

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. 627.6645, F.S.;  
31          revising the notice requirements for

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

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29 Be It Enacted by the Legislature of the State of Florida:  
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1 Section 1. Paragraph (d) is added to subsection (1) of  
2 section 626.022, Florida Statutes, 1998 Supplement, to read:

3 626.022 Scope of part.--

4 (1) This part applies as to insurance agents,  
5 solicitors, service representatives, adjusters, and insurance  
6 agencies; as to any and all kinds of insurance; and as to  
7 stock insurers, mutual insurers, reciprocal insurers, and all  
8 other types of insurers, except that:

9 (d) This part does not apply to a certified public  
10 accountant licensed under chapter 473 who is acting within the  
11 scope of the practice of public accounting, as defined in s.  
12 473.302, provided that the activities of the certified public  
13 accountant are limited to advising a client of the necessity  
14 of obtaining insurance, the amount of insurance needed, or the  
15 line of coverage needed, and provided that the certified  
16 public accountant does not directly or indirectly receive or  
17 share in any commission, referral fee, or solicitor's fee.

18 Section 2. Subsection (6) is added to section 626.883,  
19 Florida Statutes, to read:

20 626.883 Administrator as intermediary; collections  
21 held in fiduciary capacity; establishment of account;  
22 disbursement; payments on behalf of insurer.--

23 (6) All payments to a health care provider by a fiscal  
24 intermediary for noncapitated providers must include an  
25 explanation of services being reimbursed which includes, at a  
26 minimum, the patient's name, the date of service, the  
27 procedure code, the amount of reimbursement, and the  
28 identification of the plan on whose behalf the payment is  
29 being made. For capitated providers, the statement of services  
30 must include the number of patients covered by the contract,  
31 the rate per patient, the total amount of the payment, and the

1 identification of the plan on whose behalf the payment is  
2 being made.

3 Section 3. Subsections (36) and (37) are added to  
4 section 641.31, Florida Statutes, 1998 Supplement, to read:

5 641.31 Health maintenance contracts.--

6 (36) A health maintenance organization may increase  
7 the copayment for any benefit, or delete, amend, or limit any  
8 of the benefits to which a subscriber is entitled under the  
9 group contract only, upon written notice to the contract  
10 holder at least 45 days in advance of the time of coverage  
11 renewal. The health maintenance organization may amend the  
12 contract with the contract holder, with such amendment to be  
13 effective immediately at the time of coverage renewal. The  
14 written notice to the contract holder shall specifically  
15 identify any deletions, amendments, or limitations to any of  
16 the benefits provided in the group contract during the current  
17 contract period which will be included in the group contract  
18 upon renewal. This subsection does not apply to any increases  
19 in benefits. The 45-day notice requirement shall not apply if  
20 benefits are amended, deleted, or limited at the request of  
21 the contract holder.

22 (37) All health maintenance contracts that provide  
23 coverage for massage must also cover the services of persons  
24 licensed to practice massage pursuant to chapter 480 if the  
25 massage is prescribed by a contracted physician licensed under  
26 chapter 458, chapter 459, chapter 460, or chapter 461 as  
27 medically necessary and the prescription specifies the number  
28 of treatments. Such massage services are subject to the same  
29 terms, conditions, and limitations as those of other covered  
30 services.

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1           Section 4. Subsection (9) is added to section 641.315,  
2 Florida Statutes, to read:

3           641.315 Provider contracts.--

4           (9) A contract between a health maintenance  
5 organization and a provider of health care services may not  
6 contain any provision that in any way prohibits or restricts:

7           (a) The health care provider from entering into a  
8 commercial contract with any other health maintenance  
9 organization; or

10           (b) The health maintenance organization from entering  
11 into a commercial contract with any other health care  
12 provider.

13           Section 5. Paragraph (a) of subsection (2) of section  
14 641.316, Florida Statutes, 1998 Supplement, is amended to  
15 read:

16           641.316 Fiscal intermediary services.--

17           (2)(a) The term "fiduciary" or "fiscal intermediary  
18 services" means reimbursements received or collected on behalf  
19 of health care professionals for services rendered, patient  
20 and provider accounting, financial reporting and auditing,  
21 receipts and collections management, compensation and  
22 reimbursement disbursement services, or other related  
23 fiduciary services pursuant to health care professional  
24 contracts with health maintenance organizations. All payments  
25 to a health care provider by a fiscal intermediary for  
26 noncapitated providers must include an explanation of services  
27 being reimbursed which includes, at a minimum, the patient's  
28 name, the date of service, the procedure code, the amount of  
29 reimbursement, and the identification of the plan on whose  
30 behalf the payment is being made. For capitated providers, the  
31 statement of services must include the number of patients

1 covered by the contract, the rate per patient, the total  
2 amount of the payment, and the identification of the plan on  
3 whose behalf the payment is being made.

