HOUSE OF REPRESENTATIVES
AS FURTHER REVISED BY THE COMMITTEE ON
HEALTH CARE SERVICES
FINAL BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 4495 (Passed as CS/CS/SB 1800)

RELATING TO: Health Insurance

SPONSOR(S): Committee on Health Care Services, Rep. Albright & others

COMPANION BILL(S): CS/CS/SB 1800 (s), HB 4535 (c), SB 1324 (c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 10 NAYS 1
(2) CIVIL JUSTICE AND CLAIMS (W/D)
(3) FINANCE AND TAXATION YEAS 10 NAYS 0
(4) GENERAL GOVERNMENT APPROPRIATIONS YEAS 8 NAYS 1
(5)

I. FINAL ACTION STATUS:

Became Law without Governor's Signature; Chapter No. 98-159, L.O.F.

II. SUMMARY:

HB 4495 is designed to correct several “glitches” which occurred as a result of the enactment of CS/SB 1682, which placed into Florida law the provisions of the federal “Health Care Portability and Accountability Act of 1996" (HIPAA). In this regard, this bill does the following three things: Conforms Florida law on group health insurance conversion requirements to the provisions of HIPAA specifically related to renewability; incorporates the provisions of the federal “Mental Health Parity Act of 1996" into the Florida Insurance Code; and clarifies which provisions of Florida’s Long-Term Care Insurance Act apply to limited benefit policies, adds a disclosure statement for limited benefit policies, and conforms the definition of “preexisting condition” for long-term care policies to HIPAA.

In addition, this bill: exempts from legal process, garnishment or attachment moneys paid into or out of a Medical Savings account or Roth IRA; reinstates an exemption from licensure under chapter 395, F.S., (which regulates hospitals) for certain beds of a health maintenance organization (the exemption was inadvertently repealed in a 1996 law); revises minimum standards for Medicare supplement policies to conform to federal law; exempts policies which provide for expanded coverage, written in conjunction with comprehensive medical policies, from the requirements of the small group law (s. 627.6699, F.S.); increases minimum surplus and reporting requirements, and insolvency protection standards for HMOs; expands eligibility for guaranteed availability of individual coverage to include persons with 18 months of prior coverage under an individual plan; and revises requirements relating to establishment of the standard risk rate, notice of conversion policy options, and required bonds for fiscal intermediary organizations.

The fiscal impact on the state for state employee health benefits for employees and dependents in the self-insurance plan related to the “Federal Mental Health Parity Act of 1996" is estimated to be $3 million in fiscal year 1998-99. The fiscal impact of this provision on local governments is indeterminate.

III. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

HIPAA--During the 1997 Session of the Legislature, CS/SB 1682 was enacted into law (Ch. 97-179, Laws of Florida). The purpose of this law was to conform the Florida Insurance Code to the provisions of the federal "Health Insurance Portability and Accountability Act of 1996" (HIPAA). HIPAA requires, effective July 1, 1997, that any person with 18 months of creditable coverage, who does not have access to other specified health insurance, must be given access to an insurance policy. Creditable coverage is defined to include any of the following: a group health plan, individual health insurance, Medicare, Medicaid, the Florida Comprehensive Health Association, and others. However, the last period of creditable coverage must have been under a group health plan.

Federal law permits states to adopt an "acceptable alternative mechanism" for access to health insurance of HIPAA eligibles, which must be approved by HCFA. CS/SB 1682 creates this alternative mechanism as follows:

- For HIPAA eligibles who have access to a conversion policy, the policy serves as access to an insurance policy.
- Insurers offering a conversion policy must offer at least two different policy forms (standard and basic or equivalent).
- The premium rate on HMO conversion policies is capped at 200% of the standard risk rate. (Conversion policies offered by insurers are already capped at this rate.)
- All other HIPAA eligibles must be given access to an individual health insurance policy by any insurer selling individual policies in Florida. Again, at least two policy forms must be offered.
- A "reinsurance pool" is created for individual insurers who wish to reinsure HIPAA eligibles. The pool is closely modeled on the small group reinsurance pool.
- Reinsuring individual health insurers, and then all health insurers (excluding risk assuming carriers) are subject to assessments to fund the reinsurance pool.

In addition, the CS/SB 1682 conformed the Florida Insurance Code to the provisions of HIPAA for individual, group, small group, and HMO policies.

Conversion Policies--Employees and dependents covered under a group health insurance policy may, pursuant to s. 627.6675, F.S., obtain a conversion policy if their eligibility under the group health plan terminates for any reason except for the failure to pay premiums or replacement by an alternative health plan within 63 days of discontinuance of the group coverage. This right to a conversion policy is interpreted as applying at the end of the period of time that the individual elects to continue the group coverage under COBRA or the state continuation law.

