1 A bill to be entitled
2 An act relating to insurance contracts;
3 amending s. 626.022, F.S.; providing an
4 exception from certain insurance licensing
5 requirements for certified public accountants
6 acting within the scope of their profession;
7 amending s. 626.883, F.S.; requiring that
8 certain information be included with the
9 payments made by a fiscal intermediary to a
10 health care provider; amending s. 641.31, F.S.,
11 relating to health maintenance contracts;
12 requiring a health maintenance organization to
13 provide notice prior to increasing the
14 copayments or limiting any benefits under a
15 group contract; requiring certain health
16 maintenance contracts to cover persons licensed
17 to practice massage under certain
18 circumstances; amending s. 641.315, F.S.;
19 providing that a contract between a health
20 maintenance organization and a health care
21 provider may not restrict the provider from
22 entering into a contract with any other health
23 maintenance organizations and may not restrict
24 the health maintenance organization from
25 entering into a contract with any other
26 provider; amending s. 641.316, F.S.; requiring
27 that certain information be included with the
28 payments made by a fiscal intermediary to a
29 health care provider; providing for
30 applicability; amending s. 641.315, F.S.;
31 prohibiting a health maintenance organization's

1 contract from preventing a subscriber from
2 receiving certain services; amending s. 641.31,
3 F.S.; prohibiting a health maintenance
4 organization's contract from preventing a
5 subscriber from receiving certain services;
6 amending s. 641.3155, F.S.; prohibiting a
7 health maintenance organization from denying
8 payment to certain physicians for inpatient
9 hospital services; amending s. 627.6645, F.S.;
10 revising the notice requirements for
11 cancellation or nonrenewal of a group health
12 insurance policy; specifying conditions under
13 which the insurer may retroactively cancel
14 coverage due to nonpayment of premium; amending
15 s. 627.6675, F.S.; revising the time limits for
16 an employee or group member to apply for an
17 individual converted policy when termination of
18 group coverage is due to failure of the
19 employer to pay the premium; revising the
20 requirements for the premium for the converted
21 policy; allowing a group insurer to contract
22 with another insurer to issue an individual
23 converted policy under certain conditions;
24 amending s. 641.3108, F.S.; revising the notice
25 requirements for cancellation or nonrenewal of
26 a health maintenance organization contract;
27 specifying conditions under which the
28 organization may retroactively cancel coverage
29 due to nonpayment of premium; amending s.
30 641.3922, F.S.; revising the time limits for an
31 employee or group member to apply for a

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1 converted contract from a health maintenance
2 organization when termination of group coverage
3 is due to failure of the employer to pay the
4 premium; revising the requirements for the
5 premium for the converted contract; providing
6 an effective date.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Paragraph (d) is added to subsection (1) of
11 section 626.022, Florida Statutes, 1998 Supplement, to read:
12 626.022 Scope of part.--
13 (1) This part applies as to insurance agents,
14 solicitors, service representatives, adjusters, and insurance
15 agencies; as to any and all kinds of insurance; and as to
16 stock insurers, mutual insurers, reciprocal insurers, and all
17 other types of insurers, except that:
18 (d) This part does not apply to a certified public
19 accountant licensed under chapter 473 who is acting within the
20 scope of the practice of public accounting, as defined in s.
21 473.302, provided that the activities of the certified public
22 accountant are limited to advising a client of the necessity
23 of obtaining insurance, the amount of insurance needed, or the
24 line of coverage needed, and provided that the certified
25 public accountant does not directly or indirectly receive or
26 share in any commission, referral fee, or solicitor's fee.
27 Section 2. Subsection (6) is added to section 626.883,
28 Florida Statutes, to read:
29 626.883 Administrator as intermediary; collections
30 held in fiduciary capacity; establishment of account;
31 disbursement; payments on behalf of insurer.--

