By the Committee on Health Care Services and Representatives Albright, Geller, Arnall, Casey, Bloom, Peaden, Heyman, Rodriguez-Chomat, Byrd, Flanagan, Goode and Littlefield

A bill to be entitled

An act relating to health insurance; amending s. 624.91, F.S.; limiting the time of participation in the Health Kids Corporation; amending s. 627.6406, F.S., relating to coverage for maternity care; prohibiting an insurer from imposing certain limitations on benefits, coverage, or reimbursement; amending s. 627.6425, F.S.; requiring an insurer that provides individual coverage to renew or continue coverage; providing certain exceptions; requiring an insurer to provide notice of discontinuation; authorizing an insurer to modify coverage; revising requirements for renewability of individual coverage; creating s. 627.6475, F.S.; providing for an individual reinsurance pool; providing purpose; providing definitions; providing applicability and scope; providing requirements for availability of coverage; requiring maintenance of records; providing an election for carriers; providing an election process; requiring operations of the program to be subject to the board of the Florida Small Employer Reinsurance Program; requiring the establishment of a separate account; providing for standards to assure fair marketing; authorizing the Department of Insurance to adopt rules; creating s. 627.6487, F.S.; providing for guaranteed availability of health insurance coverage to eligible individuals;

prohibiting an insurer or health maintenance organization from declining coverage for eligible individuals or imposing preexisting conditions; providing definitions; providing certain exceptions; creating s. 627.64871, F.S.; providing for application of requirements for certification of coverage; providing exceptions; creating s. 627.6489, F.S.; authorizing the Florida Comprehensive Health Association to contract with insurers to provide disease management services; creating s. 627.6512, F.S.; exempting certain group health insurance policies from specified requirements with respect to excepted benefits; amending s. 627.6561, F.S., relating to exclusions for preexisting conditions; providing definitions; specifying circumstances under which an insurer may impose an exclusion for a preexisting condition; providing exceptions; providing requirements for creditable coverage; providing for an election of methods for calculating creditable coverage; requiring disclosure of certain elections; providing for establishing creditable coverage; providing exceptions; requiring an issuer to provide certification pursuant to rules adopted by the department; creating s. 627.65615, F.S.; providing for special enrollment periods for employees and dependents; specifying conditions for special enrollment periods; creating s. 627.65625, F.S.; prohibiting an insurer from

discriminating against individual participants and beneficiaries based on health status; creating s. 627.6571, F.S.; specifying circumstances under which an insurer that issues group health insurance policies must renew or continue coverage; providing for notice of discontinuation; providing a process for notification; authorizing an insurer to modify coverage; amending s. 627.6574, F.S., relating to coverage for maternity care; prohibiting a group, blanket, or franchise policy from imposing certain limitations on enrolling or renewing coverage; prohibiting an insurer from imposing certain limitations on benefits, coverage, or reimbursement; prohibiting an insurer from providing monetary payments or rebates; amending s. 627.6675, F.S.; revising time limitations for application for and payment of a converted policy; requiring an insurer to offer a standard health benefit plan; amending s. 627.6699, F.S., relating to the Employee Health Care Access Act; revising definitions; providing requirements for policies with respect to preexisting conditions; providing exceptions; requiring special enrollment periods; authorizing a small carrier to deny coverage under certain circumstances; revising requirements for renewing coverage; increasing membership of the board of the Small Employer Health Reinsurance Program; requiring a small

employer to disclose certain information with respect to a health benefit plan; amending s. 627.9404, F.S.; providing additional definitions; amending s. 627.9407, F.S.; specifying additional information required to be disclosed for purposes of long-term care insurance; requiring a disclosure statement; amending s. 627.94071, F.S.; specifying additional minimum standards for home health care benefits; amending s. 627.94072, F.S.; deleting a requirement to provide cash surrender values in offering long-term care insurance policies; amending s. 627.94073, F.S.; revising notice of cancellation provisions; amending s. 627.94074, F.S.; revising standards for benefit triggers; creating s. 641.2018, F.S.; authorizing a health maintenance organization to offer high deductible contracts to certain employers; amending s. 641.31, F.S.; revising requirements for a health maintenance contract that provides coverage for maternity care; prohibiting a health maintenance organization from denying eligibility to enroll or to renew coverage; prohibiting such an organization from imposing certain limitations on benefits, coverage, or reimbursement; prohibiting such an organization from providing monetary payments or rebates; amending s. 641.3102, F.S.; prohibiting health maintenance organizations from declining to offer coverage to an eligible individual under

s. 627.6487, F.S.; creating s. 641.31071, F.S., relating to exclusions for preexisting conditions; providing definitions; specifying circumstances under which a health maintenance organization may impose an exclusion for a preexisting condition; providing exceptions; providing requirements for creditable coverage; providing for an election of methods for calculating creditable coverage; requiring disclosure of certain elections; providing for establishing creditable coverage; providing exceptions; requiring a health maintenance organization to provide certification pursuant to rules adopted by the department; creating s. 641.31072, F.S.; requiring a health maintenance organization to provide for special enrollment periods under a contract for employees and dependents; providing conditions for special enrollment periods; creating s. 641.31073, F.S.; prohibiting a health maintenance organization from discriminating against individual participants and beneficiaries based on health status; creating s. 641.31074, F.S.; requiring a health maintenance organization to renew or continue coverage of certain group health insurance contracts; requiring notice of discontinuation; prescribing a process for notification; authorizing a health maintenance organization to modify coverage; amending s. 641.3921, F.S.; clarifying circumstances under which a health maintenance organization may

issue a converted contract; amending s. 641.3922, F.S.; revising the time limitation for applying for a converted contract; revising the maximum premium rate for a converted contract; requiring a health maintenance organization to offer a standard health benefit plan; providing that the act fulfills an important state interest; repealing s. 627.6576, F.S., relating to a prohibition against discriminating against handicapped persons under policies of group, blanket, or franchise health insurance; providing for application of the act; requiring certain legislative committees to conduct a study for certain purposes and make recommendations to the Legislature; requiring the Department of Insurance to provide assistance; providing for application of the act with respect to a plan or contract maintained pursuant to a collective bargaining agreement; providing an effective date.

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

Section 1. Paragraph (b) of subsection (3) of section 624.91, Florida Statutes, 1996 Supplement, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

(3) CORPORATION AUTHORIZATION, DUTIES, POWERS.--

(b) The Florida Healthy Kids Corporation shall phase in a program to:

1. Organize school children groups to facilitate the provision of preventive health care services to children and to provide comprehensive health insurance coverage to children;

2. Arrange for the collection of any family or employer payment or premium, in an amount to be determined by the board of directors, from all participant families or employers to provide for payment for preventive health care services or premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses incurred during the period for which family or employer payments are made;

3. Establish the administrative and accounting procedures for the operation of the corporation;

4. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children;

5. Establish eligibility criteria which children must meet in order to participate in the program, provided such criteria shall include a maximum 60-month limitation on lifetime participation in the program by any child who first enrolls in the program after July 1, 1997;

6. Establish procedures under which applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation;

7. Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or insurance administrator to provide administrative services to the corporation;

8. Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage and preventive health care services to participants;

9. Develop and implement a plan to publicize the Florida Healthy Kids Corporation, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program;

10. Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation;

11. As appropriate, enter into contracts with local school boards or other agencies to provide onsite information, enrollment, and other services necessary to the operation of the corporation; and

12. Provide a report on an annual basis to the Governor, Insurance Commissioner, Commissioner of Education, Senate President, Speaker of the House of Representatives, and Minority Leaders of the Senate and the House of Representatives.

13. For the 1996-1997 fiscal year only, funds may be appropriated to the Florida Healthy Kids Corporation to organize school children groups to facilitate the provision of preventive health care services to children at sites in addition to those allowed in subparagraph 1. This subparagraph is repealed on July 1, 1997.

Section 2. Section 627.6406, Florida Statutes, 1996 Supplement, is amended to read:

627.6406 Maternity care.--

(1) Any policy of health insurance that provides coverage for maternity care must ~~shall~~ also cover the services of certified nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed under ss. 383.30-383.335.

(2) An insurer issuing a health insurance policy that ~~which~~ provides maternity and newborn coverage may not limit coverage for the length of a maternity and newborn stay in a hospital or for followup care outside of a hospital to any time period that is less than that determined to be medically necessary, in accordance with prevailing medical standards and consistent with ~~proposed 1996~~ guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists ~~as proposed on May 1, 1996~~, by the treating obstetrical care provider or the pediatric care provider.

(3) ~~Nothing in~~ This section does not affect ~~affects~~ any agreement between an insurer and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and this section does not prohibit ~~or prohibits~~ appropriate utilization review or case management by an insurer.

(4) Any policy of health insurance that provides coverage, benefits, or services for maternity or newborn care must provide coverage for postdelivery care for a mother and her newborn infant. The postdelivery care must include a postpartum assessment and newborn assessment and may be

provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards.

(5) An insurer subject to subsection (1) shall communicate active case questions and concerns regarding postdelivery care directly to the treating physician or hospital in written form, in addition to other forms of communication. Such insurers shall also use a process that ~~which~~ includes a written protocol for utilization review and quality assurance.

(6) An insurer subject to subsection (1) may not:

(a) Deny to a mother or her newborn infant eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy for the purpose of avoiding the requirements of this section.

(b) Provide monetary payments or rebates to a mother to encourage the mother to accept less than the minimum protections available under this section.

(c) Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to an individual participant or beneficiary in accordance with this section.

(d) Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(e) Subject to paragraph (7)(c), restrict benefits for any portion of a period within a hospital length of stay required under subsection (2) in a manner that is less favorable than the benefits provided for any preceding portion of such stay.

(7)(a) This section does not require a mother who is a participant or beneficiary to:

1. Give birth in a hospital.

2. Stay in the hospital for a fixed period of time following the birth of her infant.

(b) This section does not apply with respect to any health insurance coverage that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant.

(c) This section does not prevent a policy from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant, except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (2) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

Section 3. Section 627.6425, Florida Statutes, 1996 Supplement, is amended to read:

(Substantial rewording of section. See s. 627.6425, F.S., 1996 Supp., for present text.)

627.6425 Renewability of individual coverage.--

(1) Except as otherwise provided in this section, an insurer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual. For the purpose of this

section, the term "individual health insurance" means health insurance coverage, as described in s. 627.6561(5)(a)2., offered to an individual in this state, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in subsection (6) or subsection (7).

(2) An insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(a) The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the insurer has not received timely premium payments.

(b) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(c) The insurer is ceasing to offer coverage in the individual market in accordance with subsection (3) and applicable state law.

(d) In the case of a health insurer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the insurer is authorized to do business, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor of covered individuals.

(e) In the case of health insurance coverage that is made available in the individual market only through one or

more bona fide associations, as defined in s. 627.6571(5), the membership of the individual in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor of covered individuals.

(3)(a) In any case in which an insurer decides to discontinue offering a particular policy form for health insurance coverage offered in the individual market, coverage under such form may be discontinued by the insurer only if:

1. The insurer provides notice to each covered individual provided coverage under this policy form in the individual market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

2. The insurer offers to each individual in the individual market provided coverage under this policy form the option to purchase any other individual health insurance coverage currently being offered by the insurer for individuals in such market in the state; and

3. In exercising the option to discontinue coverage of this policy form and in offering the option of coverage under subparagraph 2., the insurer acts uniformly without regard to any health-status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(b)1. Subject to subparagraph (a)3., in any case in which an insurer elects to discontinue offering all health insurance coverage in the individual market in this state, health insurance coverage may be discontinued by the insurer only if:

a. The insurer provides notice to the department and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage; and

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

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

(4) At the time of coverage renewal, an insurer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with the laws of this state and effective on a uniform basis among all individuals with that policy form.

(5) In applying this section in the case of health insurance coverage that is made available by an insurer in the individual market to individuals only through one or more associations, a reference to an "individual" includes a reference to such an association of which the individual is a member.

(6) The requirements of this section do not apply to any health insurance coverage in relation to its provision of excepted benefits described in s. 627.6561(5)(b).