Under a conversion policy, group carriers are required to offer the standard policy required to be offered to small employers under s. 627.6699, F.S. The maximum premium for the conversion policy is 200 percent of the "standard risk rate" as developed by the Florida Comprehensive Health Association. The standard risk rate is based on the average rate for individual health insurance and would likely be higher than group rates.

Section 641.3922, F.S., requires an HMO to offer a conversion contract to employees and dependents with a level of benefits similar for those services included in the group HMO contract from which the termination was made, or to offer the standard policy required to be offered to small employers under s. 627.6699, F.S. The same premium cap of 200 percent of the standard risk rate (applicable for converted group insurance policies) applies to an HMO conversion contract.

Conversion policies are required by Florida law (s. 627.6675, F.S.) to be guaranteed renewable, unless certain conditions exist, including:

- Fraud or material misrepresentation in applying for any benefits under the converted policy.

- Eligibility of the insured person for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.

Federal law (HIPAA) requires that policies be guaranteed renewable unless similar conditions exist, except, federal law substitutes the word “intentional” for the word “material” in item A, and federal law does not except item B as a reason for nonrenewal. Therefore, Florida law is currently inconsistent with federal law with regard to guaranteed renewability for HIPAA eligible persons.

Long-term Care Insurance Policies--Florida's Long-Term Care Insurance Act, enacted in 1988, establishes minimum requirements for the content and sale of long-term care insurance. As specified in the purpose section of the Act (s. 627.9402, F.S.), the Legislature sought to protect consumers from unfair trade practices, to facilitate the public's understanding and comparison of long-term care policies, and to provide a climate of flexibility and innovation for the development of long-term care coverage.

Long-term care is generally considered to be assistance with daily living activities for individuals who, because of a physical or mental disability, are unable to function independently. Long-term care ranges from non-medical support services provided in a person's home to intensive medical services and continuous monitoring provided in a skilled nursing facility. As defined in the Long-Term Care Insurance Act, "long-term care insurance" means any insurance policy that provides coverage for "one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital" subject to specified exceptions (s. 627.9404, F.S.) .

In addition to other minimum standards, the Long-Term Care Insurance Act requires a long-term care policy to provide coverage for at least two years of care in a nursing home, and (as further specified by department rule) for at least one year of a lower level of care, such as home health care or adult day care.

The HIPAA establishes a federally qualified long-term care insurance policy which qualifies for favorable tax treatment in certain circumstances. The policy conditions and coverages, including benefit triggers, of this policy are specifically addressed in the federal act. These policies were authorized effective January 1, 1997. In 1996, the Legislature passed amendments to “The Long-Term Care Insurance Act”, in Chapter 96-275, Laws of Florida. This law establishes specific benefit triggers for long-term care insurance policies sold in Florida effective July 1, 1997. These benefit triggers are more

"consumer friendly" than the benefit triggers in the federal law. The federal benefit triggers differ from the Florida triggers in the following ways:

1. The federal trigger conditions the payment of benefits on the inability of the insured to perform at least two activities of daily living without assistance. The Florida trigger conditions the payment of benefits on the inability to perform not more than three activities of daily living without assistance.

2. The federal trigger further conditions the payment of benefits on the insured being chronically ill which is defined as being unable to perform at least two activities of daily living for at least 90 days. The Florida trigger contains no such requirement.

In addition to differences between state and federal law relating to long-term care insurance benefit triggers, there are also differences in the services which must be covered under a policy. State law requires that in order to be designated a “long-term care insurance policy” the policy must provide coverage for care in a nursing home and may not restrict its coverage to care only in a nursing home (see s. 627.9407(3), F.S.). Federal law permits long-term care insurance policies to limit care to a nursing home only. Policies sold in Florida which restrict care to a nursing home or provide only limited benefits like home health care are designated “limited benefit policies”. In Florida, both long-term care policies and limited benefit policies may qualify for favorable federal tax treatment if either policy meets the requirements of s. 7702B of the Internal Revenue Code. Such policies are referred to as “qualified long-term care policies” or “qualified limited benefit policies”.

Mental Health

On September 26, 1996, the Federal Mental Health Parity Act of 1996 (MHPA) was signed into law, and provides for parity in the application of limits for certain mental health benefits. These limits include:

- Aggregate Lifetime Limits--Where a group health plan (or health insurance offered in connection with such a plan) provides both medical and surgical benefits, and mental health benefits:

  No Lifetime Limits. Such plan or coverage may not impose any aggregate lifetime limits on mental health benefits if it does not include such an aggregate lifetime limit on substantially all of its medical and surgical benefits.