1 (6) All payments to a health care provider by a fiscal
2 intermediary for noncapitated providers must include an
3 explanation of services being reimbursed which includes, at a
4 minimum, the patient's name, the date of service, the
5 procedure code, the amount of reimbursement, and the
6 identification of the plan on whose behalf the payment is
7 being made. For capitated providers, the statement of services
8 must include the number of patients covered by the contract,
9 the rate per patient, the total amount of the payment, and the
10 identification of the plan on whose behalf the payment is
11 being made.
12 Section 3. Subsections (36) and (37) are added to
13 section 641.31, Florida Statutes, 1998 Supplement, to read:
14 641.31 Health maintenance contracts.--
15 (36) A health maintenance organization may increase
16 the copayment for any benefit, or delete, amend, or limit any
17 of the benefits to which a subscriber is entitled under the
18 group contract only, upon written notice to the contract
19 holder at least 45 days in advance of the time of coverage
20 renewal. The health maintenance organization may amend the
21 contract with the contract holder, with such amendment to be
22 effective immediately at the time of coverage renewal. The
23 written notice to the contract holder shall specifically
24 identify any deletions, amendments, or limitations to any of
25 the benefits provided in the group contract during the current
26 contract period which will be included in the group contract
27 upon renewal. This subsection does not apply to any increases
28 in benefits. The 45-day notice requirement shall not apply if
29 benefits are amended, deleted, or limited at the request of
30 the contract holder.
31

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1 (37) All health maintenance contracts that provide
2 coverage for massage must also cover the services of persons
3 licensed to practice massage pursuant to chapter 480 if the
4 massage is prescribed by a contracted physician licensed under
5 chapter 458, chapter 459, chapter 460, or chapter 461 as
6 medically necessary and the prescription specifies the number
7 of treatments. Such massage services are subject to the same
8 terms, conditions, and limitations as those of other covered
9 services.
10 Section 4. Subsection (9) is added to section 641.315,
11 Florida Statutes, to read:
12 641.315 Provider contracts.--
13 (9) A contract between a health maintenance
14 organization and a provider of health care services may not
15 contain any provision that in any way prohibits or restricts:
16 (a) The health care provider from entering into a
17 contract with any other health maintenance organization; or
18 (b) The health maintenance organization from entering
19 into a contract with any other health care provider.
20 Section 5. Paragraph (a) of subsection (2) of section
21 641.316, Florida Statutes, 1998 Supplement, is amended to
22 read:
23 641.316 Fiscal intermediary services.--
24 (2)(a) The term "fiduciary" or "fiscal intermediary
25 services" means reimbursements received or collected on behalf
26 of health care professionals for services rendered, patient
27 and provider accounting, financial reporting and auditing,
28 receipts and collections management, compensation and
29 reimbursement disbursement services, or other related
30 fiduciary services pursuant to health care professional
31 contracts with health maintenance organizations. All payments

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1 to a health care provider by a fiscal intermediary for
2 noncapitated providers must include an explanation of services
3 being reimbursed which includes, at a minimum, the patient's
4 name, the date of service, the procedure code, the amount of
5 reimbursement, and the identification of the plan on whose
6 behalf the payment is being made. For capitated providers, the
7 statement of services must include the number of patients
8 covered by the contract, the rate per patient, the total
9 amount of the payment, and the identification of the plan on
10 whose behalf the payment is being made.
11 (b) The term "fiscal intermediary services
12 organization" means a person or entity which performs
13 fiduciary or fiscal intermediary services to health care
14 professionals who contract with health maintenance
15 organizations other than a fiscal intermediary services
16 organization owned, operated, or controlled by a hospital
17 licensed under chapter 395, an insurer licensed under chapter
18 624, a third-party administrator licensed under chapter 626, a
19 prepaid limited health service organization licensed under
20 chapter 636, a health maintenance organization licensed under
21 this chapter, or physician group practices as defined in s.
22 455.654(3)(f).
23 Section 6. Subsection (9) is added to section 641.315,
24 Florida Statutes, to read:
25 641.315 Provider contracts.--
26 (9) No health maintenance organization's contract
27 shall prevent a subscriber from continuing to receive services
28 from the subscriber's contracted primary care physician or
29 contracted admitting physician during an inpatient stay.
30 Section 7. Subsection (38) is added to section 641.31,
31 Florida Statutes, 1998 Supplement, to read:

641.31 Health maintenance contracts.--

(38) No health maintenance organization's contract shall prevent a subscriber from continuing to receive services from the subscriber's contracted primary care physician or contracted admitting physician during an inpatient stay.

Section 8. Subsection (4) is added to section 641.3155, Florida Statutes, 1998 Supplement, to read:

641.3155 Provider contracts; payment of claims.--

(4) A health maintenance organization shall not deny payment to a contract primary care physician or contract admitting physician for inpatient hospital services provided by the contracted physician to the subscriber.