(7) The requirements of this section do not apply to any health insurance coverage in relation to its provision of excepted benefits described in s. 627.6561(5)(c), (d), or (e),

if the benefits are provided under a separate policy, certificate, or contract of insurance.

(8) This section applies to health insurance coverage offered, sold, issued, or renewed in the individual market on or after July 1, 1997.

Section 4. Section 627.6475, Florida Statutes, is created to read:

627.6475 Individual reinsurance pool.--

(1) PURPOSE.--The purpose of this section is to provide for the establishment of a reinsurance program for coverage of individuals who are eligible for issuance of individual health insurance from a health insurance issuer pursuant to s. 627.6487.

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

(a) "Board," "carrier," and "health benefit plan" have the same meaning ascribed in s. 627.6699(3).

(b) "Health insurance issuer," "issuer," and "individual health insurance" have the same meaning ascribed in s. 627.6487(2).

(c) "Reinsuring carrier" means a health insurance issuer that elects to comply with the requirements set forth in subsection (7).

(d) "Risk-assuming carrier" means a health insurance issuer that elects to comply with the requirements set forth in subsection (6).

(e) "Eligible individual" has the same meaning ascribed in s. 627.6487(3).

(3) APPLICABILITY AND SCOPE.--This section applies to individual health insurance offered by a health insurance issuer to an eligible individual.

(4) MAINTENANCE OF RECORDS.--Each health insurance issuer that offers individual health insurance must maintain at its principal place of business a complete and detailed description of its rating practices and renewal practices, as required for small employer carriers pursuant to s. 627.6699(8).

(5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER.--

(a) Each health insurance issuer that offers individual health insurance must elect to become a risk-assuming carrier or a reinsuring carrier for purposes of this section. Each such issuer must make an initial election, binding through December 31, 1999. The issuer's initial election must be made no later than October 31, 1997. By October 31, 1997, all issuers must file a final election, which is binding for 2 years, from January 1, 1998, through December 31, 1999, after which an election shall be binding for a period of 5 years. The department may permit an issuer to modify its election at any time for good cause shown, after a hearing.

(b) The department shall establish an application process for issuers seeking to change their status under this subsection.

(c) An election to become a risk-assuming carrier is subject to approval under this subsection.

(d) An issuer that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier may not reinsure or continue to reinsure any individual health benefits plan under subsection (7) once the issuer becomes a risk-assuming carrier, and the issuer must pay a prorated assessment based upon business issued as a reinsuring carrier

for any portion of the year that the business was reinsured. An issuer that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier may reinsure individual health insurance under the terms set forth in subsection (7) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

(6) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.--

(a)1. A health insurance issuer that offers individual health insurance may become a risk-assuming carrier by filing with the department a designation of election under this subsection in a format and manner prescribed by the department. The department shall approve the election of a health insurance issuer to become a risk-assuming carrier if the department finds that the issuer is capable of assuming that status pursuant to the criteria set forth in paragraph (b).

2. The department must approve or disapprove any designation as a risk-assuming carrier within 60 days after a filing.

(b) In determining whether to approve an application by an issuer to become a risk-assuming carrier, the department shall consider:

1. The issuer's financial ability to support the assumption of the risk of individuals.

2. The issuer's history of rating and underwriting individuals.

3. The issuer's commitment to market fairly to all individuals in the state or its service area, as applicable.

4. The issuer's ability to assume and manage the risk of enrolling individuals without the protection of the reinsurance program provided in subsection (7).

(c) The department shall provide public notice of an issuer's designation of election under this subsection to become a risk-assuming carrier and shall provide at least a 21-day period for public comment prior to making a decision on the election. The department shall hold a hearing on the election at the request of the issuer.

(d) The department may rescind the approval granted to a risk-assuming carrier under this subsection if the department finds that the carrier no longer meets the criteria of paragraph (b).

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

(a) The individual health reinsurance program shall operate subject to the supervision and control of the board of the small employer health reinsurance program established pursuant to s. 627.6699(11). The board shall establish a separate, segregated account for eligible individuals reinsured pursuant to this section, which account may not be commingled with the small employer health reinsurance account.

(b) A reinsuring carrier may reinsure with the program coverage of an eligible individual, subject to each of the following provisions:

1. A reinsuring carrier may reinsure an eligible individual within 60 days after commencement of the coverage of the eligible individual.

2. The program may not reimburse a participating carrier with respect to the claims of a reinsured eligible individual until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the

program. In addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year, and the program shall reinsure the remainder.

3. The board shall annually adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the "Commerce Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the United States Department of Labor, unless the board proposes and the department approves a lower adjustment factor.

4. A reinsuring carrier may terminate reinsurance for all reinsured eligible individuals on any plan anniversary.

5. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 2., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 2., which may not be ceded to the program.

6. The board may consider adjustments to the premium rates charged for reinsurance by the program or carriers that use effective cost-containment measures, including high-cost case management, as defined by the board.

7. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed-care provisions, or methods of operation consistently with both reinsured business and nonreinsured business.

(c)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring eligible individuals pursuant to this section. The methodology must include a system for classifying individuals which reflects the types of case characteristics commonly used by carriers in this state. The methodology must provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the department, and shall be set at levels that reasonably approximate gross premiums charged to eligible individuals for individual health insurance by health insurance issuers. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. An eligible individual may be reinsured for a rate that is five times the rate established by the board.

2. The board shall periodically review the methodology established, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates that are subject to the approval of the department.

(d) If individual health insurance for an eligible individual is entirely or partially reinsured with the program pursuant to this section, the premium charged to the eligible individual for any rating period for the coverage issued must be the same premium that would have been charged to that individual if the health insurance issuer elected not to reinsure coverage for that individual.

(e)1. Before March 1 of each calendar year, the board shall determine and report to the department the program net loss in the individual account for the previous year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate gains and losses.

2. Any net loss in the individual account for the year shall be recouped by assessing the carriers as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount that may not exceed 5 percent of each reinsuring carrier's premiums for individual health insurance. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount that may not exceed 0.5 percent of each carrier's health benefit plan premiums.

b. Except as provided in paragraph (f), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

c. The board shall equitably assess reinsuring carriers for operating losses of the individual account based

on market share. The board shall annually assess each carrier a portion of the operating losses of the individual account. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against reinsuring carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

d. Subject to the approval of the department, the board shall adjust the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,

if any, that restrictions are placed on them which are not imposed on other carriers.

3. Before March 1 of each year, the board shall determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings and recommendations to the department in the format established in s. 627.6699(11) for the comparable report for the small employer reinsurance program.

(f) Notwithstanding paragraph (e), the administrative expenses of the program shall be recouped by assessing risk-assuming carriers and reinsuring carriers, and such amounts may not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of individual health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.

(g) Except as otherwise provided in this section, the board and the department shall have all powers, duties, and responsibilities with respect to carriers that issue and reinsure individual health insurance, as specified for the

board and the department in s. 627.6699(11) with respect to small employer carriers, including, but not limited to, the provisions of s. 627.6699(11) relating to:

1. Use of assessments that exceed the amount of actual losses and expenses.

2. The annual determination of each carrier's proportion of the assessment.

3. Interest for late payment of assessments.

4. Authority for the department to approve deferment of an assessment against a carrier.

5. Limited immunity from legal actions or carriers.

6. Development of standards for compensation to be paid to agents. Such standards shall be limited to those specifically enumerated in s. 627.6699(13)(d).

7. Monitoring compliance by carriers with this section.

(8) STANDARDS TO ASSURE FAIR MARKETING.--

(a) Each health insurance issuer that offers individual health insurance shall actively market coverage to eligible individuals in the state. The provisions of s. 627.6699(13) that apply to small employer carriers that market policies to small employers shall also apply to health insurance issuers that offer individual health insurance with respect to marketing policies to individuals.

(b) A violation of this section by a health insurance issuer or an agent is an unfair trade practice under s. 626.9541 or ss. 641.3903 and 641.3907.

(9) RULEMAKING AUTHORITY.--The department may adopt rules to administer this section, including rules governing compliance by carriers.

Section 5. Section 627.6487, Florida Statutes, is created to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.--

(1) Subject to the requirements of this section, each health insurance issuer that offers individual health insurance coverage in this state may not, with respect to an eligible individual who desires to enroll in individual health insurance coverage:

(a) Decline to offer such coverage to, or deny enrollment of, such individual; or

(b) Impose any preexisting condition exclusion with respect to such coverage. For purposes of this section, the term "preexisting condition" means, with respect to coverage, a limitation of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(2) For the purposes of this section:

(a) "Health insurance issuer" and "issuer" mean an authorized insurer or a health maintenance organization.

(b) "Individual health insurance" means health insurance, as defined in s. 627.6561(5)(a)2., which is offered to an individual, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s. 624.6561(5)(b) or, if the benefits are provided under a separate policy, certificate, or

contract, the term does not include excepted benefits specified in s. 627.6561(5)(c), (d), or (e).

(3) For the purposes of this section, the term "eligible individual" means an individual:

(a)1. For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage, as defined in s. 627.6561(5) and (6), is 18 or more months; and

2. Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan;

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in section 2791, of the Public Health Service Act;

2. A conversion policy under s. 627.6675 or s. 641.3921;

3. Medicare, part A or part B of Title XVIII of the Social Security Act as amended; or

4. A state plan under Medicaid, Title XIX of the Social Security Act, as amended, or any successor program,

and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (1)(a) was not terminated based on a factor described in s. 627.6571(2)(a) or (b), relating to nonpayment of premiums or fraud, unless such nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

(d) Who, having been offered the option of continuation coverage under a COBRA continuation provision or under s. 627.6692, elected such coverage; and

(e) Who, if the individual elected such continuation provision, has exhausted such continuation coverage under such provision or program.

(4)(a) The health insurance issuer may elect to limit the coverage offered under subsection (1) if the issuer offers at least two different policy forms of health insurance coverage, both of which:

1. Are designed for, made generally available to, actively marketed to, and enroll both eligible and other individuals by the issuer; and

2. Meet the requirement of paragraph (b).

For purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders are considered to be different policy forms.

(b) The requirement of this subsection is met for health insurance coverage policy forms offered by an issuer in the individual market if the issuer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in this state or applicable marketing or service area, as prescribed in rules adopted by the department, in the individual market in the period involved. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(5)(a) In the case of a health insurance issuer that offers individual health insurance coverage through a network plan, the issuer may:

1. Limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan; and

2. Within the service area of such plan, deny such coverage to such individuals if the issuer has demonstrated to the department that:

a. It will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees; and

b. It is applying this paragraph uniformly to individuals without regard to any health-status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(b) An issuer, upon denying individual health insurance coverage in any service area in accordance with subparagraph (a)2., may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

(6)(a) A health insurance issuer may deny individual health insurance coverage to an eligible individual if the issuer has demonstrated to the department that:

1. It does not have the financial reserves necessary to underwrite additional coverage; and

2. It is applying this paragraph uniformly to all individuals in the individual market in this state consistent with the laws of this state and without regard to any

health-status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(b) An issuer, upon denying individual health insurance coverage in any service area in accordance with paragraph (a), may not offer such coverage in the individual market within such service area for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the department that the issuer has sufficient financial reserves to underwrite additional coverage, whichever occurs later.

(7)(a) Subsection (1) does not require that a health insurance issuer that offers health insurance coverage only in connection with group health plans or through one or more bona fide associations, as defined in s. 627.6571(5), or both, offer such health insurance coverage in the individual market.

(b) A health insurance issuer that offers health insurance coverage in connection with group health plans is not deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

(8) This section does not:

(a) Restrict the amount of the premium rates that an issuer may charge an individual for individual health insurance coverage; or

(b) Prevent a health insurance issuer that offers individual health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(9) Each health insurance issuer that offers individual health insurance coverage to an eligible individual

shall elect to become a risk-assuming carrier or a reinsuring carrier, as provided by s. 627.6475.

