contracts issued or renewed on or after that date.

IV. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

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

The bill may result in modest increased costs to the criminal justice system since the penalties for insurance fraud have been increased.

The Department of Insurance will have to adopt rules pertaining to the Anti-Fraud Reward program. The department estimates a fiscal impact of $250,000 for this effort, and the money will be derived from the Insurance Commissioner's Regulatory Trust Fund.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

   See Non-Recurring Effects above.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   Insurers and HMOs will be required to expend funds and allocate administrative resources to meet the notice requirements imposed under the bill. These entities will need to continually maintain a current listing of all employees under the group plan with their addresses should employee notification of contract cancellation become necessary.

   Florida HMOs will incur the costs associated with either filing anti-fraud plans with the Department of Insurance or establishing special investigative units.

2. Direct Private Sector Benefits:

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

   Health maintenance organizations will benefit because their designated employees will be able to share confidential insurance fraud information with other insurers and certain insurance fraud violations will become violations against HMOs.

   The bill will hopefully reduce the incidence of insurance fraud since the related penalties are significantly increased.

   Entities applying for licensure pertaining to various types of credit insurance (credit property, credit life, and credit disability insurance) will benefit by having to file one application form with the Department of Insurance and paying reduced fees.

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

   None.

D. FISCAL COMMENTS:

   None.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

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

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties and municipalities have to raise revenue in the aggregate.

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

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

VI. COMMENTS:

None.

VII. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The bill as approved in its final form differs considerably from PCB HCS 99-07 as approved by the Committee on Health Care Services on March 29, 1999, and filed and numbered as HB 2071. The following issues were not addressed in the original bill:

- Credit insurance;
- Insurance fraud and anti-fraud efforts and penalties; and
- Collateral protection insurance.

In addition, minor revisions were adopted to further refine the provisions of the base bill relating to health care coverage cancellation notice requirements.

VIII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Staff Director:

Phil E. Williams Phil E. Williams

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Staff Director:

Phil E. Williams Phil E. Williams