Section 9. Subsection (1) of section 627.6645, Florida Statutes, is amended and subsection (5) is added to that section to read:

627.6645 Notification of cancellation, expiration, nonrenewal, or change in rates.--

(1) Every insurer delivering or issuing for delivery a group health insurance policy under the provisions of this part shall give the policyholder at least 45 days' advance notice of cancellation, expiration, nonrenewal, or a change in rates. Such notice shall be mailed to the policyholder's last address as shown by the records of the insurer. However, if cancellation is for nonpayment of premium, only the requirements of subsection (5)~~this section shall not~~ apply. Upon receipt of such notice, the policyholder shall forward, as soon as practicable, the notice of expiration, cancellation, or nonrenewal to each certificateholder covered under the policy.

(5) If cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date

1 prior to the date that notice of cancellation was provided to
2 the policyholder unless the insurer mails notice of
3 cancellation to the policyholder prior to 45 days after the
4 date the premium was due. Such notice must be mailed to the
5 policyholder's last address as shown by the records of the
6 insurer and may provide for a retroactive date of cancellation
7 no earlier than midnight of the date that the premium was due.
8 Section 10. Section 627.6675, Florida Statutes, 1998
9 Supplement, is amended to read:
10 627.6675 Conversion on termination of
11 eligibility.--Subject to all of the provisions of this
12 section, a group policy delivered or issued for delivery in
13 this state by an insurer or nonprofit health care services
14 plan that provides, on an expense-incurred basis, hospital,
15 surgical, or major medical expense insurance, or any
16 combination of these coverages, shall provide that an employee
17 or member whose insurance under the group policy has been
18 terminated for any reason, including discontinuance of the
19 group policy in its entirety or with respect to an insured
20 class, and who has been continuously insured under the group
21 policy, and under any group policy providing similar benefits
22 that the terminated group policy replaced, for at least 3
23 months immediately prior to termination, shall be entitled to
24 have issued to him or her by the insurer a policy or
25 certificate of health insurance, referred to in this section
26 as a "converted policy." A group insurer may meet the
27 requirements of this section by contracting with another
28 insurer, authorized in this state, to issue an individual
29 converted policy, which policy has been approved by the
30 department under s. 627.410.An employee or member shall not
31 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.

(1) TIME LIMIT.--Written application for the converted policy shall be made and the first premium must be paid to the insurer, not later than 63 days after termination of the group policy. However, if termination was the result of failure to pay any required premium or contribution and such nonpayment of premium was due to acts of an employer or policyholder other than the employee or certificateholder, written application for the converted policy must be made and the first premium must be paid to the insurer not later than 63 days after notice of termination is mailed by the insurer or the employer, whichever is earlier, to the employee's or certificateholder's last address as shown by the record of the insurer or the employer, whichever is applicable. In such case of termination due to nonpayment of premium by the employer or policyholder, the premium for the converted policy may not exceed the rate for the prior group coverage for the period of coverage under the converted policy prior to the date notice of termination is mailed to the employee or certificateholder. For the period of coverage after such date, the premium for the converted policy is subject to the requirements of subsection (3).

(2) EVIDENCE OF INSURABILITY.--The converted policy shall be issued without evidence of insurability.

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

(a) The premium for the converted policy shall be determined in accordance with premium rates applicable to the

1 age and class of risk of each person to be covered under the
2 converted policy and to the type and amount of insurance
3 provided. However, the premium for the converted policy may
4 not exceed 200 percent of the standard risk rate as
5 established by the department, pursuant to this subsection.
6 (b) Actual or expected experience under converted
7 policies may be combined with such experience under group
8 policies for the purposes of determining premium and loss
9 experience and establishing premium rate levels for group
10 coverage.
11 (c) The department shall annually determine standard
12 risk rates, using reasonable actuarial techniques and
13 standards adopted by the department by rule. The standard risk
14 rates must be determined as follows:
15 1. Standard risk rates for individual coverage must be
16 determined separately for indemnity policies, preferred
17 provider/exclusive provider policies, and health maintenance
18 organization contracts.
19 2. The department shall survey insurers and health
20 maintenance organizations representing at least an 80 percent
21 market share, based on premiums earned in the state for the
22 most recent calendar year, for each of the categories
23 specified in subparagraph 1.
24 3. Standard risk rate schedules must be determined,
25 computed as the average rates charged by the carriers
26 surveyed, giving appropriate weight to each carrier's
27 statewide market share of earned premiums.
28 4. The rate schedule shall be determined from analysis
29 of the one county with the largest market share in the state
30 of all such carriers.
31