(10) This section applies to individual health insurance coverage offered on or after January 1, 1998. An individual who would have been eligible for coverage on July 1, 1997, shall be eligible for coverage on January 1, 1998, and shall remain eligible for the same period of time after January 1, 1998, that the individual would have remained eligible for coverage after July 1, 1997.

Section 6. Section 627.64871, Florida Statutes, is created to read:

627.64871 Certification of coverage.--

(1) Section 627.6561(8), applies to health insurance coverage offered by an insurer in the individual market in the same manner as it applies to health insurance coverage offered by an insurer in connection with a group health plan in the small-group market or large-group market.

(2) This section does not apply to any health insurance coverage in relation to its provision of excepted benefits described in s. 627.6561(5)(b).

(3) This section does not apply to any health insurance coverage in relation to its provision of excepted benefits described in s. 627.6561(5)(c), (d), or (e), if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) This section applies to health insurance coverage offered, sold, issued, renewed, or in effect on or after July 1, 1997.

Section 7. Section 627.6489, Florida Statutes, is created to read:

627.6489 Disease Management Program.--

(1) The association may contract with insurers to provide disease management services for insurers that elect to participate in the association disease management program.

(2) An insurer that elects to contract for such services shall provide the association with all medical records and claims information necessary for the association to effectively manage the services.

(3) Monies collected by the association for providing disease management services shall be used by the association to pay administrative expenses associated with the disease management program and to reduce any deficits incurred by the association. No funds received at any time by the association as a result of assessments against insurers may be used in connection with the disease management program. No costs related to the disease management program provided to an insurer shall be assessed against any other insurer.

Section 8. Section 627.6512, Florida Statutes, is created to read:

627.6512 Exemption of certain group health insurance policies.--Sections 627.6561, 627.65615, 627.65625, and 627.6571, do not apply to:

(1) Any group insurance policy in relation to its provision of excepted benefits described in s. 627.6561(5)(b).

(2) Any group health insurance policy in relation to its provision of excepted benefits described in s. 627.6561(5)(c), if the benefits:

(a) Are provided under a separate policy, certificate, or contract of insurance; or

(b) Are otherwise not an integral part of the policy.

(3) Any group health insurance policy in relation to its provision of excepted benefits described in s. 627.6561(5)(d), if all of the following conditions are met:

(a) The benefits are provided under a separate policy, certificate, or contract of insurance;

(b) There is no coordination between the provision of such benefits and any exclusion of benefits under any group policy maintained by the same policyholder; and

(c) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health policy maintained by the same policyholder.

(4) Any group health policy in relation to its provision of excepted benefits described in s. 627.6561(5)(e), if the benefits are provided under a separate policy, certificate, or contract of insurance.

Section 9. Section 627.6561, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 627.6561, F.S., for present text.)

627.6561 Preexisting conditions.--

(1) As used in this section, the term:

(a) "Enrollment date" means, with respect to an individual covered under a group health policy, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period of such enrollment.

(b) "Late enrollee" means, with respect to coverage under a group health policy, a participant or beneficiary who enrolls under the policy other than during:

1. The first period in which the individual is eligible to enroll under the policy.

2. A special enrollment period, as provided under s. 627.65615.

(c) "Waiting period" means, with respect to a group health policy and an individual who is a potential participant or beneficiary of the policy, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the policy.

(2) Subject to the exceptions specified in subsection (4), an insurer that offers group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(a) Such exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(b) Such exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date; and

(c) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, as defined in subsection (5), applicable to the participant or beneficiary as of the enrollment date.

(3) Genetic information may not be treated as a condition described in paragraph (2)(a) in the absence of a diagnosis of the condition related to such information.

(4)(a) Subject to paragraph (b), an insurer that offers group health insurance coverage, may not impose any preexisting condition exclusion in the case of:

1. An individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision does not apply to coverage before the date of such adoption or placement for adoption.

3. Pregnancy.

(b) Subparagraphs (a)1. and 2. do not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(5)(a) The term, "creditable coverage," means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act.

2. Health insurance coverage consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer.

3. Medicare, part A or part B of Title XVIII of the Social Security Act, as amended.

4. Medicaid, Title XIX of the Social Security Act, as amended, other than children eligible solely for the federal program for the distribution of pediatric vaccines.

5. Chapter 55 of Title 10, United States Code.

6. A medical care program of the Indian Health Service or of a tribal organization.

7. The Florida Comprehensive Health Association or another state health benefit risk pool.

8. A health plan offered under chapter 89 of Title 5, United States Code.

9. A public health plan as defined by rules adopted by the department. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

10. A health benefit plan under s. 5(e) of the Peace Corps Act (22 United States Code, 2504(e)).

(b) Creditable coverage does not include coverage that consists solely of one or more or any combination thereof of the following excepted benefits:

1. Coverage only for accident, or disability income insurance, or any combination thereof.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Workers' compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit-only insurance.

7. Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

8. Other similar insurance coverage, specified in rules adopted by the department, under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be

consistent with regulations adopted by the United States Department of Health and Human Services.

(c) The following benefits do not constitute creditable coverage, if offered separately:

1. Limited scope dental or vision benefits.

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

3. Such other similar, limited benefits as are specified in rules adopted by the department.

(d) The following benefits do not constitute creditable coverage if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness.

2. Hospital indemnity or other fixed indemnity insurance.

(e) Benefits provided through a Medicare supplemental health insurance, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan are not considered creditable coverage if offered as a separate insurance policy.

(6)(a) A period of creditable coverage may not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(b) Any period during which an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage may not be taken into

account in determining the 63-day period under paragraph (a) or paragraph (4)(b).

(7)(a) Except as otherwise provided under paragraph (b), an insurer shall count a period of creditable coverage without regard to the specific benefits covered under the period.

(b) An insurer may elect to count, as creditable coverage, coverage of benefits within each of several classes or categories of benefits specified in rules adopted by the department rather than as provided under paragraph (a). To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election, an insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(c) In the case of an election with respect to an insurer under paragraph (b), the insurer shall:

1. Prominently state in 10-point type or larger in any disclosure statements concerning the policy, and state to each certificateholder at the time of enrollment under the policy, that the insurer has made such election; and

2. Include in such statements a description of the effect of this election.

(8)(a) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in this subsection or in such other manner as is specified in rules adopted by the department. To the extent possible, such rules must be consistent with

regulations adopted by the United States Department of Health and Human Services.

(b) An insurer that offers group health insurance coverage shall provide the certification described in paragraph (a):

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision or continuation pursuant to s. 627.6692.

2. In the case of an individual becoming covered under a COBRA continuation provision or pursuant to s. 627.6692, at the time the individual ceases to be covered under such a provision.

3. Upon the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in this paragraph.

The certification under subparagraph 1. may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision or continuation pursuant to s. 627.6692.

(c) The certification described in this section is a written certification that must include:

1. The period of creditable coverage of the individual under the policy and the coverage, if any, under such COBRA continuation provision or continuation pursuant to s. 627.6692; and

2. The waiting period, if any, imposed with respect to the individual for any coverage under such policy.

(d) In the case of an election described in subsection (7) by an insurer, if the insurer enrolls an individual for

coverage under the plan and the individual provides a certification of coverage of the individual, as provided in this subsection:

1. Upon request of such insurer, the insurer that issued the certification provided by the individual shall promptly disclose to such requesting plan or insurer information on coverage of classes and categories of health benefits available under such insurer's plan or coverage.

2. Such insurer may charge the requesting insurer for the reasonable cost of disclosing such information.

(e) The department shall adopt rules to prevent an insurer's failure to provide information under this subsection with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(9)(a) Except as provided in paragraph (b), no period before July 1, 1996, shall be taken into account in determining creditable coverage.

(b) The department shall adopt rules that provide a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for paragraph (a), may be given credit for creditable coverage for such periods through the presentation of documents or other means. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(10) Except as otherwise provided in this subsection, paragraph (8)(b) applies to events that occur on or after July 1, 1996.

(a) In no case is a certification required to be provided under paragraph (8)(b) prior to June 1, 1997.

(b) In the case of an event that occurs on or after July 1, 1996, and before October 1, 1996, a certification is not required to be provided under paragraph (8)(b), unless an individual, with respect to whom the certification is required to be made, requests such certification in writing.

(11) In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event that occurred before July 1, 1996:

(a) The individual may present evidence of other creditable coverage in order to establish the period of creditable coverage.

(b) An insurer is not subject to any penalty or enforcement action with respect to the insurer's crediting, or not crediting, such coverage if the insurer has sought to comply in good faith with applicable provisions of this section.

(12) For purposes of subsection (9), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of this section may not be treated as a termination of such collective bargaining agreement.

(13) This section does not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (5)(b).

(14) This section does not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraphs (5)(c), (d), or (e), if the benefits are provided under a separate policy, certificate, or contract of insurance.

(15) This section applies to health insurance coverage offered, sold, issued, renewed, or in effect on or after July 1, 1997.

Section 10. Section 627.65615, Florida Statutes, is created to read:

627.65615 Special enrollment periods.--

(1) An insurer that issues a group health insurance policy shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the policy, or a dependent of such an employee if the dependent is eligible but not enrolled for coverage under such terms, to enroll for coverage under the terms of the policy if each of the following conditions is met:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent. For the purpose of this section, the terms "group health plan" and "health insurance coverage" have the same meaning ascribed in s. 2791 of the Public Health Service Act.

(b) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or insurer, if applicable, required such a statement at such time and provided the employee with notice of such requirement and the consequences of such requirement at such time.

(c) The employee's or dependent's coverage described in paragraph (a):

1. Was under a COBRA continuation provision or continuation pursuant to s. 627.6692, and the coverage under such provision was exhausted; or

2. Was not under such a provision and the coverage was terminated as a result of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of employer contributions toward such coverage.

(d) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (c)1., or termination or employer contribution described in subparagraph (c)2.

(2) For dependent beneficiaries, if:

(a) A group health insurance policy makes coverage available with respect to a dependent of an individual;

(b) The individual is a participant under the policy, or has met any waiting period applicable to becoming a participant under the policy, and is eligible to be enrolled under the policy but for a failure to enroll during a previous enrollment period; and

(c) A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the insurer shall provide for a dependent special enrollment period described in subsection (3) during which the person,

or, if not otherwise enrolled, the individual, may be enrolled under the policy as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(3) A dependent special enrollment period under subsection (2) shall be a period of not less than 30 days and shall begin on the later of:

(a) The date that dependent coverage is made available; or

(b) The date of the marriage, birth, or adoption or placement for adoption described in subsection (2)(c).

(4) If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(a) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.

(b) In the case of a dependent's birth, as of the date of such birth.

(c) In the case of dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

Section 11. Section 627.65625, Florida Statutes, is created to read:

627.65625 Prohibiting discrimination against individual participants and beneficiaries based on health status.--

(1) Subject to subsection (2), an insurer that offers a group health insurance policy may not establish rules for

eligibility, including continued eligibility, of an individual to enroll under the terms of the policy based on any of the following health-status-related factors in relation to the individual or a dependent of the individual:

(a) Health status.

(b) Medical condition, including physical and mental illnesses.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence.

(h) Disability.

(2) Subsection (1) does not:

(a) Require an insurer to provide particular benefits other than those provided under the terms of such plan or coverage.

(b) Prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) For purposes of subsection (1), rules for eligibility to enroll under a policy include rules for defining any applicable waiting periods of enrollment.

(4)(a) An insurer that offers health insurance coverage may not require any individual, as a condition of enrollment or continued enrollment under the policy, to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled under the policy on the basis of any health-status-related

factor in relation to the individual or to an individual enrolled under the policy as a dependent of the individual.

(b) This subsection does not:

1. Restrict the amount that an employer may be charged for coverage under a group health insurance policy; or

2. Prevent an insurer that offers group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Section 12. Section 627.6571, Florida Statutes, is created to read:

627.6571 Guaranteed renewability of coverage.--

(1) Except as otherwise provided in this section, an insurer that issues a group health insurance policy must renew or continue in force such coverage at the option of the policyholder.