  Lifetime Limits. If such a plan or coverage does include an aggregate lifetime limit on substantially all of its medical and surgical benefits, the plan or coverage shall either:

  -- Apply its applicable lifetime limits both to medical and surgical benefits, and to mental health benefits without distinction in the application of the limits between these categories of benefits; or

  -- Not include any aggregate lifetime limit on mental health benefits that is less than the plan’s applicable lifetime limit for substantially all of its medical and surgical benefits.

Different Limits. In the case of a plan or coverage that is not described above and that includes no or different aggregate lifetime limits for different categories of medical and surgical benefits, regulations shall establish rules that calculate an average aggregate lifetime limit for mental health benefits.

- Annual Limits--

  No Limits. Similarly, in the case of a group health plan providing both medical and surgical benefits and mental health benefits, a plan which does not include annual limits on all of its medical and surgical benefits may not impose any annual limit on mental health benefits.

  Annual Limits. A plan which imposes annual limits on its medical and surgical benefits may either:

  -- Apply the applicable annual limit without distinction to both its medical and surgical benefits and its mental health benefits; or

  -- Not include any annual limit on mental health benefits that is less than the applicable annual limit for any other benefits.

  Different Limits. In the case of plans which have no or different annual limits on different categories of medical and surgical benefits, regulations shall establish rules that calculate an average annual limit for mental health benefits.

- Exemptions--

  Small Employer Exemption. The new law does not apply to any plan or coverage of any employer who employed between 2 and 50 employees during the preceding calendar year, and who employed less than 2 employees on the first day of the plan year.

  Increased Cost Exemption. This mental health parity provision shall not apply to a group health plan if the application of the new provision results in an increase in cost of at least 1% under the plan or coverage.

- Separate Application to Each Option Offered--In the case of a plan that offers a participant or beneficiary two or more benefit packages under the plan, the statutory provisions shall be applied separately with respect to each option.

- Construction--

  -- The new law does not require any plan or coverage to provide any mental health benefits.

  -- The new law does not affect any existing terms or conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration or scope of mental health benefits under such plans, except as specifically provided regarding parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

-- The new legislation also does not apply to benefits for substance abuse or chemical dependency.

- Effective Date--

-- The MHPA applies to group health plans beginning on or after January 1, 1998.

-- Under a so-called “sunset” provision, the MHPA requirements do not apply to benefits received on or after September 30, 2001.

- There is no separate effective date for collectively bargained plans.

Florida Law--Section 627.668, F.S., relates to optional coverage for mental and nervous disorders. This law requires every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting group health insurance or providing prepaid health care in this state to make available to the policyholder as part of the application, for an appropriate additional premium, benefits for the necessary care and treatment of mental and nervous disorders.

Under group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors may not be less favorable for mental health than for physical illness generally, except that:

- Inpatient benefits may be limited to not less than 30 days per benefit year as defined in the policy or contract. If inpatient hospital benefits are provided beyond 30 days per benefit year, the durational limits, dollar amounts, and coinsurance factors thereto need not be the same as applicable to physical illness generally.

- Outpatient benefits may be limited to $1,000 for consultations with a licensed mental health professional. If benefits are provided beyond the $1,000 per benefit year, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as applicable to physical illness generally.

- Partial hospitalization benefits must be provided under the direction of a licensed physician. Alcohol rehabilitation programs accredited by the Joint Commission on Accreditation of Hospitals or approved by the state and licensed drug abuse rehabilitation programs must also be qualified providers under this section. In any benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are utilized, the total benefits paid for all such services must not exceed the cost of 30 days of inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond these limits, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.

Although the federal “Mental Health Parity Act of 1996" applies to health insurance policies issued in Florida, the Department of Insurance has no enforcement authority over this law. In addition, the federal law may be in conflict with several of the provisions in state law. In the event of a conflict, federal law prevails.

Medical Savings Accounts (MSA)

As a part of HIPAA, Congress authorized a four year MSA demonstration project, which runs through January 1, 2001. During the four year period, the total number of tax exempt MSAs is limited to 750,000, excluding previously uninsured persons.

An MSA works in the following manner. An individual or employer makes monthly tax-free deposits into a policyholder's MSA, established through a bank or insurance company. The account holder must also have a high-deductible, or catastrophic, health insurance policy that kicks in after the deductible is reached. There are no restrictions on which party covers the cost of the high deductible plan, and employers typically pay 75 percent of the premium.