1 5. The rate for other counties must be determined by
2 using the weighted average of each carrier's county factor
3 relationship to the county determined in subparagraph 4.
4 6. The rate schedule must be determined for different
5 age brackets and family size brackets.
6 (4) EFFECTIVE DATE OF COVERAGE.--The effective date of
7 the converted policy shall be the day following the
8 termination of insurance under the group policy.
9 (5) SCOPE OF COVERAGE.--The converted policy shall
10 cover the employee or member and his or her dependents who
11 were covered by the group policy on the date of termination of
12 insurance. At the option of the insurer, a separate converted
13 policy may be issued to cover any dependent.
14 (6) OPTIONAL COVERAGE.--The insurer shall not be
15 required to issue a converted policy covering any person who
16 is or could be covered by Medicare. The insurer shall not be
17 required to issue a converted policy covering a person if
18 paragraphs (a) and (b) apply to the person:
19 (a) If any of the following apply to the person:
20 1. The person is covered for similar benefits by
21 another hospital, surgical, medical, or major medical expense
22 insurance policy or hospital or medical service subscriber
23 contract or medical practice or other prepayment plan, or by
24 any other plan or program.
25 2. The person is eligible for similar benefits,
26 whether or not actually provided coverage, under any
27 arrangement of coverage for individuals in a group, whether on
28 an insured or uninsured basis.
29 3. Similar benefits are provided for or are available
30 to the person under any state or federal law.
31

1 (b) If the benefits provided under the sources
2 referred to in subparagraph (a)1. or the benefits provided or
3 available under the sources referred to in subparagraphs (a)2.
4 and 3., together with the benefits provided by the converted
5 policy, would result in overinsurance according to the
6 insurer's standards. The insurer's standards must bear some
7 reasonable relationship to actual health care costs in the
8 area in which the insured lives at the time of conversion and
9 must be filed with the department prior to their use in
10 denying coverage.
11 (7) INFORMATION REQUESTED BY INSURER.--
12 (a) A converted policy may include a provision under
13 which the insurer may request information, in advance of any
14 premium due date, of any person covered thereunder as to
15 whether:
16 1. The person is covered for similar benefits by
17 another hospital, surgical, medical, or major medical expense
18 insurance policy or hospital or medical service subscriber
19 contract or medical practice or other prepayment plan or by
20 any other plan or program.
21 2. The person is covered for similar benefits under
22 any arrangement of coverage for individuals in a group,
23 whether on an insured or uninsured basis.
24 3. Similar benefits are provided for or are available
25 to the person under any state or federal law.
26 (b) The converted policy may provide that the insurer
27 may refuse to renew the policy or the coverage of any person
28 only for one or more of the following reasons:
29 1. Either the benefits provided under the sources
30 referred to in subparagraphs (a)1. and 2. for the person or
31 the benefits provided or available under the sources referred

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1 to in subparagraph (a)3. for the person, together with the
2 benefits provided by the converted policy, would result in
3 overinsurance according to the insurer's standards on file
4 with the department.
5 2. The converted policyholder fails to provide the
6 information requested pursuant to paragraph (a).
7 3. Fraud or intentional misrepresentation in applying
8 for any benefits under the converted policy.
9 4. Other reasons approved by the department.
10 (8) BENEFITS OFFERED.--
11 (a) An insurer shall not be required to issue a
12 converted policy that provides benefits in excess of those
13 provided under the group policy from which conversion is made.
14 (b) An insurer shall offer the benefits specified in
15 s. 627.668 and the benefits specified in s. 627.669 if those
16 benefits were provided in the group plan.
17 (c) An insurer shall offer maternity benefits and
18 dental benefits if those benefits were provided in the group
19 plan.
20 (9) PREEXISTING CONDITION PROVISION.--The converted
21 policy shall not exclude a preexisting condition not excluded
22 by the group policy. However, the converted policy may provide
23 that any hospital, surgical, or medical benefits payable under
24 the converted policy may be reduced by the amount of any such
25 benefits payable under the group policy after the termination
26 of covered under the group policy. The converted policy may
27 also provide that during the first policy year the benefits
28 payable under the converted policy, together with the benefits
29 payable under the group policy, shall not exceed those that
30 would have been payable had the individual's insurance under
31 the group policy remained in force.