(2) An insurer may nonrenew or discontinue a group health insurance policy based only on one or more of the following conditions:

(a) The policyholder has failed to pay premiums or contributions in accordance with the terms of the policy or the insurer has not received timely premium payments.

(b) The policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the policy.

(c) The policyholder has failed to comply with a material provision of the plan which relates to rules for employer contributions or group participation.

(d) The insurer is ceasing to offer a particular type of coverage in a market in accordance with subsection (3) and applicable state law.

(e) In the case of an insurer that offers health insurance coverage through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the insurer or in the area in which the insurer is authorized to do business and, in the case of the small-group market, the insurer would deny enrollment with respect to such plan under s. 627.6699(5)(i).

(f) In the case of health insurance coverage that is made available only through one or more bona fide associations as defined in subsection (5), the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor that relates to any covered individuals.

(3)(a) An insurer may discontinue offering a particular policy form of group health insurance coverage offered in the small-group market or large-group market only if:

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

2. The insurer offers to each policyholder provided coverage of this form in such market the option to purchase all, or in the case of the large-group market, any other

health insurance coverage currently being offered by the insurer in such market; and

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

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

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

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

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

(c) A mailing to one household constitutes a mailing to all covered persons residing in that household. A separate mailing is required for each separate household.

(4) At the time of coverage renewal, an insurer may modify the health insurance coverage for a product offered:

(a) In the large-group market; or

(b) In the small-group market if, for coverage that is available in such market other than only through one or more bona fide associations as defined in subsection (5), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product.

(5) As used in this section, the term "bona fide association" means an association that:

(a) Has been actively in existence for at least 5 years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any health-status-related factor that relates to an individual, including an employee of an employer or a dependent of an employee;

(d) Makes health insurance coverage offered through the association available to all members regardless of any health-status-related factor that relates to such members or individuals eligible for coverage through a member; and

(e) Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(6) In applying this section in the case of health insurance coverage that is made available by an insurer in the small-group market or large-group market to employers only through one or more associations, a reference to "policyholder" is deemed, with respect to coverage provided to

an employer member of the association, to include a reference to such employer.

Section 13. Section 627.6574, Florida Statutes, 1996 Supplement, is amended to read:

627.6574 Maternity care.--

(1) Any group, blanket, or franchise policy of health insurance that provides coverage for maternity care must ~~shall~~ also cover the services of certified nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed under ss. 383.30-383.335.

(2) Any group, blanket, or franchise policy of health insurance that provides maternity and newborn coverage may not limit coverage for the length of a maternity and newborn stay in a hospital or for followup care outside of a hospital to any time period that is less than that determined to be medically necessary, in accordance with prevailing medical standards and consistent with ~~proposed 1996~~ guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists ~~as proposed on May 1, 1996~~, by the treating obstetrical care provider or the pediatric care provider.

(3) ~~Nothing in~~ This section does not affect ~~affects~~ any agreement between an insurer and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and this section does not prohibit ~~or prohibits~~ appropriate utilization review or case management by an insurer.

(4) Any group, blanket, or franchise policy of health insurance that provides coverage, benefits, or services for maternity or newborn care must provide coverage for

postdelivery care for a mother and her newborn infant. The postdelivery care must include a postpartum assessment and newborn assessment and may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards.

(5) An insurer subject to subsection (1) shall communicate active case questions and concerns regarding postdelivery care directly to the treating physician or hospital in written form, in addition to other forms of communication. Such insurers shall also use a process that ~~which~~ includes a written protocol for utilization review and quality assurance.

(6) An insurer subject to subsection (1) may not:

(a) Deny to a mother or her newborn infant eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy for the purpose of avoiding the requirements of this section.

(b) Provide monetary payments or rebates to a mother to encourage the mother to accept less than the minimum protections available under this section.

(c) Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to an individual participant or beneficiary in accordance with this section.

(d) Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide

care to an individual participant or beneficiary in a manner inconsistent with this section.

(e) Subject to paragraph (7)(c), restrict benefits for any portion of a period within a hospital length of stay required under subsection (2) in a manner that is less favorable than the benefits provided for any preceding portion of such stay.

(7)(a) This section does not require a mother who is a participant or beneficiary to:

1. Give birth in a hospital.

2. Stay in the hospital for a fixed period of time following the birth of her infant.

(b) This section does not apply with respect to any health insurance coverage that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant.

(c) This section does not prevent a policy from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant, except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (2) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

Section 14. Subsection (1), paragraph (a) of subsection (3), and subsection (11) of section 627.6675, Florida Statutes, are amended, to read:

627.6675 Conversion on termination of eligibility.--Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services

plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." An employee or member shall not be entitled to a converted policy if termination of his insurance under the group policy occurred because he 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 ~~31~~ days after termination of the group policy.

(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 age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. However, the premium for the converted policy may not exceed 200 percent of the standard risk rate as established by the Florida Comprehensive Health Association,

adjusted for differences in benefit levels and structure between the converted policy and the policy offered by the Florida Comprehensive Health Association.

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

Section 15. (1) The changes made by this act to section 627.6675, Florida Statutes, apply to conversion policies offered, sold, issued, or renewed on or after January 1, 1998.

(2) An individual who was entitled on July 1, 1997, to a conversion policy under section 627.6675, Florida Statutes, shall be entitled on January 1, 1998, to a conversion policy meeting the requirements of section 627.6675, Florida Statutes, as amended by this act. Such an individual shall remain entitled to a conversion policy for the same period of time after January 1, 1998, as the individual would have remained eligible after July 1, 1997, including the condition that application for coverage be made within 63 days of the termination of the group coverage.

Section 16. Subsections (3), (5), and (7), and paragraph (b) of subsection (11) of section 627.6699, Florida Statutes, 1996 Supplement, are amended, and present subsections (14) and (15) of that section are redesignated as subsections (15) and (16), respectively, and a new subsection (14) is added to that section, to read:

627.6699 Employee Health Care Access Act.--

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

(a) "Actuarial certification" means a written statement, by a member of the American Academy of Actuaries or another person acceptable to the department, that a small employer carrier is in compliance with subsection (6), based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans.

(b) "Basic health benefit plan" and "standard health benefit plan" mean low-cost health care plans developed pursuant to subsection (12).

(c) "Board" means the board of directors of the program.

(d) "Carrier" means a person who provides health benefit plans in this state, including an authorized insurer, a health maintenance organization, a multiple-employer welfare arrangement, or any other person providing a health benefit plan that is subject to insurance regulation in this state. However, the term does not include a multiple-employer welfare arrangement, which multiple-employer welfare arrangement operates solely for the benefit of the members or the members and the employees of such members, and was in existence on January 1, 1992.

(e) "Case management program" means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the carrier.

(f) "Creditable coverage" has the same meaning ascribed in s. 627.6561.

(g)~~(f)~~ "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the health benefit plan covering that employee.

(h)~~(g)~~ "Eligible employee" means an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements or other requirements of this act. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.

(i)~~(h)~~ "Established geographic area" means the county or counties, or any portion of a county or counties, within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(j)~~(i)~~ "Guaranteed-issue basis" means an insurance policy that must be offered to an employer, employee, or dependent of the employee, regardless of health status, preexisting conditions, or claims history.

(k)~~(j)~~ "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(l)~~(k)~~ "Late enrollee" means an eligible employee or dependent as defined under s. 627.6561(1)(b).~~who requests enrollment in a health benefit plan of a small employer after the initial enrollment period provided under the terms of the plan has ended. However, an eligible employee or dependent is not considered a late enrollee if the enrollee:~~

~~1. Was covered under another employer health benefit plan at the time the individual was eligible to enroll; lost coverage under that plan as a result of termination of employment, the termination of the other plan's coverage, the death of a spouse, or divorce; and requests enrollment within 30 days after coverage under that plan was terminated;~~

~~2. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or~~

~~3. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.~~

(m)~~(l)~~ "Limited benefit policy or contract" means a policy or contract that provides coverage for each person insured under the policy for a specifically named disease or diseases, a specifically named accident, or a specifically named limited market that fulfills an experimental or reasonable need, such as the small group market.

(n)~~(m)~~ "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j)~~(k)~~.

(o)~~(n)~~ "Participating carrier" means any carrier that issues health benefit plans in this state except a small employer carrier that elects to be a risk-assuming carrier.

(p)~~(o)~~ "Plan of operation" means the plan of operation of the program, including articles, bylaws, and operating rules, adopted by the board under subsection (11).

~~(p) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to:~~

~~1. A condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received as to that condition; or~~

~~2. Pregnancy existing on the effective date of coverage.~~

(q) "Program" means the Florida Small Employer Carrier Reinsurance Program created under subsection (11).

~~(r) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:~~

~~1. An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health plan; or~~

~~2. An individual health insurance policy, including coverage issued by a health maintenance organization, a fraternal benefit society, or a multiple-employer welfare arrangement, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan,~~

~~provided that such policy has been in effect for a period of at least 1 year.~~

(r)~~(s)~~ "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(s)~~(t)~~ "Reinsuring carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection (11).

(t)~~(u)~~ "Risk-assuming carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection (10).

(u)~~(v)~~ "Self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years.

(v)~~(w)~~ "Small employer" means, in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, ~~and that, on at least 50 percent of its working days during the preceding calendar quarter,~~ employed an average of at least one but not more than 50 eligible employees on business days during the preceding calendar year, and employed at least one employee on the first day of the plan year~~, the majority of whom were employed within this state~~. ~~In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for~~

~~purposes of state taxation, may be considered a single employer.~~ For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.

(w)~~(x)~~ "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers.

(5) AVAILABILITY OF COVERAGE.--

(a) Beginning January 1, 1993, every small employer carrier issuing new health benefit plans to small employers in this state must, as a condition of transacting business in this state, offer to eligible small employers a standard health benefit plan and a basic health benefit plan. Such a small employer carrier shall issue a standard health benefit plan or a basic health benefit plan to every eligible small employer that elects to be covered under such plan, agrees to make the required premium payments under such plan, and to satisfy the other provisions of the plan.

(b) In the case of a small employer carrier which does not, on or after January 1, 1993, offer coverage but which does, on or after January 1, 1993, renew or continue coverage in force, such carrier shall be required to provide coverage to newly eligible employees and dependents on the same basis as small employer carriers which are offering coverage on or after January 1, 1993.

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Beginning January 1, 1994, offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 3 to 50 eligible

employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

2. Beginning April 15, 1994, offer and issue basic and standard small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with one or two eligible employees, which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

3. Offer to eligible small employers the standard and basic health benefit plans. This subparagraph does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.

(d) A small employer carrier must file with the department, in a format and manner prescribed by the committee, a standard health care plan and a basic health care plan to be used by the carrier.

(e) The department at any time may, after providing notice and an opportunity for a hearing, disapprove the continued use by the small employer carrier of the standard or basic health benefit plan on the grounds that such plan does not meet the requirements of this section.

(f) Except as provided in paragraph (g), a health benefit plan covering small employers~~, issued or renewed on or after October 1, 1992,~~ must comply with preexisting condition provisions specified in s. 627.6561 or, for health maintenance contracts, in s. 641.31071.~~the following provisions:~~

~~1. Preexisting condition provisions must not exclude coverage for a period beyond 12 months following the individual's effective date of coverage; and~~

~~2. Preexisting condition provisions may relate only to:~~

~~a. Conditions that, during the 6-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or~~

~~b. A pregnancy existing on the effective date of coverage.~~

(g) A health benefit plan covering small employers, issued or renewed on or after January 1, 1994, must comply with the following conditions:

1. All health benefit plans must be offered and issued on a guaranteed-issue basis, except that benefits purchased through riders as provided in paragraph (c) may be medically underwritten for the group, but may not be individually underwritten as to the employees or the dependents of such employees. Additional or increased benefits may only be offered by riders.

2. The provisions of paragraph (f) apply to health benefit plans issued to a small employer who has two ~~three~~ or more eligible employees, and to health benefit plans that are

issued to a small employer who has fewer than two ~~three~~ eligible employees and that cover an employee who has had creditable ~~qualifying previous~~ coverage continually to a date not more than 63 ~~30~~ days before the effective date of the new coverage.