4 (b) The term "fiscal intermediary services  
5 organization" means a person or entity which performs  
6 fiduciary or fiscal intermediary services to health care  
7 professionals who contract with health maintenance  
8 organizations other than a fiscal intermediary services  
9 organization owned, operated, or controlled by a hospital  
10 licensed under chapter 395, an insurer licensed under chapter  
11 624, a third-party administrator licensed under chapter 626, a  
12 prepaid limited health service organization licensed under  
13 chapter 636, a health maintenance organization licensed under  
14 this chapter, or physician group practices as defined in s.  
15 455.654(3)(f).

16 Section 6. Subsection (1) of section 627.6645, Florida  
17 Statutes, is amended and subsection (5) is added to that  
18 section to read:

19 627.6645 Notification of cancellation, expiration,  
20 nonrenewal, or change in rates.--

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

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1 cancellation, or nonrenewal to each certificateholder covered  
2 under the policy.

3 (5) If cancellation is due to nonpayment of premium,  
4 the insurer may not retroactively cancel the policy to a date  
5 prior to the date that notice of cancellation was provided to  
6 the policyholder unless the insurer mails notice of  
7 cancellation to the policyholder prior to 45 days after the  
8 date the premium was due. Such notice must be mailed to the  
9 policyholder's last address as shown by the records of the  
10 insurer and may provide for a retroactive date of cancellation  
11 no earlier than midnight of the date that the premium was due.

12 Section 7. Section 627.6675, Florida Statutes, 1998  
13 Supplement, is amended to read:

14 627.6675 Conversion on termination of  
15 eligibility.--Subject to all of the provisions of this  
16 section, a group policy delivered or issued for delivery in  
17 this state by an insurer or nonprofit health care services  
18 plan that provides, on an expense-incurred basis, hospital,  
19 surgical, or major medical expense insurance, or any  
20 combination of these coverages, shall provide that an employee  
21 or member whose insurance under the group policy has been  
22 terminated for any reason, including discontinuance of the  
23 group policy in its entirety or with respect to an insured  
24 class, and who has been continuously insured under the group  
25 policy, and under any group policy providing similar benefits  
26 that the terminated group policy replaced, for at least 3  
27 months immediately prior to termination, shall be entitled to  
28 have issued to him or her by the insurer a policy or  
29 certificate of health insurance, referred to in this section  
30 as a "converted policy." A group insurer may meet the  
31 requirements of this section by contracting with another

1 insurer, authorized in this state, to issue an individual  
2 converted policy, which policy has been approved by the  
3 department under s. 627.410. An employee or member shall not  
4 be entitled to a converted policy if termination of his or her  
5 insurance under the group policy occurred because he or she  
6 failed to pay any required contribution, or because any  
7 discontinued group coverage was replaced by similar group  
8 coverage within 31 days after discontinuance.

9 (1) TIME LIMIT.--Written application for the converted  
10 policy shall be made and the first premium must be paid to the  
11 insurer, not later than 63 days after termination of the group  
12 policy. However, if termination was the result of failure to  
13 pay any required premium or contribution and such nonpayment  
14 of premium was due to acts of an employer or policyholder  
15 other than the employee or certificateholder, written  
16 application for the converted policy must be made and the  
17 first premium must be paid to the insurer not later than 63  
18 days after notice of termination is mailed by the insurer or  
19 the employer, whichever is earlier, to the employee's or  
20 certificateholder's last address as shown by the record of the  
21 insurer or the employer, whichever is applicable. In such case  
22 of termination due to nonpayment of premium by the employer or  
23 policyholder, the premium for the converted policy may not  
24 exceed the rate for the prior group coverage for the period of  
25 coverage under the converted policy prior to the date notice  
26 of termination is mailed to the employee or certificateholder.  
27 For the period of coverage after such date, the premium for  
28 the converted policy is subject to the requirements of  
29 subsection (3).

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



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

3           (a) The premium for the converted policy shall be  
4 determined in accordance with premium rates applicable to the  
5 age and class of risk of each person to be covered under the  
6 converted policy and to the type and amount of insurance  
7 provided. However, the premium for the converted policy may  
8 not exceed 200 percent of the standard risk rate as  
9 established by the department, pursuant to this subsection.