The allowable deductible ranges from $1,500 to $2,250 for individual coverage, with a maximum of $3,000 in out-of-pocket expenses, and $3,000 to $4,500 - with an out-of-pocket maximum of $5,500 - for families. No more than 65 percent of the deductible for single coverage, and 75 percent of the family deductible, can be deposited in an MSA annually. Although the feds did not establish minimum funding levels, the bank or insurance company that issues the MSA may set its own funding floor.

Money is withdrawn from the MSA - typically by check or debit card, but some plans require individuals to file written claims - to pay for qualified medical expenses, which include vision and dental care, prescription drugs, psychotherapy and physical therapy as well as basic doctor and hospital bills.

At the end of the year, leftover funds can be rolled over into the following year's MSA deposit or left to accumulate a tax-free nest egg. Remaining MSA funds can also be used, without tax penalty, to pay premiums for long-term care insurance, COBRA coverage and health insurance for an individual receiving unemployment compensation. Any funds spent on non-medical, or unqualified expenses are subject to income tax and a 15 percent withdrawal penalty, with the exception of policyholders over age 65, who can make penalty-free withdrawals for non-medical expenses.

Protection from Creditors

Article X, section 4 of the Florida Constitution allows a debtor to exempt a homestead of unlimited value from the claims of creditors as long as it is used as a residence. Specifically, section 4 provides that a person may exempt up to 160 acres if the property is located outside a municipality or up to 1/2 acre if the property is located within a municipality. Courts have held that the purpose of the article X, section 4 exemption is to preserve for an unfortunate citizen and his family certain things necessary to earn a livelihood. Vandiver v. Vincient, 130 So.2d 704 (Fla. 2d DCA 1962). See also In re Owen, 961 F.2d 170 (under the Florida Constitution, homestead property is exempt from forced sale and is insulated from judgment, decree or execution lien).

In addition to the protection from creditors for homestead contained in the Constitution, s. 222.22, F.S., provides that moneys paid into or out of a Florida Prepaid Postsecondary Education Expense trust fund, established pursuant to s. 240.551, F.S., are not liable to attachment, garnishment, or legal process in favor of any creditor of the purchaser or beneficiary of the advance payment contract, so long as the contract has not been terminated.

HMO Outpatient Holding Beds

In a 1987 rewrite of chapter 641, F.S., relating to HMOs, the Legislature exempted from regulation under chapter 395, F.S., (the hospital licensing chapter) up to 10 outpatient holding beds within an HMO for short-term and hospice-type patients (see s. 21 of ch. 87-236, L.O.F., codified as s. 641.495(10), F.S.). The exemption required that the HMO be accredited. This exemption was amended in 1991 so that it applied only to such beds in place on or before January 1, 1991. Only one HMO ever had these type of beds and the limitation imposed in 1991 prevented the acquisition of such beds by any other HMO.

In 1996, s. 641.495 was amended by s. 32, ch. 96-199, L.O.F., which purported to amend s. 641.495 in its entirety, but the amendment did not publish the text of existing subsection (10), which contains the HMO exemption for outpatient beds. This fact is foot noted in the Florida Statutes.

HMO Surplus Requirements

Current Florida law (s. 641.225, F.S.,) requires an HMO to maintain a minimum surplus of $.5 million or 10 percent of total liabilities, whichever is greater. In addition, each HMO must deposit with the Department of Insurance, in cash or securities, an amount which is the greater of twice the HMO's reasonably estimated average monthly uncovered expenditures or $100,000. Recently, two HMOs have failed financially and have had to be rehabilitated by the Department of Insurance. These two financial failures have caused the department to question the adequacy of current minimum surplus and solvency requirements.

Fiscal Intermediary Services

These services are regulated under s.641.316, F.S. Currently, there are a number of these entities that perform fiduciary or fiscal intermediary services for health care practitioners (service providers) who contract with an HMO or other managed health organization. These organizations can receive the billing from the providers, bill the managed care entities and distribute the funds received from the managed care entities to the appropriate provider. They provide a service to both the provider and the managed care entities. Considerable amounts of money flow through these fiscal intermediaries. The number of fiscal intermediaries and the amount of money handled in a fiscal year is not known. They are not required to register with the Department of Insurance, and prior to 1997, maintain a fidelity bond, or have annual financial or compliance audits. While most fiscal intermediaries are reputable and handle all provider funds correctly, there have been incidents where an intermediary either went bankrupt or misappropriated health care provider funds.