~~3. With respect to any employee or dependent excluded from coverage due to disease or medical condition or whose coverage had been restricted for certain diseases or medical conditions prior to January 1, 1993, and who has continued to be an eligible employee or dependent as of April 1, 1993, an open enrollment period shall be provided for a 90-day period beginning within 60 days following the effective date of this act, during which period any such employee or dependent shall be entitled to be included within coverage and/or issued coverage without restrictions for certain diseases or medical conditions.~~

3.~~4.~~ For health benefit plans that are issued to a small employer who has fewer than two ~~three~~ employees and that cover an employee who has not been continually covered by creditable ~~qualifying previous~~ coverage within 63 ~~30~~ days before the effective date of the new coverage, preexisting condition provisions must not exclude coverage for a period beyond 24 months following the employee's effective date of coverage and may relate only to:

a. Conditions that, during the 24-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(h) All health benefit plans issued under this section must comply with the following conditions:

1. ~~In determining whether a preexisting condition provision applies to an eligible employee or dependent, credit must be given for the time the person was covered under qualifying previous coverage if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under the plan.~~

~~2. Late enrollees may be excluded from coverage only for the greater of 18 months or the period of an 18-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months after the effective date of coverage.~~ For employers who have fewer than <u>two</u> ~~three~~ employees, a late enrollee may be excluded from coverage for no longer than 24 months if he was not covered by <u>creditable</u> ~~qualifying previous~~ coverage continually to a date not more than <u>63</u> ~~30~~ days before the effective date of his new coverage.

<u>2.</u>~~3.~~ Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier. A small employer carrier may vary application of minimum participation

requirements and minimum employer contribution requirements only by the size of the small employer group.

3.~~4.~~ In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider as an eligible employee employees or dependents who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met, except a small employer carrier may count eligible employees who have coverage under another health plan that is sponsored by that employer.

4.~~5.~~ A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

5.~~6.~~ If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

6.~~7.~~ A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

7.~~8.~~ An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

(i)1. A small employer carrier need not offer coverage or accept applications pursuant to paragraph (a):

a. To a small employer if the small employer is not physically located in an established geographic service area of the small employer carrier, provided such geographic service area shall not be less than a county;

b. To an employee if the employee does not work or reside within an established geographic service area of the small employer carrier; or

c. To a small employer group within an area in which the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the department, that it cannot, within its network of providers, deliver service adequately to the members of such groups because of obligations to existing group contract holders and enrollees.

2. A small employer carrier that cannot offer coverage pursuant to sub-subparagraph 1.c. may not offer coverage in the applicable area to new cases of employer groups having more than 50 eligible employees or small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the department that it has regained its ability to deliver services to small employer groups.

3.a. A small employer carrier may deny health insurance coverage in the small-group market if the carrier has demonstrated to the department that:

(I) It does not have the financial reserves necessary to underwrite additional coverage; and

(II) It is applying this sub-subparagraph uniformly to all employers in the small-group market in this state consistent with this section and without regard to the claims experience of those employers and their employees and their dependents or any health-status-related factor that relates to such employees and dependents.

b. A small employer carrier, upon denying health insurance coverage in connection with health benefit plans in accordance with sub-subparagraph a., may not offer coverage in connection with group health benefit plans in the small-group market in this state for a period of 180 days after the date such coverage is denied or until the insurer has demonstrated to the department that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later. The department may provide for the application of this sub-subparagraph on a service-area-specific basis. ~~The department shall, by rule, require each small employer carrier to report, along with its annual statement for calendar year 1992, its gross annual premiums for health benefit plans issued to small employers during calendar year 1992, including both new and renewal business. No later than May 1, 1993, the department shall calculate each carrier's percentage of all small employer carrier premiums for calendar year 1992.~~

~~b. During calendar year 1993, a small employer carrier may elect to not offer coverage or accept applications pursuant to paragraph (a):~~

~~(I) After its gross annual premiums for all small employer group health benefit plans written or renewed for that year, excluding blocks of business assumed from other~~

~~carriers, exceeds 25 percent of the total of all small employer carrier premiums for calendar year 1992; or~~

~~(II) After its gross annual premiums for small employer group health benefit plans written or renewed for that year, excluding blocks of business assumed from other carriers, exceeds three times that carrier's gross annual premiums for small employer group health benefit plans written or renewed during calendar year 1992, if its share of small employer carrier business for calendar year 1992 calculated under sub-subparagraph a. exceeds 2 percent.~~

~~c. The election under sub-subparagraph b. is effective upon filing of a notice of election with the department. The department may, within 30 days after the filing of the notice, disapprove the election if it finds that the carrier does not meet the criteria of sub-subparagraph b. If the department disapproves the election, the carrier is subject to paragraph (a), effective on the date of such disapproval.~~

~~d. An election under sub-subparagraph b. expires on December 31, 1993, or upon revocation, whichever occurs earlier.~~

~~e. A carrier may file with the department a notice revoking its election under sub-subparagraph b. after the election has been in effect for at least 3 months. Such revocation of an election takes effect on the first day of the calendar quarter following the filing of such notice with the department and subjects the carrier to all requirements of paragraph (a).~~

~~f. While a carrier's election under sub-subparagraph b. is in effect, the carrier may not write any further small employer group health benefit plans.~~

~~g. A carrier may not make an election under sub-subparagraph b. more than once.~~

4.~~a.~~ Beginning in 1994, the department shall, by rule, require each small employer carrier to report, on or before March 1 of each year, its gross annual premiums for all health benefit plans issued to small employers during the previous calendar year, and also to report its gross annual premiums for new, but not renewal, standard and basic health benefit plans subject to this section issued during the previous calendar year. No later than May 1 of each year, the department shall calculate each carrier's percentage of all small employer group health premiums for the previous calendar year and shall calculate the aggregate gross annual premiums for new, but not renewal, standard and basic health benefit plans for the previous calendar year.

~~b. Beginning with calendar year 1994, a small employer carrier may elect to not offer coverage or accept applications pursuant to paragraph (a):~~

~~(I) After its gross annual premiums for new, but not renewal, health benefit plans subject to this section for that year, excluding blocks of business assumed from other carriers, exceeds 25 percent of the aggregate gross annual premiums for new, but not renewal, health benefit plans subject to this section for the previous calendar year as determined under sub-subparagraph a.; or~~

~~(II) After its gross annual premiums for new, but not renewal, health benefit plans subject to this section, excluding blocks of business assumed from other carriers, exceeds three times the carrier's percentage of all small employer group premiums for the previous calendar year as determined under sub-subparagraph a., multiplied by the~~

~~aggregate gross annual premiums for new health benefit plans for the previous year as determined under sub-subparagraph a. A carrier may not exercise this option unless its percentage of all small employer group premiums for the previous calendar year as determined under sub-subparagraph a. exceeds 2 percent.~~

~~c. The election under sub-subparagraph b. is effective upon filing of a notice of election with the department. The department may, within 30 days after the filing of the notice, disapprove the election if it finds that the carrier does not meet the criteria of sub-subparagraph b. If the department disapproves the election, the carrier is subject to paragraph (a), effective on the date of such disapproval.~~

~~d. An election under sub-subparagraph b. expires on December 31 of the year in which the election was made or upon revocation, whichever occurs earlier.~~

~~e. A carrier may file with the department a notice revoking its election under sub-subparagraph b. after the election has been in effect for at least 3 months. Such revocation of an election takes effect on the first day of the calendar quarter following the filing of such notice with the department and subjects the carrier to all requirements of paragraph (a).~~

~~f. While a carrier's election under sub-subparagraph b. is in effect, the carrier may not write any further new small employer group health benefit plans during the remainder of the calendar year.~~

~~g. A carrier may not make an election under sub-subparagraph b. more than once in any calendar year.~~

~~(j) A small employer carrier may not offer coverage or accept applications pursuant to paragraph (a) if the~~

~~department finds that the acceptance of an application or applications would endanger the financial condition of the small employer carrier or endanger the interests of the small employer carrier's insureds.~~

(j)~~(k)~~ The boundaries of geographic areas used by a small employer carrier must coincide with county lines. A carrier may not apply different geographic rating factors to the rates of small employers located within the same county.

(7) RENEWABILITY OF COVERAGE.--~~Except as provided in paragraph (b),~~A health benefit plan that is subject to this section is renewable for all eligible employees and dependents pursuant to s. 627.6561.~~at the option of the small employer, except for any of the following reasons:~~

~~(a) Nonpayment of required premiums;~~

~~(b) Fraud or misrepresentation by the small employer or fraud or misrepresentation by the insured individual or subscriber or the individual's or subscriber's representative;~~

~~(c) Noncompliance with plan provisions;~~

~~(d) Noncompliance with the carrier's minimum participation requirements;~~

~~(e) Noncompliance with the carrier's employer contribution requirements;~~

~~(f) The small employer's termination of the business in which it was engaged on the effective date of the plan; or~~

~~(g) A determination by the department that the continuation of the coverage is not in the best interest of the policyholders or certificateholders or will impair the carrier's ability to meet its contractual obligations. In such instances, the department must assist affected small employers in finding replacement coverage.~~

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(b)1. The program shall operate subject to the supervision and control of the board.

2. Until December 31, 1993, the board shall consist of the commissioner or his designee, who shall serve as chairman, and seven additional members appointed by the commissioner on or before May 1, 1992, as follows:

a. One member shall be a representative of the largest health insurer in the state, as determined by market share as of December 31, 1991.

b. One member shall be a representative of the largest health maintenance organization in the state, as determined by market share as of December 31, 1991.

c. Three members shall be selected from a list of individuals recommended by the Health Insurance Association of America.

d. Two members shall be selected from a list of individuals recommended by the Florida Insurance Council.

The terms of members appointed under this subparagraph expire on December 31, 1993. The appointment of a member under this subparagraph does not preclude the commissioner from appointing the same person to serve as a member under subparagraph 3.

3. Beginning January 1, 1994, the board shall consist of the commissioner or his designee, who shall serve as chairman, and eight additional members who are representatives of carriers and are appointed by the commissioner.~~and serve as follows:~~

4. Effective upon this act becoming a law, the board shall consist of the commissioner or his or her designee, who shall serve as the chairperson, and 13 additional members who

are representatives of carriers and insurance agents and are appointed by the commissioner and serve as follows:

a. The commissioner shall include representatives of small employer carriers subject to assessment under this subsection. If two or more carriers elect to be risk-assuming carriers, the membership must include at least two representatives of risk-assuming carriers; if one carrier is risk-assuming, one member must be a representative of such carrier. At least one member must be a carrier who is subject to the assessments, but is not a small employer carrier. Subject to such restrictions, at least five members shall be selected from individuals recommended by small employer carriers pursuant to procedures provided by rule of the department. Three members shall be selected from a list of health insurance carriers that issue individual health insurance policies. At least two of the three members selected must be reinsuring carriers. Two members shall be selected from a list of insurance agents who are actively engaged in the sale of health insurance.

b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the commissioner shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.

5.~~4.~~ The commissioner may remove a member for cause.

6.~~5.~~ Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.

7.~~6.~~ The commissioner may require an entity that recommends persons for appointment to submit additional lists of recommended appointees.

(14) DISCLOSURE OF INFORMATION.--

(a) In connection with the offering of a health benefit plan to a small employer, a small employer carrier shall:

1. Make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b); and

2. Upon request of the small employer, provide such information.

(b)1. Subject to subparagraph 3., with respect to a small employer carrier that offers a health benefit plan to a small employer, information described in this paragraph is information that concerns:

a. The provisions of such coverage concerning an insurer's right to change premium rates and the factors that may affect changes in premium rates;

b. The provisions of such coverage that relate to renewability of coverage;

c. The provisions of such coverage that relate to any preexisting condition exclusions; and

d. The benefits and premiums available under all health insurance coverage for which the employer is qualified.

2. Information required under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

3. An insurer is not required under this subsection to disclose any information that is proprietary or a trade secret under state law.