10           (b) Actual or expected experience under converted  
11 policies may be combined with such experience under group  
12 policies for the purposes of determining premium and loss  
13 experience and establishing premium rate levels for group  
14 coverage.

15           (c) The department shall annually determine standard  
16 risk rates, using reasonable actuarial techniques and  
17 standards adopted by the department by rule. The standard risk  
18 rates must be determined as follows:

19           1. Standard risk rates for individual coverage must be  
20 determined separately for indemnity policies, preferred  
21 provider/exclusive provider policies, and health maintenance  
22 organization contracts.

23           2. The department shall survey insurers and health  
24 maintenance organizations representing at least an 80 percent  
25 market share, based on premiums earned in the state for the  
26 most recent calendar year, for each of the categories  
27 specified in subparagraph 1.

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

1           4. The rate schedule shall be determined from analysis  
2 of the one county with the largest market share in the state  
3 of all such carriers.

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

7           6. The rate schedule must be determined for different  
8 age brackets and family size brackets.

9           (4) EFFECTIVE DATE OF COVERAGE.--The effective date of  
10 the converted policy shall be the day following the  
11 termination of insurance under the group policy.

12           (5) SCOPE OF COVERAGE.--The converted policy shall  
13 cover the employee or member and his or her dependents who  
14 were covered by the group policy on the date of termination of  
15 insurance. At the option of the insurer, a separate converted  
16 policy may be issued to cover any dependent.

17           (6) OPTIONAL COVERAGE.--The insurer shall not be  
18 required to issue a converted policy covering any person who  
19 is or could be covered by Medicare. The insurer shall not be  
20 required to issue a converted policy covering a person if  
21 paragraphs (a) and (b) apply to the person:

22           (a) If any of the following apply to the person:

23           1. The person is covered for similar benefits by  
24 another hospital, surgical, medical, or major medical expense  
25 insurance policy or hospital or medical service subscriber  
26 contract or medical practice or other prepayment plan, or by  
27 any other plan or program.

28           2. The person is eligible for similar benefits,  
29 whether or not actually provided coverage, under any  
30 arrangement of coverage for individuals in a group, whether on  
31 an insured or uninsured basis.

1           3. Similar benefits are provided for or are available  
2 to the person under any state or federal law.

3           (b) If the benefits provided under the sources  
4 referred to in subparagraph (a)1. or the benefits provided or  
5 available under the sources referred to in subparagraphs (a)2.  
6 and 3., together with the benefits provided by the converted  
7 policy, would result in overinsurance according to the  
8 insurer's standards. The insurer's standards must bear some  
9 reasonable relationship to actual health care costs in the  
10 area in which the insured lives at the time of conversion and  
11 must be filed with the department prior to their use in  
12 denying coverage.

13           (7) INFORMATION REQUESTED BY INSURER.--

14           (a) A converted policy may include a provision under  
15 which the insurer may request information, in advance of any  
16 premium due date, of any person covered thereunder as to  
17 whether:

18           1. The person is covered for similar benefits by  
19 another hospital, surgical, medical, or major medical expense  
20 insurance policy or hospital or medical service subscriber  
21 contract or medical practice or other prepayment plan or by  
22 any other plan or program.

23           2. The person is covered for similar benefits under  
24 any arrangement of coverage for individuals in a group,  
25 whether on an insured or uninsured basis.

26           3. Similar benefits are provided for or are available  
27 to the person under any state or federal law.

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

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

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

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

12           4. Other reasons approved by the department.

13           (8) BENEFITS OFFERED.--

14           (a) An insurer shall not be required to issue a  
15 converted policy that provides benefits in excess of those  
16 provided under the group policy from which conversion is made.

17           (b) An insurer shall offer the benefits specified in  
18 s. 627.668 and the benefits specified in s. 627.669 if those  
19 benefits were provided in the group plan.

20           (c) An insurer shall offer maternity benefits and  
21 dental benefits if those benefits were provided in the group  
22 plan.

23           (9) PREEXISTING CONDITION PROVISION.--The converted  
24 policy shall not exclude a preexisting condition not excluded  
25 by the group policy. However, the converted policy may provide  
26 that any hospital, surgical, or medical benefits payable under  
27 the converted policy may be reduced by the amount of any such  
28 benefits payable under the group policy after the termination  
29 of covered under the group policy. The converted policy may  
30 also provide that during the first policy year the benefits  
31 payable under the converted policy, together with the benefits

1 payable under the group policy, shall not exceed those that  
2 would have been payable had the individual's insurance under  
3 the group policy remained in force.