In 1997, an attempt was made by the Legislature to regulate these entities in CS/CS/HB 297 and 325. The proposed legislation provided by the Department of Insurance (DOI) required registration with the Department of Insurance and maintenance of a $10 million fidelity bond for certain entities performing fiscal intermediary services for health care practitioners who contract with certain managed care entities. However, during 1997-98, only two or three of the fiscal intermediaries inquired of the Department of Insurance

about registering and none of the entities actually registered or obtained the required $10 million bond. Indications were that the required bond was not available.

B. EFFECT OF PROPOSED CHANGES:

The Florida Department of Insurance will have the authority to enforce the provisions of the federal “Mental Health Parity Act”, which will be codified into the Florida Insurance Code.

Requirements in state law relating to renewal of conversion policies and Medicare supplement policies will be consistent with federal requirements.

The provisions of Florida’s Long-Term Care Insurance Act which apply to limited benefit policies will be clarified. Limited benefit policies will be required to include a disclosure statement for prospective policyholders which indicates that the limited benefit policy either meets federal qualifications for tax exemption or does not, and the definition of “preexisting condition” for long-term care policies in the Florida Insurance Code will be consistent with the federal definition contained in HIPAA.

Moneys paid into or out of a Medical Savings Account or a Roth IRA will not be liable to attachment, garnishment, or legal process on behalf of a person establishing the MSA or the beneficiary of the MSA.

One HMO which, on or before January 1, 1991, had fewer than 10 outpatient holding beds for short-term and hospice-type patients in an ambulatory care facility for its members will continue to be exempt from regulation under part I of chapter 395, F.S., so long as the HMO meets specified accreditation requirements.

HMOs will be less likely to become insolvent due to enhanced solvency protection standards.

The Department of Insurance, rather than the Florida Comprehensive Health Association, will have responsibility for calculating the standard risk rate for individual conversion policies issued by group health insurers and HMOs. The standard risk rate also serves as the benchmark for establishing FCHA premiums.

Eligibility for guarantee-issue of an individual health insurance policy will be expanded to include persons with 18 months of prior coverage under an individual plan, if the prior insurance coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO. (Current law requires that the most recent coverage must be group coverage.)

C. APPLICATION OF PRINCIPLES:

1. Less Government:

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

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

      Yes, the bill gives the Department of Insurance additional rule making authority and enforcement authority.

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

      Yes, insurance companies and HMOs will be required to provide additional benefits, and HMOs will be required to meet enhanced solvency protection standards.

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

      No.

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

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

      N/A

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

      N/A

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

      N/A

2. Lower Taxes:

   a. Does the bill increase anyone's taxes?

   No.

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

No.

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

N/A

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

N/A

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

No.

3. Personal Responsibility:

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

No.

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

Insurance companies pay for regulatory costs through licensing fees. These costs are passed on to consumers through premium increases. Therefore, consumers who benefit from this legislation pay the cost.

4. Individual Freedom:

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

No.

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

No.

5. Family Empowerment:

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

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

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

N/A

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

N/A

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

No.

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

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 222.22, 627.410, 627.425, 627.6487, 627.6498, 627.6571, 627.6575, 627.6415, 627.6578, 627.6675, 627.6685, 627.6699, 627.674, 627.6741, 627.9403, 627.9404, 627.9407, 627.94073, 641.225, 641.285, 641.26, 641.31, 641.316, 641.3922, and 641.495 F.S.

E. SECTION-BY-SECTION RESEARCH:

Section 1. Amends s. 222.21, F.S., relating to the exemption of pension money and retirement or profit-sharing benefits from legal processes, to specifically exempt Roth IRA resources from creditors' claims. This revision is necessary because federal Internal Revenue Code revisions which created the Roth IRA did so as a new section of IRS law.

Section 2. Amends s. 222.22, F.S., relating to exemption of moneys from legal process, to specify that moneys paid into or out of a Medical Savings Account by or on behalf of a person depositing money into an MSA are not liable to attachment, garnishment, or legal process in favor of any creditor.

Section 3. Amends s. 627.410, F.S., to provide an exception to certain health insurance rating requirements for disability income policies and accidental death policies. Currently, certain rating practices are prohibited for health insurance policies issued in Florida, including: (1) select and ultimate premium schedules, (2) premium class definitions which classify the insured based on year of issue or duration since issue, and (3) attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over. The statute does not further define these terms but, in general, these rating prohibitions are designed to require insurers to account in the initial, first-year premium for cost increases that are expected as a policyholder ages, rather than a rating plan that schedules premium increases as a policyholder ages. The bill specifies that these prohibited rating practices do not apply to disability income policies or accidental death policies.