Section 17. Section 627.9404, Florida Statutes, 1996 Supplement, is amended to read:

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

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

(2) "Applicant" means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

(b) In the case of a group long-term care insurance policy, the proposed certificateholder.

(3) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(4) "Chronically ill" means certified, within the preceding 12-month period, by a licensed health care practitioner as:

(a) Being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity;

(b) Having a level of disability similar to the level of disability described in paragraph (a); or

(c) Requiring substantial supervision for protection from threats to health and safety due to severe cognitive impairment.

(5)~~(4)~~ "Cognitive impairment" means a deficiency in a person's short-term or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(6) "Licensed health care practitioner" means any physician, nurse licensed under chapter 464, or psychotherapist licensed under chapter 490 or chapter 491, or any individual who meets any requirements prescribed by rule by the Insurance Commissioner.

(7) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual, including the protection from threats to health and safety due to severe cognitive impairment.

(8)~~(5)~~ "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by any of the entities specified in s. 627.9403.

(9) "Qualified long-term care services" means necessary diagnostic, preventive, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(10) "Qualified long-term care insurance policy" means an accident and health insurance contract as defined in s. 7702B(b) of the Internal Revenue Code.

Section 18. Subsection (1) of section 627.9407, Florida Statutes, is amended, and subsection (12) is added to said section, to read:

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

(1) STANDARDS.--The department shall adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures of the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, disclosure of tax consequences, benefit triggers, prohibition against post-claims underwriting, reporting requirements, standards for marketing, and definitions of terms.

(12) DISCLOSURE.--A qualified long-term care insurance policy must include a disclosure statement within the policy and within the outline of coverage that the policy is intended to be a qualified long-term contract. A long-term care

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

Section 19. Subsections (6), (7), (8), (9), and (10) are added to section 627.94071, Florida Statutes, 1996 Supplement, to read:

627.94071 Minimum standards for home health care benefits.--A long-term care insurance policy, certificate, or rider that contains a home health care benefit must meet or exceed the minimum standards specified in this section. The policy, certificate, or rider may not exclude benefits by any of the following means:

(6) Excluding coverage for personal care services provided by a home health aide.

(7) Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.

(8) Requiring that the insured/claimant have an acute condition before home health care services are covered.

(9) Limiting benefits to services provided by Medicare-certified agencies or providers.

(10) Excluding coverage for adult day care services.

Section 20. Subsection (2) of section 627.94072, Florida Statutes, 1996 Supplement, is amended to read:

627.94072 Mandatory offers.--

(2) An insurer that offers a long-term care insurance policy, certificate, or rider in this state must offer a nonforfeiture protection provision providing reduced paid-up insurance, ~~cash surrender values which may include return of premiums,~~ extended term, shortened benefit period, or any other benefits approved by the department if all or part of a premium is not paid. Nonforfeiture benefits and any additional premium for such benefits must be computed in an actuarially sound manner, using a methodology that has been filed with and approved by the department.

Section 21. Section 627.94073, Florida Statutes, 1996 Supplement, is amended to read:

627.94073 Notice of cancellation; grace period.--

(1) A long-term care policy shall provide that the insured is entitled to a grace period of not less than 30 days, within which payment of any premium after the first may be made. The insurer may require payment of an interest charge not in excess of 8 percent per year for the number of days elapsing before the payment of the premium, during which period the policy shall continue in force. If the policy becomes a claim during the grace period before the overdue premium is paid, the amount of such premium or premiums with interest not in excess of 8 percent per year may be deducted in any settlement under the policy.

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

notification of possible lapse in coverage to the policyholder and to a specified secondary addressee if such addressee has been designated in writing by name and address by the policyholder. For policies issued or renewed on or after October 1, 1996, the insurer shall notify the policyholder, at least once every 2 years, of the right to designate a secondary addressee. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse.--I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice." Notice shall be given by first class United States mail, postage prepaid, and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

(3) If a policy is canceled due to nonpayment of premium, the policyholder shall be entitled to have the policy reinstated if, within a period of not less than 5 months ~~150 days~~ after the date of cancellation, the policyholder or any secondary addressee designated pursuant to subsection (2)

demonstrates that the failure to pay the premium when due was unintentional and due to the cognitive impairment or loss of functional capacity of the policyholder. Policy reinstatement shall be subject to payment of overdue premiums. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.The insurer may require payment of an interest charge not in excess of 8 percent per year for the number of days elapsing before the payment of the premium, during which period the policy shall continue in force if the demonstration of cognitive impairment is made. If the policy becomes a claim during the 180-day period before the overdue premium is paid, the amount of the premium or premiums with interest not in excess of 8 percent per year may be deducted in any settlement under the policy.

(4) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate policy through a payroll or pension deduction plan, the requirements in subsection (2) need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

Section 22. Section 627.94074, Florida Statutes, 1996 Supplement, is amended to read:

627.94074 Standards for benefit triggers.--

(1)(a) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on

cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment; or.

(b) If a policy is a qualified long-term care insurance policy, the policy shall condition the payment of benefits on a determination of the insured as being chronically ill; having a level of disability similar, as provided by rule of the Insurance Commissioner, to the insured's ability to perform activities of daily living; or being cognitively impaired as described in paragraph (6)(b). Eligibility for the payment of benefits shall not be more restrictive than requiring a deficiency in the ability to perform not more than three of the activities of daily living.

(2) Activities of daily living shall include at least:

(a) "Bathing," which means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

(b) "Continence," which means the ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

(c) "Dressing," which means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(d) "Eating," which means feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.

(e) "Toileting," which means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(f) "Transferring," which means moving into or out of a bed, chair, or wheelchair.

(3) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in subsection (2) as long as they are defined in the policy.

(4) An issuer of qualified long-term care contracts is limited to considering only the activities of daily living listed in subsection (2).

(5)~~(4)~~ An insurer may use additional provisions, for a policy described in paragraph (1)(a), for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict and are not in lieu of, the requirements contained in subsections (1) and (2).

(6)~~(5)~~ For purposes of this section, the determination of a deficiency due to loss of functional capacity or cognitive impairment shall not be more restrictive than:

(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living, meaning physical assistance, minimal, moderate, or maximal, without which the individual would not be able to perform the activity of daily living; or

(b) ~~If the deficiency is~~ Due to the presence of a cognitive impairment, requiring supervision, including ~~or~~ verbal cueing by another person ~~is needed~~ in order to protect the insured or others.

(7)~~(6)~~ Assessment of activities of daily living and cognitive impairment shall be performed by licensed or

certified professionals, such as physicians, nurses, or social workers.

(8)~~(7)~~ Long-term care insurance policies shall include a clear description of the process for appealing and resolving the benefit determinations.

(9)~~(8)~~ The requirement set forth in this section shall be effective on July 1, 1997, and shall apply as follows:

(a) Except as provided in paragraph (b), the provisions of this section apply to a long-term care policy issued in this state on or after July 1, 1997.

(b) The provisions of this section do not apply to certificates under a group long-term care insurance policy in force on July 1, 1997.

Section 23. Section 641.2018, Florida Statutes, is created to read:

641.2018 High-deductible contracts for medical savings accounts.--Notwithstanding the provisions of this part and part III related to the requirement for providing comprehensive coverage, a health maintenance organization may offer a high-deductible contract to employers that establish medical savings accounts, as defined in section 220(d) of the Internal Revenue Code.

Section 24. Subsection (18) of section 641.31, Florida Statutes, 1996 Supplement, is amended to read:

641.31 Health maintenance contracts.--

(18)(a) Health maintenance contracts that ~~which~~ provide coverage, benefits, or services for maternity care must ~~shall~~ provide, as an option to the subscriber, the services of nurse-midwives and midwives licensed pursuant to chapter 467, and the services of birth centers licensed

pursuant to ss. 383.30-383.335, if such services are available within the service area.

(b) Any health maintenance contract that ~~which~~ provides maternity or newborn coverage may not limit coverage for the length of a maternity or newborn stay in a hospital or for followup care outside of a hospital to any time period that is less than that determined to be medically necessary, in accordance with prevailing medical standards and consistent with ~~proposed 1996~~ guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists ~~as proposed on May 1, 1996~~, by the treating obstetrical care provider or the pediatric care provider.

(c) ~~Nothing in~~ This section does not affect ~~affects~~ any agreement between a health maintenance organization and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and this section does not prohibit ~~or prohibits~~ appropriate utilization review or case management by a health maintenance organization.

(d) Any health maintenance contract that provides coverage, benefits, or services for maternity or newborn care must provide coverage for postdelivery care for a mother and her newborn infant. The postdelivery care must include a postpartum assessment and newborn assessment and may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother, and the performance of any

medically necessary clinical tests and immunizations in keeping with prevailing medical standards.

(e) A health maintenance organization subject to paragraph (b) shall communicate active case questions and concerns regarding postdelivery care directly to the treating physician or hospital in written form, in addition to other forms of communication. Such organization shall also use a process that ~~which~~ includes a written protocol for utilization review and quality assurance.

(f) Any health maintenance organization subject to paragraph (b) may not:

1. Deny to a mother or her newborn infant eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract for the purpose of avoiding the requirements of this section.

2. Provide monetary payments or rebates to a mother to encourage the mother to accept less than the minimum protections available under this section.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to an individual participant or beneficiary in accordance with this section.

4. Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

5. Subject to paragraph (i), restrict benefits for any portion of a period within a hospital length of stay required under paragraph (b) in a manner that is less favorable than the benefits provided for any preceding portion of such stay.

(g) This subsection does not require a mother who is a participant or beneficiary to:

1. Give birth in a hospital.

2. Stay in the hospital for a fixed period of time following the birth of her infant.

(h) This subsection does not apply with respect to any coverage offered by a health maintenance organization that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant.

(i) This subsection does not prevent a health maintenance organization from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn infant under the contract or under health insurance coverage offered in connection with a group health plan, except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under paragraph (b) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

Section 25. Section 641.3102, Florida Statutes, is amended to read:

641.3102 Restrictions upon expulsion or refusal to issue or renew contract.--

(1) A health maintenance organization that offers individual health maintenance contracts in this state may not decline to offer coverage to an eligible individual as required in s. 627.6487.

(2) A health maintenance organization shall not expel or refuse to renew the coverage of, or refuse to enroll, any individual member of a subscriber group on the basis of the

race, color, creed, marital status, sex, or national origin of the subscriber or individual. A health maintenance organization shall not expel or refuse to renew the coverage of any individual member of a subscriber group on the basis of the age, health status, health care needs, or prospective costs of health care services of the subscriber or individual. Nothing in this section shall prohibit a health maintenance organization from requiring that, as a condition of continued eligibility for membership, dependents of a subscriber, upon reaching a specified age, convert to a converted contract or that individuals entitled to have payments for health costs made under Title XVIII of the United States Social Security Act, as amended, be issued a health maintenance contract for Medicare beneficiaries so long as the health maintenance organization is authorized to issue health maintenance contracts for Medicare beneficiaries.

Section 26. Section 641.31071, Florida Statutes, is created to read:

641.31071 Preexisting conditions.--

(1) As used in this section, the term:

(a) "Enrollment date" means, with respect to an individual covered under a group health maintenance organization contract, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period of such enrollment.

(b) "Late enrollee" means, with respect to coverage under a group health maintenance organization contract, a participant or beneficiary who enrolls under the contract other than during:

1. The first period in which the individual is eligible to enroll under the plan.

2. A special enrollment period, as provided under s. 641.31072.

(c) "Waiting period" means, with respect to a group health maintenance organization contract and an individual who is a potential participant or beneficiary under the contract, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the contract.

(2) Subject to the exceptions specified in subsection (4), a health maintenance organization that offers group coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(a) Such exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(b) Such exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date; and

(c) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, as defined in subsection (5), applicable to the participant or beneficiary as of the enrollment date.

(3) Genetic information shall not be treated as a condition described in paragraph (2)(a) in the absence of a diagnosis of the condition related to such information.

(4)(a) Subject to paragraph (b), a health maintenance organization that offers group coverage may not impose any preexisting condition exclusion in the case of:

1. An individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of such adoption or placement for adoption.

3. Pregnancy.

(b) Subparagraphs (a)1. and 2. do not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(5)(a) The term, "creditable coverage," means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan, as defined in s. 2791, of the Public Health Service Act.