4 (10) REQUIRED OPTION FOR MAJOR MEDICAL  
5 COVERAGE.--Subject to the provisions and conditions of this  
6 part, the employee or member shall be entitled to obtain a  
7 converted policy providing major medical coverage under a plan  
8 meeting the following requirements:

9 (a) A maximum benefit equal to the lesser of the  
10 policy limit of the group policy from which the individual  
11 converted or \$500,000 per covered person for all covered  
12 medical expenses incurred during the covered person's  
13 lifetime.

14 (b) Payment of benefits at the rate of 80 percent of  
15 covered medical expenses which are in excess of the  
16 deductible, until 20 percent of such expenses in a benefit  
17 period reaches \$2,000, after which benefits will be paid at  
18 the rate of 90 percent during the remainder of the contract  
19 year unless the insured is in the insurer's case management  
20 program, in which case benefits shall be paid at the rate of  
21 100 percent during the remainder of the contract year. For  
22 the purposes of this paragraph, "case management program"  
23 means the specific supervision and management of the medical  
24 care provided or prescribed for a specific individual, which  
25 may include the use of health care providers designated by the  
26 insurer. Payment of benefits for outpatient treatment of  
27 mental illness, if provided in the converted policy, may be at  
28 a lesser rate but not less than 50 percent.

29 (c) A deductible for each calendar year that must be  
30 \$500, \$1,000, or \$2,000, at the option of the policyholder.

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1           (d) The term "covered medical expenses," as used in  
2 this subsection, shall be consistent with those customarily  
3 offered by the insurer under group or individual health  
4 insurance policies but is not required to be identical to the  
5 covered medical expenses provided in the group policy from  
6 which the individual converted.

7           (11) ALTERNATIVE PLANS.--The insurer shall, in  
8 addition to the option required by subsection (10), offer the  
9 standard health benefit plan, as established pursuant to s.  
10 627.6699(12). The insurer may, at its option, also offer  
11 alternative plans for group health conversion in addition to  
12 the plans required by this section.

13           (12) RETIREMENT COVERAGE.--If coverage would be  
14 continued under the group policy on an employee following the  
15 employee's retirement prior to the time he or she is or could  
16 be covered by Medicare, the employee may elect, instead of  
17 such continuation of group insurance, to have the same  
18 conversion rights as would apply had his or her insurance  
19 terminated at retirement by reason or termination of  
20 employment or membership.

21           (13) REDUCTION OF COVERAGE DUE TO MEDICARE.--The  
22 converted policy may provide for reduction of coverage on any  
23 person upon his or her eligibility for coverage under Medicare  
24 or under any other state or federal law providing for benefits  
25 similar to those provided by the converted policy.

26           (14) CONVERSION PRIVILEGE ALLOWED.--The conversion  
27 privilege shall also be available to any of the following:

28           (a) The surviving spouse, if any, at the death of the  
29 employee or member, with respect to the spouse and the  
30 children whose coverages under the group policy terminate by  
31 reason of the death, otherwise to each surviving child whose

1 coverage under the group policy terminates by reason of such  
2 death, or, if the group policy provides for continuation of  
3 dependents' coverages following the employee's or member's  
4 death, at the end of such continuation.

5 (b) The former spouse whose coverage would otherwise  
6 terminate because of annulment or dissolution of marriage, if  
7 the former spouse is dependent for financial support.

8 (c) The spouse of the employee or member upon  
9 termination of coverage of the spouse, while the employee or  
10 member remains insured under the group policy, by reason of  
11 ceasing to be a qualified family member under the group  
12 policy, with respect to the spouse and the children whose  
13 coverages under the group policy terminate at the same time.

14 (d) A child solely with respect to himself or herself  
15 upon termination of his or her coverage by reason of ceasing  
16 to be a qualified family member under the group policy, if a  
17 conversion privilege is not otherwise provided in this  
18 subsection with respect to such termination.

19 (15) BENEFIT LEVELS.--If the benefit levels required  
20 in subsection (10) exceed the benefit levels provided under  
21 the group policy, the conversion policy may offer benefits  
22 which are substantially similar to those provided under the  
23 group policy in lieu of those required in subsection (10).

24 (16) GROUP COVERAGE INSTEAD OF INDIVIDUAL  
25 COVERAGE.--The insurer may elect to provide group insurance  
26 coverage instead of issuing a converted individual policy.