Section 4. Amends s. 627.6425, F.S., relating to exceptions to guaranteed renewability of individual health insurance policies, to clarify that if an insurer discontinues offering a particular policy form, the insurer must provide current policyholders with at least 90 days notice prior to *non-renewal* (and offer the option to purchase any other individual coverage currently being offered). This is intended to eliminate a possible interpretation that an insurer may cancel policies mid-term, with 90-days notice.

Section 5. Amends s. 627.6487, F.S., to expand the definition of "eligible individual" for purposes of entitlement to guaranteed-issuance of an individual health insurance policy. The current law, enacted in 1997 to conform to HIPAA, guarantees availability of individual coverage to persons with 18 months of prior creditable coverage, if their most recent coverage was under a *group* health plan, governmental plan, or church plan. The bill expands eligibility for guaranteed-issuance of individual coverage to include persons with 18 months of prior coverage, whose most recent coverage was under an *individual* plan, if the prior insurance coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO.

Section 6. Amends s. 627.6498, F.S. to require the Department of Insurance, rather than the FCHA, to annually establish the *standard risk rates* that serve as the basis for determining premiums established for the FCHA. As currently provided, the maximum rates for the FCHA would be 200 percent, 225 percent, and 250 percent of the standard risk rate for low, medium, and high risk individuals, respectively. See Section 11, below, which provides standards for this determination and for use of the standard risk rate in establishing maximum premiums for conversion policies.

Section 7. Amends s. 627.6571, F.S., relating to exceptions to guaranteed renewability of group policies, to clarify that if an insurer discontinues offering a particular policy form, the insurer must provide current policyholders with at least 90 days notice prior to *non-renewal*. This is intended to eliminate a possible interpretation that an insurer may cancel policies mid-term with 90-days' notice. Also, a technical change clarifies that an insurer may elect to discontinue offering all coverage in either the small group or large group market, or both.

Section 8. Amends s. 627.6575, F.S., relating to coverage for newborn children under a group health insurance policy, to require that an insurer may not deny coverage of a newborn child if notice is given within 60 days of the birth of the child. Current law specifies no time limit on the notice requirement and the department has interperted the notice period to be until the child turns age 18 years.

Section 9. Amends s. 627.6415, F.S., relating to coverage for natural born, adopted and foster children under an individual health insurance policy, to require that an insurer may not deny coverage of a child if notice is given within 60 days of the birth or placement of the child. Current law specifies no time limit on the notice requirement and the department has interperted the notice period to be until the child turns age 18 years.

Section 10. Amends s. 627.6578, F.S., relating to coverage for natural born, adopted and foster children under a group health insurance policy, to require that an insurer may not deny coverage of a newborn child if notice is given within 60 days of the birth or placement of the child. Current law specifies no time limit on the notice requirement and the department has interperted the notice period to be until the child turns age 18 years.

Section 11. Amends s. 627.6675, F.S. relating to conversion policies required to be offered by group insurers to persons who lose eligibility for group coverage, to make the following changes related to maximum premiums for conversion policies, grounds for non-renewal, and information that must be provided about conversion policy premiums to prospective applicants:

Subsection (3): Currently, the maximum premium for conversion policies is set at 200 percent of the standard risk rate, as determined by the FCHA. The bill requires the Department of Insurance, rather than the FCHA, to annually establish the standard risk rate, using reasonable actuarial techniques and standards adopted by rule of the department. The standard risk rate must be determined separately for indemnity policies, preferred provider/exclusive provider policies, and HMO contracts, based on a survey of insurers and HMOs representing 80 percent of the statewide market share for each type of policy. Standard risk rate schedules are to be computed as the average rates charged by the insurers surveyed, giving appropriate weight to each carrier's statewide market share, broken down by county, age brackets, and family-size.

Subsection (7): Revising the grounds for non-renewal of a conversion policy to be consistent with HIPAA, by: (1) changing "fraud or *material* misrepresentation" to "fraud or *intentional* misrepresentation" in applying for benefits under the policy, and (2) deleting as a ground, eligibility of the insured for Medicare or any other state or federal law providing similar benefits to the conversion policy.

Subsection (17): Requiring insurers to mail to individuals who are eligible for a conversion policy, an election and premium notice form, including an outline of coverage, within 14 days of request or notice to the insurer that an individual is considering applying for a conversion policy.

Section 12. Creates s. 627.6685, F.S., relating to mental health coverage, with the following subsections:

Subsection (1) - Creates definitions for the section.