2. Health insurance coverage consisting of medical care, provided directly, through insurance or reimbursement or otherwise, and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer.

3. Medicare, part A or part B of Title XVIII of the Social Security Act, as amended.

4. Medicaid, Title XIX of the Social Security Act, as amended, other than children eligible solely for the federal program for the distribution of pediatric vaccines.

5. Chapter 55 of Title 10, United States Code.

6. A medical care program of the Indian Health Service or of a tribal organization.

7. The Florida Comprehensive Health Association or another state health benefit risk pool.

8. A health plan offered under chapter 89 of Title 5, United States Code.

9. A public health plan as defined by rule of the department. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

10. A health benefit plan under s. 5(e) of the Peace Corps Act (22 United States Code, 2504(e)).

(b) Creditable coverage does not include coverage that consists solely of one or more or any combination thereof of the following excepted benefits:

1. Coverage only for accident, or disability income insurance, or any combination thereof.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Workers' compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit-only insurance.

7. Coverage for onsite medical clinics.

8. Other similar insurance coverage, specified in rules adopted by the department, under which benefits for medical care are secondary or incidental to other insurance benefits. To the greatest extent possible, such rules must be

consistent with regulations adopted by the United States Department of Health and Human Services.

(c) The following benefits do not constitute creditable coverage, if offered separately:

1. Limited scope dental or vision benefits.

2. Benefits or long-term care, nursing home care, home health care, community-based care, or any combination of these.

3. Such other similar, limited benefits as are specified in rules adopted by the department. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(d) The following benefits do not constitute creditable coverage if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness.

2. Hospital indemnity or other fixed indemnity insurance.

(e) Benefits provided through Medicare supplemental health insurance, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan are not considered creditable coverage if offered as a separate insurance policy.

(6)(a) A period of creditable coverage may not be counted, with respect to enrollment of an individual under a group health maintenance organization contract, if, after such period and before the enrollment date, there was a 63-day

period during all of which the individual was not covered under any creditable coverage.

(b) Any period during which an individual is in a waiting period, or in an affiliation period as defined in subsection (9), for any coverage under a group health maintenance organization contract may not be taken into account in determining the 63-day period under paragraph (a) or paragraph (4)(b).

(7)(a) Except as otherwise provided under paragraph (b), a health maintenance organization shall count a period of creditable coverage without regard to the specific benefits covered under the period.

(b) A health maintenance organization may elect to count as creditable coverage, coverage of benefits within each of several classes or categories of benefits specified in rules adopted by the department rather than as provided under paragraph (a). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election, a health maintenance organization shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(c) In the case of an election with respect to a health maintenance organization under paragraph (b), the organization shall:

1. Prominently state in 10-point type or larger in any disclosure statements concerning the contract, and state to each enrollee at the time of enrollment under the contract, that the organization has made such election; and

2. Include in such statements a description of the effect of this election.

(8)(a) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in this subsection or in such other manner as may be specified in rules adopted by the department.

(b) A health maintenance organization that offers group coverage shall provide the certification described in paragraph (a):

1. At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision or continuation pursuant to s. 627.6692.

2. In the case of an individual becoming covered under a COBRA continuation provision or pursuant to s. 627.6692, at the time the individual ceases to be covered under such a provision.

3. Upon the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in this paragraph.

The certification under subparagraph 1. may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision or continuation pursuant to s. 627.6692.

(c) The certification is a written certification of:

1. The period of creditable coverage of the individual under the contract and the coverage, if any, under such COBRA continuation provision or continuation pursuant to s. 627.6692; and

2. The waiting period, if any, imposed with respect to the individual for any coverage under such contract.

(d) In the case of an election described in subsection (7) by a health maintenance organization, if the organization enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual, as provided by this subsection:

1. Upon request of such health maintenance organization, the insurer or health maintenance organization that issued the certification provided by the individual shall promptly disclose to such requesting organization information on coverage of classes and categories of health benefits available under such insurer's or health maintenance organization's plan or coverage.

2. Such insurer or health maintenance organization may charge the requesting organization for the reasonable cost of disclosing such information.

(e) The department shall adopt rules to prevent an insurer's or health maintenance organization's failure to provide information under this subsection with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health maintenance organization coverage.

(9)(a) A health maintenance organization may provide for an affiliation period with respect to coverage through the organization only if:

1. No preexisting condition exclusion is imposed with respect to coverage through the organization;

2. The period is applied uniformly without regard to any health-status-related factors; and

3. Such period does not exceed 2 months or 3 months in the case of a late enrollee.

(b) For the purposes of this section, the term "affiliation period" means a period that, under the terms of the coverage offered by the health maintenance organization, must expire before the coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium may be charged to the participant or beneficiary for any coverage during the period. Such period begins on the enrollment date and runs concurrently with any waiting period under the plan.

(c) As an alternative to the method authorized by paragraph (a), a health maintenance organization may address adverse selection in a method approved by the department.

(10)(a) Except as provided in paragraph (b), no period before July 1, 1996, shall be taken into account in determining creditable coverage.

(b) The department shall adopt rules that provide a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for paragraph (a), may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(11) Except as otherwise provided in this subsection, the requirements of paragraph (8)(b) shall apply to events that occur on or after July 1, 1996.

(a) In no case is a certification required to be provided under paragraph (8)(b) prior to June 1, 1997.

(b) In the case of an event that occurs on or after July 1, 1996, and before October 1, 1996, a certification is not required to be provided under paragraph (8)(b), unless an individual, with respect to whom the certification is required to be made, requests such certification in writing.

(12) In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before July 1, 1996:

(a) The individual may present evidence of other creditable coverage in order to establish the period of creditable coverage.

(b) A health maintenance organization is not subject to any penalty or enforcement action with respect to the organization's crediting, or not crediting, such coverage if the organization has sought to comply in good faith with applicable provisions of this section.

(13) For purposes of subsection (10), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of this section may not be treated as a termination of such collective bargaining agreement.

Section 27. Section 641.31072, Florida Statutes, is created to read:

641.31072 Special enrollment periods.--

(1) A health maintenance organization that issues a group health insurance policy shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the contract, or a dependent of such an employee if the dependent is eligible but not enrolled for coverage under such terms, to enroll for coverage under the terms of the contract if each of the following conditions is met:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent. For the purpose of this section, the terms "group health plan"

and "health insurance coverage" have the same meaning ascribed in s. 2791 of the Public Health Service Act.

(b) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health maintenance organization, if applicable, required such a statement at such time and provided the employee with notice of such requirement and the consequences of such requirement at such time.

(c) The employee's or dependent's coverage described in paragraph (a):

1. Was under a COBRA continuation provision or continuation pursuant to s. 627.6692, and the coverage under such provision was exhausted; or

2. Was not under such a provision and the coverage was terminated as a result of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of employer contributions toward such coverage.

(d) Under the terms of the contract, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (c)1., or termination or employer contribution described in subparagraph (c)2.

(2) For dependent beneficiaries, if:

(a) A group health maintenance organization contract makes coverage available with respect to a dependent of an individual;

(b) The individual is a participant under the contract, or has met any waiting period applicable to becoming a participant under the contract, and is eligible to be enrolled under the contract but for a failure to enroll during a previous enrollment period; and

(c) A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the health maintenance organization shall provide for a dependent special enrollment period described in subsection (3) during which the person, or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(3) A dependent special enrollment period under subsection (2) shall be a period of not less than 30 days and shall begin on the later of:

(a) The date dependent coverage is made available; or

(b) The date of the marriage, birth, or adoption or placement for adoption described in subsection (2)(c).

(4) If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(a) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.

(b) In the case of a dependent's birth, as of the date of such birth.

(c) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

Section 28. Section 641.31073, Florida Statutes, is created to read:

641.31073 Prohibiting discrimination against individual participants and beneficiaries based on health status.--

(1) Subject to subsection (2), a health maintenance organization that offers group health insurance coverage may not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the contract based on any of the following health-status-related factors in relation to the individual or a dependent of the individual:

(a) Health status.

(b) Medical condition, including physical and mental illnesses.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence.

(h) Disability.

(2) Subsection (1) does not:

(a) Require a health maintenance organization to provide particular benefits other than those provided under the terms of such plan or coverage.

(b) Prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) For purposes of subsection (1), rules for eligibility to enroll under a contract include rules for defining any applicable affiliation or waiting periods of enrollment.

(4)(a) A health maintenance organization that offers health insurance coverage may not require any individual, as a condition of enrollment or continued enrollment under the contract, to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled under the contract on the basis of any health-status-related factor in relation to the individual or to an individual enrolled under the contract as a dependent of the individual.

(b) This subsection does not:

1. Restrict the amount that an employer may be charged for coverage under a group health insurance contract.

2. Prevent a health maintenance organization offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Section 29. Section 641.31074, Florida Statutes, is created to read:

641.31074 Guaranteed renewability of coverage.--

(1) Except as otherwise provided in this section, a health maintenance organization that issues a group health

insurance contract must renew or continue in force such coverage at the option of the contract holder.

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

(a) The contract holder has failed to pay premiums or contributions in accordance with the terms of the contract or the health maintenance organization has not received timely premium payments.

(b) The contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract.

(c) The contract holder has failed to comply with a material provision of the plan which relates to rules for employer contributions or group participation.

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

(e) There is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the health maintenance organization or in the area in which the health maintenance organization is authorized to do business and, in the case of the small-group market, the organization would deny enrollment with respect to such plan under s. 627.6699(5)(i).

(f) In the case of coverage that is made available only through one or more bona fide associations as defined in s. 627.6571(5), the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this

paragraph uniformly without regard to any health-status-related factor that relates to any covered individuals.

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

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

2. The health maintenance organization offers to each contract holder provided coverage of this form in such market the option to purchase all other health insurance coverage currently being offered by the health maintenance organization in such market; and

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

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

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

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

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

(4) At the time of coverage renewal, a health maintenance organization may modify the coverage for a product offered:

(a) In the large-group market; or

(b) In the small-group market if, for coverage that is available in such market other than only through one or more bona fide associations, as defined in s. 627.6571(5), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product.

(5) In applying this section in the case of health insurance coverage that is made available by a health maintenance organization in the small-group market or large-group market to employers only through one or more associations, a reference to "contract holder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

Section 30. Section 641.3921, Florida Statutes, is amended to read:

641.3921 Conversion on termination of eligibility.--A group health maintenance contract delivered or issued for delivery in this state by a health maintenance organization shall provide that a subscriber or covered dependent whose coverage under the group health maintenance contract has been terminated for any reason, including discontinuance of the group health maintenance contract in its entirety or with respect to a covered class, and who has been continuously covered under the group health maintenance contract, and under any group health maintenance contract providing similar benefits which it replaces, for at least 3 months immediately prior to termination, shall be entitled to have issued to him by the health maintenance organization a health maintenance contract, hereafter referred to as a "converted contract." A subscriber or covered dependent shall not be entitled to have a converted contract issued to him if termination of his coverage under the group health maintenance contract occurred for any of the following reasons:

(1) Failure to pay any required premium or contribution unless such nonpayment of premium was due to acts of an employer or person other than the individual;

(2) Replacement of any discontinued group coverage by similar group coverage within 31 days;

(3) Fraud or material misrepresentation in applying for any benefits under the health maintenance contract;

(4) Disenrollment for cause. When the requirements of paragraphs (a), (b), and (c) have been met, a health maintenance organization may disenroll a subscriber for cause if the subscriber's behavior is disruptive, unruly, abusive,

or uncooperative to the extent that his continuing membership in the organization seriously impairs the organization's ability to furnish services to either the subscriber or other subscribers.

(a) Effort to resolve the problem. The organization must make a serious effort to resolve the problem presented by the subscriber, including the use or attempted use of subscriber grievance procedures.

(b) Consideration of extenuating circumstances. The organization must ascertain that the subscriber's behavior does not directly result from an existing medical condition.