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1 (10) REQUIRED OPTION FOR MAJOR MEDICAL
2 COVERAGE.--Subject to the provisions and conditions of this
3 part, the employee or member shall be entitled to obtain a
4 converted policy providing major medical coverage under a plan
5 meeting the following requirements:
6 (a) A maximum benefit equal to the lesser of the
7 policy limit of the group policy from which the individual
8 converted or $500,000 per covered person for all covered
9 medical expenses incurred during the covered person's
10 lifetime.
11 (b) Payment of benefits at the rate of 80 percent of
12 covered medical expenses which are in excess of the
13 deductible, until 20 percent of such expenses in a benefit
14 period reaches $2,000, after which benefits will be paid at
15 the rate of 90 percent during the remainder of the contract
16 year unless the insured is in the insurer's case management
17 program, in which case benefits shall be paid at the rate of
18 100 percent during the remainder of the contract year. For
19 the purposes of this paragraph, "case management program"
20 means the specific supervision and management of the medical
21 care provided or prescribed for a specific individual, which
22 may include the use of health care providers designated by the
23 insurer. Payment of benefits for outpatient treatment of
24 mental illness, if provided in the converted policy, may be at
25 a lesser rate but not less than 50 percent.
26 (c) A deductible for each calendar year that must be
27 $500, $1,000, or $2,000, at the option of the policyholder.
28 (d) The term "covered medical expenses," as used in
29 this subsection, shall be consistent with those customarily
30 offered by the insurer under group or individual health
31 insurance policies but is not required to be identical to the

1 covered medical expenses provided in the group policy from
2 which the individual converted.
3 (11) ALTERNATIVE PLANS.--The insurer shall, in
4 addition to the option required by subsection (10), offer the
5 standard health benefit plan, as established pursuant to s.
6 627.6699(12). The insurer may, at its option, also offer
7 alternative plans for group health conversion in addition to
8 the plans required by this section.
9 (12) RETIREMENT COVERAGE.--If coverage would be
10 continued under the group policy on an employee following the
11 employee's retirement prior to the time he or she is or could
12 be covered by Medicare, the employee may elect, instead of
13 such continuation of group insurance, to have the same
14 conversion rights as would apply had his or her insurance
15 terminated at retirement by reason or termination of
16 employment or membership.
17 (13) REDUCTION OF COVERAGE DUE TO MEDICARE.--The
18 converted policy may provide for reduction of coverage on any
19 person upon his or her eligibility for coverage under Medicare
20 or under any other state or federal law providing for benefits
21 similar to those provided by the converted policy.
22 (14) CONVERSION PRIVILEGE ALLOWED.--The conversion
23 privilege shall also be available to any of the following:
24 (a) The surviving spouse, if any, at the death of the
25 employee or member, with respect to the spouse and the
26 children whose coverages under the group policy terminate by
27 reason of the death, otherwise to each surviving child whose
28 coverage under the group policy terminates by reason of such
29 death, or, if the group policy provides for continuation of
30 dependents' coverages following the employee's or member's
31 death, at the end of such continuation.

1 (b) The former spouse whose coverage would otherwise
2 terminate because of annulment or dissolution of marriage, if
3 the former spouse is dependent for financial support.
4 (c) The spouse of the employee or member upon
5 termination of coverage of the spouse, while the employee or
6 member remains insured under the group policy, by reason of
7 ceasing to be a qualified family member under the group
8 policy, with respect to the spouse and the children whose
9 coverages under the group policy terminate at the same time.
10 (d) A child solely with respect to himself or herself
11 upon termination of his or her coverage by reason of ceasing
12 to be a qualified family member under the group policy, if a
13 conversion privilege is not otherwise provided in this
14 subsection with respect to such termination.
15 (15) BENEFIT LEVELS.--If the benefit levels required
16 in subsection (10) exceed the benefit levels provided under
17 the group policy, the conversion policy may offer benefits
18 which are substantially similar to those provided under the
19 group policy in lieu of those required in subsection (10).
20 (16) GROUP COVERAGE INSTEAD OF INDIVIDUAL
21 COVERAGE.--The insurer may elect to provide group insurance
22 coverage instead of issuing a converted individual policy.
23 (17) NOTIFICATION.--A notification of the conversion
24 privilege shall be included in each certificate of coverage.
25 The insurer shall mail an election and premium notice form,
26 including an outline of coverage, on a form approved by the
27 department, within 14 days after an individual who is eligible
28 for a converted policy gives notice to the insurer that the
29 individual is considering applying for the converted policy or
30 otherwise requests such information. The outline of coverage
31 must contain a description of the principal benefits and