Subsection (2) - Specifies limitations on plan benefits. If a group health plan contains no aggregate lifetime limit or annual limit on medical benefits, the plan may not impose an aggregate lifetime limit or annual limit on mental health benefits. If a plan does include an aggregate lifetime limit or annual limit on medical benefits, the plan must either not distinguish between medical benefits and mental health benefits in the application of the aggregate lifetime limit or annual limit, or not include any aggregate lifetime limit or annual limit on mental health benefits which is less than that limit. In the case of a plan not described in the foregoing, the department is required to adopt rules to deal with situations where policies include limits on individual components of the policy, to provide parity between medical benefits and mental health benefits. Nothing in this section requires a plan to provide any mental health benefits, or as affecting the terms and conditions of a mental health benefit if such benefit is provided, such as limiting the number of visits or days of coverage and requirements relating to medical necessity, the amount, duration, or scope of mental health benefits covered, except with respect to parity for aggregate lifetime limits and annual limits.

Subsection (3) - The provisions of this section are not applicable to any small group policy issued under the "Health Care Access Act" (s. 627.6699, F.S.); and the section does not apply to any plan where it will result in an increase in the cost of the plan of at least one percent.

Subsection (4) - Specifies that the provisions of this section apply separately to each option for any plan which offers two or more benefit package options.

Subsection (5) - Specifies that the section does not apply after September 30, 2001.

Subsection (6) - Provides that the provisions of this section prevail in the event there is a conflict between this section and s. 627.668, F.S., which relates to optional coverage for mental and nervous disorders.

Section 13. Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act, to incorporate into the definition of "health benefit plan" an exception for employer-

provided supplemental plans that may be provided as part of an enhanced employee benefit package.

Section 14. Amends s. 627.674, F.S., relating to minimum standards for Medicare supplement policies, to requires that rules adopted by the department must be no less comprehensive or beneficial to insureds than federal law.

Section 15. Amends s. 627.6741, F.S., relating to issuance, cancellation, and renewal of Medicare supplement policies, to revise standards for the issuance of Medicare supplement policies. Current Florida Law requires insurers to guaranty the issuance of coverage to any individual during the first 6 months after they reach age 65 and enroll in Part B, and to any individual who is 65 or older during the 2 month period following termination of coverage under a group plan. This amendment provides that if any such individual has at least 6 months of prior creditable coverage, the Medicare supplement policy may not exclude benefits based on a pre-existing condition. Credit must be given towards a pre-existing condition exclusion for time covered under a previous Medicare supplement policy or a group policy. The department would be required to adopt rules relating to the guaranteed issuance of coverage, without preexisting condition exclusions, for continuously covered individuals, consistent with the federal law.

Section 16. Amends s. 627.9403, F.S., relating to scope, to clarify that a limited benefit policy that limits coverage to care in a nursing home or to one or more lower levels of care specified by department rule must meet all requirements of Part XVII of ch. 627, F.S., relating to long-term care insurance policies, except specified provisions which are not applicable.

Section 17. Amends s. 627.9404, F.S., relating to definitions, to define “limited benefit policy” as meaning any policy that limits coverage to care in a nursing home or to one or more lower levels of care required or authorized to be provided by the Act or by department rule; and to add a definition of “qualified long-term care limited benefit insurance policy” as meaning an accident and health insurance contract as defined in s. 7702B of the Internal Revenue Code and all applicable sections of this part. (In order to be marketed as a “long-term care” policy, a policy must cover care in a nursing home and at least one or more lower levels of care, such as home health care, which are specified by department rule. However, a policy may limit coverage to care in a nursing home or to one or more lower levels of care as long as it is marketed as a “limited benefit policy” or a “qualified long-term care limited benefit insurance policy.”).

Section 18. Amends s. 627.9407, F.S., relating to disclosure, advertising and performance standards, to revise the definition of “preexisting condition” in order to conform it to the federal definition; and to specify that a limited benefit policy which is qualified under s. 7702B of the Internal Revenue Code must include a disclosure statement to that affect. Limited benefit policies which are not federally qualified must also disclose that to the prospective policyholder.

Section 19. Amends s. 627.94073, F.S., relating to notice of cancellation and grace periods, to make a technical change in subsection (2) to clarify the application of the subsection to limited benefit insurance policies.

Section 20. Amends s. 641.225, F.S., relating to HMO surplus requirements, to increase minimum surplus requirements from $.5 million to $1.5 million, or 10 percent of total

liabilities, or 2 percent of annualized premium, which ever is greater. These increases in minimum surplus requirements will be phased in over a three year period.