(c) Documentation. The organization must document the problems, efforts, and medical conditions as described in this subsection;

(5) Willful and knowing misuse of the health maintenance organization identification membership card by the subscriber;

(6) Willful and knowing furnishing to the organization by the subscriber of incorrect or incomplete information for the purpose of fraudulently obtaining coverage or benefits from the organization; or

(7) The subscriber has left the geographic area of the health maintenance organization with the intent to relocate or establish a new residence outside the organization's geographic area.

Section 31. Section 641.3922, Florida Statutes, is amended to read:

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

(1) TIME LIMIT.--Written application for the converted contract shall be made and the first premium paid to the health maintenance organization not later than 63 ~~31~~ days after such termination.

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

(3) CONVERSION PREMIUM.--The premium for the converted contract shall be determined in accordance with premium rates applicable to the age and class of risk of each person to be covered under the converted contract and to the type and amount of coverage provided. However, the premium for the converted contract may not exceed 200 percent of the standard risk rate, as established by the Florida Comprehensive Health Association and adjusted for differences in benefit levels and structure between the converted policy and the policy offered by the Florida Comprehensive Health Association. The mode of payment for the converted contract shall be quarterly or more frequently at the option of the organization, unless otherwise mutually agreed upon between the subscriber and the organization.

(4) EFFECTIVE DATE OF COVERAGE.--The effective date of the converted contract shall be the day following the termination of coverage under the group health maintenance contract. However, until application is made and the first premium is paid, the health maintenance organization may charge the subscriber, on a fee-for-service basis, for any services rendered to the subscriber after the date in which the subscriber ceases to be eligible under the group health maintenance contract. When application is made and the first premium is paid, the organization shall reimburse the

subscriber for any payment made by the subscriber for covered services under the converted contract.

(5) SCOPE OF COVERAGE.--The converted contract shall cover the subscriber or dependents who were covered by the group health maintenance contract on the date of termination of coverage. At the option of the health maintenance organization, a separate converted contract may be issued to cover any dependent.

(6) OPTIONAL COVERAGE.--The health maintenance organization shall not be required to issue a converted contract covering any person if such person is or could be covered by Medicare, Title XVIII of the Social Security Act, as added by the Social Security Amendments of 1965, or as later amended or superseded. Furthermore, the health maintenance organization shall not be required to issue a converted health maintenance contract covering any person if:

(a)1. The person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

2. The person is eligible for similar benefits, whether or not covered therefor, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

3. Similar benefits are provided for or are available to the person pursuant to or in accordance with the requirements of any state or federal law; and

(b) A converted health maintenance contract may include a provision whereby the health maintenance organization may request information, in advance of any

premium due date of a health maintenance contract, of any person covered thereunder as to whether:

1. He is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

2. He is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

3. Similar benefits are provided for or are available to the person pursuant to or in accordance with the requirements of any state or federal law.

(7) REASONS FOR CANCELLATION; TERMINATION.--The converted health maintenance contract must contain a cancellation or nonrenewability clause providing that the health maintenance organization may refuse to renew the contract of any person covered thereunder, but cancellation or nonrenewal must be limited to one or more of the following reasons:

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

(b) Eligibility of the covered person for coverage under Medicare, Title XVIII of the Social Security Act, as added by the Social Security Amendments of 1965, or as later amended or superseded, or under any other state or federal law providing for benefits similar to those provided by the converted health maintenance contract, except for Medicaid, Title XIX of the Social Security Act, as amended by the Social

Security Amendments of 1965, or as later amended or superseded.

(c) Disenrollment for cause, after following the procedures outlined in s. 641.3921(4).

(d) Willful and knowing misuse of the health maintenance organization identification membership card by the subscriber or the willful and knowing furnishing to the organization by the subscriber of incorrect or incomplete information for the purpose of fraudulently obtaining coverage or benefits from the organization.

(e) Failure, after notice, to pay required premiums.

(f) The subscriber has left the geographic area of the health maintenance organization with the intent to relocate or establish a new residence outside the organization's geographic area.

(g) A dependent of the subscriber has reached the limiting age under the converted contract, subject to subsection (12); but the refusal to renew coverage shall apply only to coverage of the dependent, except in the case of handicapped children.

(h) A change in marital status that makes a person ineligible under the original terms of the converted contract, subject to subsection (12).

(8) BENEFITS OFFERED.--A health maintenance organization shall not be required to issue a converted contract which provides benefits in excess of those provided under the group health maintenance contract from which conversion is made. The converted health maintenance contract shall meet the requirements of law pertaining to health maintenance contracts and shall include a level of benefits for minimum services which is substantially similar to the

level of benefits for these services included in the group health maintenance organization contract from which the termination is made.

(9) PREEXISTING CONDITION PROVISION.--The converted health maintenance contract shall not exclude a preexisting condition not excluded by the group contract. However, the converted health maintenance contract may provide that any coverage benefits thereunder may be reduced by the amount of any coverage or benefits under the group health maintenance contract after the termination of the person's coverage or benefits thereunder. The converted health maintenance contract may also include provisions so that during the first coverage year the coverage or benefits under the converted contract, together with the coverage or benefits under the group health maintenance contract, shall not exceed those that would have been provided had the individual's coverage or benefits under the group contract remained in force and effect.

(10) ALTERNATE PLANS.--<u>The health maintenance organization shall offer a standard health benefit plan as established pursuant to s. 627.6699(12).</u>The health maintenance organization may, at its option, also offer alternative plans for group health conversion in addition to those required by this section, provided any alternative plan is approved by the department or is a converted policy, approved under s. 627.6675 and issued by an insurance company authorized to transact insurance in this state. Approval by the department of an alternative plan shall be based on compliance by the alternative plan with the provisions of this part and the rules promulgated thereunder, applicable

provisions of the Florida Insurance Code and rules promulgated thereunder, and any other applicable law.

(11) RETIREMENT COVERAGE.--In the event that coverage would be continued under the group health maintenance contract on an employee following his retirement prior to the time he is or could be covered by Medicare, he may elect, in lieu of such continuation of group coverage, to have the same conversion rights as would apply had his coverage terminated at retirement by reason of termination of employment or membership.

(12) CONVERSION PRIVILEGE ALLOWED.--Subject to the conditions set forth above, the conversion privilege shall also be available:

(a) To the surviving spouse, if any, at the death of the subscriber, with respect to the spouse and such children whose coverages under the group health maintenance contract terminate by reason of such death, otherwise to each surviving child whose coverage under the group health maintenance contract terminates by reason of such death or, if the group contract provides for continuation of dependents' coverages following the subscriber's death, at the end of such continuation;

(b) To the former spouse whose coverage would otherwise terminate because of annulment or dissolution of marriage, if the former spouse is dependent for financial support;

(c) To the spouse of the subscriber upon termination of coverage of the spouse, while the subscriber remains covered under the group health maintenance contract, by reason of ceasing to be a qualified family member under the group health maintenance contract, with respect to the spouse and

such children whose coverages under the group health maintenance contract terminate at the same time; or

(d) To a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group health maintenance contract or under any converted contract, if a conversion privilege is not otherwise provided above with respect to such termination.

(13) GROUP COVERAGE IN LIEU OF INDIVIDUAL COVERAGE.--The health maintenance organization may elect to provide group health maintenance organization coverage through a group converted contract in lieu of the issuance of an individual converted contract.

(14) NOTIFICATION.--A notification of the conversion privilege shall be included in each health maintenance contract and in any certificate or member's handbook.

Section 32. (1) The changes made by this act to section 641.3922, Florida Statutes, apply to conversion policies offered, sold, issued, or renewed on or after January 1, 1998.

(2) An individual who was entitled on July 1, 1997, to a conversion contract under section 641.3922, Florida Statutes, shall be entitled on January 1, 1998, to a conversion contract meeting the requirements of section 641.3922, Florida Statutes, as amended by this act. Such an individual shall remain entitled to a conversion contract for the same period of time after January 1, 1998, that the individual would have remained eligible after July 1, 1997, including the condition that application for coverage be made within 63 days of the termination of the group coverage.

Section 33. The provisions of this act fulfill an important state interest.

Section 34. Section 627.6576, Florida Statutes, is repealed.

Section 35. (1) Except as provided in subsection (2) and as otherwise provided in this act, the changes made by this act apply to policies or contracts with plan years that begin on or after July 1, 1997.

(2) Except as provided in section 627.6561(9), (10), and (11), and section 641.31071(10), (11), and (12), Florida Statutes, in the case of a group health plan or group health insurance contract maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers which is ratified before this act becomes a law, sections 627.6561, 627.65615, 627.65625, 627.6571, 627.6699, 641.31071, 641.31072, 641.31073, and 641.31074, Florida Statutes, except for section 627.6561(8)(b), Florida Statutes, as amended or created by this act, apply to policies or contracts with plan years that begin on or after the later of:

(a) The date on which the last of any collective bargaining agreement that relates to the plan terminates, determined without regard to any extension thereof, which is agreed to after the date this act becomes a law; or

(b) July 1, 1997.

Section 36. The Banking and Insurance Committee of the Senate and the Health Care Services Committee of the House of Representatives are directed to conduct an interim study to make recommendations to the Legislature for the 1998 Regular Session regarding high cost insureds and potential insureds and how the needs of such insureds are being met under this

act. The Department of Insurance is directed to assist with the provision of information and the gathering of data as required or deemed appropriate by the committees.

Section 37. The amendments in this act to s. 627.6487(3)(b)2., Florida Statutes, and to ss. 627.6675 and 641.3922, Florida Statutes, shall not take effect unless the Health Care Finance Administration of the United States Department of Health and Human Services approves this act as providing an acceptable alternative mechanism, as provided in s. 2744 of the Public Health Service Act, or the act is deemed approved due to the expiration of the time periods prescribed in s. 2744(b)(5) of the Public Health Service Act.

Section 38. Except as otherwise provided in this act, this act shall take effect upon becoming a law.

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HOUSE SUMMARY

Eliminates provisions that would have required out-of-state group policies covering Florida residents to meet the new requirements in the bill that apply to group policies issued in Florida (preexisting condition limitations, special enrollment period, prohibited discrimination against individual members of a group, and guaranteed renewability).

Applies guaranteed renewability requirements for individual health insurance policies to certificates of coverage issued to individuals in Florida as part of a group policy issued to an association outside of Florida.

Applies guarantee-issue requirements that apply to individual health insurers to insurers issuing certificates of coverage issued to individuals in Florida as part of a group policy issued to an association outside of Florida.

Requires that the development of standards for compensation for agents that may be established by the Small Employer Reinsurance Program must follow criteria previously established for small group insurance. Adds two health insurance agent members to the board of the Small Employer Reinsurance Program.

Requires that persons who would have been eligible on July 1, 1997, for an individual conversion policy or HMO conversion contract or guarantee issuance of individual coverage, are eligible on January 1, 1998. Such a person remains eligible for the same length of time after January 1, 1998, that they would have remained eligible after July 1, 1997.

Authorizes HMOs to sell high-deductible contracts to employers that establish medical savings accounts.

Authorizes issuance of federally qualified long-term-care insurance contracts notwithstanding any inconsistent provisions under current Florida law. Requires disclosure to an applicant for a long-term-care policy whether the policy does, or does not, qualify for favorable federal tax treatment. Requires the Department of Insurance to adopt rules that must identify the provisions of current law that are inconsistent with the requirements for a federally qualified long-term-care policy.

Eliminates the 150 percent of standard risk rate cap on premiums for individual conversion policies and reinserts the current 200 percent cap.

Changes the premium cap on HMO conversion contracts from 150 percent to 200 percent of the standard rate.

Provides that the bill fulfill an important state interest.

Provides that conversion law changes (both both group health and group HMO) take effect upon the earlier of approval by the federal Health Care Finance Administration (HCFA) or 90 days after submission to HCFA if HCFA does not disapprove.

Directs the Banking and Insurance Committee of the Senate and the Health Care Committee of the House of Representatives to study how the needs of high cost insureds and potential insureds are met by this act.

Provides technical conforming changes.