27 (17) NOTIFICATION.--A notification of the conversion  
28 privilege shall be included in each certificate of coverage.  
29 The insurer shall mail an election and premium notice form,  
30 including an outline of coverage, on a form approved by the  
31 department, within 14 days after an individual who is eligible

1 for a converted policy gives notice to the insurer that the  
2 individual is considering applying for the converted policy or  
3 otherwise requests such information. The outline of coverage  
4 must contain a description of the principal benefits and  
5 coverage provided by the policy and its principal exclusions  
6 and limitations, including, but not limited to, deductibles  
7 and coinsurance.

8 (18) OUTSIDE CONVERSIONS.--A converted policy that is  
9 delivered outside of this state must be on a form that could  
10 be delivered in the other jurisdiction as a converted policy  
11 had the group policy been issued in that jurisdiction.

12 (19) APPLICABILITY.--This section does not require  
13 conversion on termination of eligibility for a policy or  
14 contract that provides benefits for specified diseases, or for  
15 accidental injuries only, disability income, Medicare  
16 supplement, hospital indemnity, limited benefit,  
17 nonconventional, or excess policies.

18 (20) Nothing in this section or in the incorporation  
19 of it into insurance policies shall be construed to require  
20 insurers to provide benefits equal to those provided in the  
21 group policy from which the individual converted, provided,  
22 however, that comprehensive benefits are offered which shall  
23 be subject to approval by the Insurance Commissioner.

24 Section 8. Section 641.3108, Florida Statutes, is  
25 amended to read:

26 641.3108 Notice of cancellation of contract.--

27 (1) Except for nonpayment of premium or termination of  
28 eligibility, no health maintenance organization may cancel or  
29 otherwise terminate or fail to renew a health maintenance  
30 contract without giving the subscriber at least 45 days'  
31 notice in writing of the cancellation, termination, or



1 nonrenewal of the contract. The written notice shall state the  
2 reason or reasons for the cancellation, termination, or  
3 nonrenewal. All health maintenance contracts shall contain a  
4 clause which requires that this notice be given.

5 (2) If cancellation is due to nonpayment of premium,  
6 the health maintenance organization may not retroactively  
7 cancel the contract to a date prior to the date that notice of  
8 cancellation was provided to the subscriber unless the  
9 organization mails notice of cancellation to the subscriber  
10 prior to 45 days after the date the premium was due. Such  
11 notice must be mailed to the subscriber's last address as  
12 shown by the records of the organization and may provide for a  
13 retroactive date of cancellation no earlier than midnight of  
14 the date that the premium was due.

15 (3) In the case of a health maintenance contract  
16 issued to an employer or person holding the contract on behalf  
17 of the subscriber group, the health maintenance organization  
18 may make the notification through the employer or group  
19 contract holder, and, if the health maintenance organization  
20 elects to take this action through the employer or group  
21 contract holder, the organization shall be deemed to have  
22 complied with the provisions of this section upon notifying  
23 the employer or group contract holder of the requirements of  
24 this section and requesting the employer or group contract  
25 holder to forward to all subscribers the notice required  
26 herein.

27 Section 9. Subsection (1) of section 641.3922, Florida  
28 Statutes, 1998 Supplement, is amended to read:

29 641.3922 Conversion contracts; conditions.--Issuance  
30 of a converted contract shall be subject to the following  
31 conditions:

1           (1) TIME LIMIT.--Written application for the converted  
2 contract shall be made and the first premium paid to the  
3 health maintenance organization not later than 63 days after  
4 such termination. However, if termination was the result of  
5 failure to pay any required premium or contribution and such  
6 nonpayment of premium was due to acts of an employer or group  
7 contract holder other than the employee or individual  
8 subscriber, written application for the contract must be made  
9 and the first premium must be paid not later than 63 days  
10 after notice of termination is mailed by the organization or  
11 the employer, whichever is earlier, to the employee's or  
12 individual's last address as shown by the record of the  
13 organization or the employer, whichever is applicable. In such  
14 case of termination due to nonpayment of premium by the  
15 employer or group contract holder, the premium for the  
16 converted contract may not exceed the rate for the prior group  
17 coverage for the period of coverage under the converted  
18 contract prior to the date notice of termination is mailed to  
19 the employee or individual subscriber. For the period of  
20 coverage after such date, the premium for the converted  
21 contract is subject to the requirements of subsection (3).

22           Section 10. This act shall take effect July 1, 1999,  
23 and shall apply to all contracts renewed or entered into on or  
24 after that date.

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