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1 coverage provided by the policy and its principal exclusions
2 and limitations, including, but not limited to, deductibles
3 and coinsurance.
4 (18) OUTSIDE CONVERSIONS.--A converted policy that is
5 delivered outside of this state must be on a form that could
6 be delivered in the other jurisdiction as a converted policy
7 had the group policy been issued in that jurisdiction.
8 (19) APPLICABILITY.--This section does not require
9 conversion on termination of eligibility for a policy or
10 contract that provides benefits for specified diseases, or for
11 accidental injuries only, disability income, Medicare
12 supplement, hospital indemnity, limited benefit,
13 nonconventional, or excess policies.
14 (20) Nothing in this section or in the incorporation
15 of it into insurance policies shall be construed to require
16 insurers to provide benefits equal to those provided in the
17 group policy from which the individual converted, provided,
18 however, that comprehensive benefits are offered which shall
19 be subject to approval by the Insurance Commissioner.
20 Section 11. Section 641.3108, Florida Statutes, is
21 amended to read:
22 641.3108 Notice of cancellation of contract.--
23 (1) Except for nonpayment of premium or termination of
24 eligibility, no health maintenance organization may cancel or
25 otherwise terminate or fail to renew a health maintenance
26 contract without giving the subscriber at least 45 days'
27 notice in writing of the cancellation, termination, or
28 nonrenewal of the contract. The written notice shall state the
29 reason or reasons for the cancellation, termination, or
30 nonrenewal. All health maintenance contracts shall contain a
31 clause which requires that this notice be given.

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1 (2) If cancellation is due to nonpayment of premium,
2 the health maintenance organization may not retroactively
3 cancel the contract to a date prior to the date that notice of
4 cancellation was provided to the subscriber unless the
5 organization mails notice of cancellation to the subscriber
6 prior to 45 days after the date the premium was due. Such
7 notice must be mailed to the subscriber's last address as
8 shown by the records of the organization and may provide for a
9 retroactive date of cancellation no earlier than midnight of
10 the date that the premium was due.
11 (3) In the case of a health maintenance contract
12 issued to an employer or person holding the contract on behalf
13 of the subscriber group, the health maintenance organization
14 may make the notification through the employer or group
15 contract holder, and, if the health maintenance organization
16 elects to take this action through the employer or group
17 contract holder, the organization shall be deemed to have
18 complied with the provisions of this section upon notifying
19 the employer or group contract holder of the requirements of
20 this section and requesting the employer or group contract
21 holder to forward to all subscribers the notice required
22 herein.
23 Section 12. Subsection (1) of section 641.3922,
24 Florida Statutes, 1998 Supplement, is amended to read:
25 641.3922 Conversion contracts; conditions.--Issuance
26 of a converted contract shall be subject to the following
27 conditions:
28 (1) TIME LIMIT.--Written application for the converted
29 contract shall be made and the first premium paid to the
30 health maintenance organization not later than 63 days after
31 such termination. However, if termination was the result of

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1 failure to pay any required premium or contribution and such
2 nonpayment of premium was due to acts of an employer or group
3 contract holder other than the employee or individual
4 subscriber, written application for the contract must be made
5 and the first premium must be paid not later than 63 days
6 after notice of termination is mailed by the organization or
7 the employer, whichever is earlier, to the employee's or
8 individual's last address as shown by the record of the
9 organization or the employer, whichever is applicable. In such
10 case of termination due to nonpayment of premium by the
11 employer or group contract holder, the premium for the
12 converted contract may not exceed the rate for the prior group
13 coverage for the period of coverage under the converted
14 contract prior to the date notice of termination is mailed to
15 the employee or individual subscriber. For the period of
16 coverage after such date, the premium for the converted
17 contract is subject to the requirements of subsection (3).
18 Section 13. This act shall take effect July 1, 1999,
19 and shall apply to all contracts renewed or entered into on or
20 after that date.
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