Section 21. Amends s. 641.285, F.S., relating to HMO insolvency protection, to each HMO to deposit with the Department of Insurance $300,000 (and from $100,000 up to $2 million based on financial conditions). The bill eliminates all of the various exceptions to the deposit requirement that may currently be approved by the department and authorizes the department to require additional deposits ranging from $100,000 to a maximum of $2 million, if the department determines that the financial condition of an HMO has deteriorated to the point that the policyholders' or subscribers' best interests are not being preserved by the activities of the HMO.

Section 22. Amends s. 641.26, F.S., relating to annual reports that must be filed by HMOs. Current law requires audited financial statements to be filed annually, certified by an independent certified public accountant (CPA). The bill requires that the report filed by the CPA must include any material weaknesses in the HMO's internal control structure as noted by the CPA during the audit, and that the HMO must provide a description of remedial actions taken that are not otherwise described in the CPA's report. Current law also requires the annual filing of a certification by an actuary as to the actuarial soundness of the HMO. The bill authorizes the department to require updates of the actuarial certification if the department has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the HMO. Work papers in support of the statement of the updated actuarial certification must be provided to the department upon request. The bill further authorizes the department to require an HMO, upon written request, to furnish such additional information as to its transactions or affairs which, in the department's opinion, may have a material effect on the HMO's financial condition. Each HMO would also be required to file a copy of its annual statement in electronic form along with such additional filings as prescribed by the department for the preceding year, with the National Association of Insurance Commissioners (NAIA), and to pay a reasonable fee to the department to cover the cost associated with the filing of an analysis of the documents by the NAIA.

Section 23. Amends s. 641.31, F.S., relating to health maintenance contracts, to require that an HMO may not deny coverage of a newborn child if notice is given within 60 days of the birth of the child. Current law specifies no time limit on the notice requirement and the department has interperted the notice period to be until the child turns age 18 years.

Section 24. Amends s. 627.31074, F.S., related to guaranteed renewability of HMO contracts. The bill makes changes to this section to be consistent with the guaranteed renewability provisions of s. 627.6571, F.S., which apply to group health insurance policies. The bill clarifies that if an HMO discontinues offering a particular policy form, the HMO must provide current contract holders with at least 90 days notice prior to *non-renewal*, eliminating a possible interpretation that an HMO may cancel policies mid-term with 90-days notice. Also, if an HMO discontinues offering a contract form, the bill requires the HMO to offer a large employer (with more than 50 employees) *any* rather than *all* other health insurance coverage offered by the HMO in the large group market. This is consistent with HIPAA law and the current group health insurance statute, s. 627.6571, F.S. The bill also clarifies that an HMO may elect to discontinue offering all coverage in either the small group or large group market, or both, and deletes a reference to acting in accordance with *applicable state law* in such circumstances, since there appears to be no other statutory requirement that applies.

Section 25. Amends s. 641.3111, F.S., related to extension of benefits under HMO contracts. Currently, if an HMO contract is terminated *by the HMO*, the contract must continue to provide benefits for at least 12 months for a person who is totally disabled, for the treatment of a specific accident or illness incurred while the subscriber was a member. This current statute has a very limited effect, because the extension of benefit's requirement does not apply if a group HMO contract is terminated by the contract holder, as compared to the extension of benefits requirement for group health insurance policies in s. 627.667, F.S., which applies whenever a group policy is terminated, including termination by the group policyholder (e.g., employer). There is no extension of benefits requirement, currently, for individual health insurance policies. The current HMO statute also provides, in subsection (4), that the extension of benefits is not required if termination of the contract by the HMO is based upon any event referred to in s. 641.3922(7)(a)-(g), F.S., which are all but one of the allowable reasons for an HMO to non-renew a conversion contract. (The one not referenced is paragraph (h), which is a change in marital status that makes a person ineligible.) No reference is made to s. 641.31074, F.S., created in 1997, which requires group HMO contracts to be guaranteed renewable, subject to exceptions listed in subsection (2), but the exceptions would appear to include all of the events listed in s. 641.3922(7)(a)-(g), F.S. In comparison, the extension of benefits law for group health insurance policies in s. 627.667, F.S., provides no similar exceptions.

The bill strikes the phrase "by the HMO" to apply the extension of benefits requirement to any termination of an HMO contract, including termination by a group contract holder. However, the bill limits the extension of benefits requirement to *group* HMO contracts, because there is no extension of benefits law for individual health insurance policies and also due to the current exceptions in subsection (4) which effectively makes the law non-applicable to individual policies. The exceptions to providing an extension of benefits are stricken, to be consistent with the group health insurance law in s. 627.667, F.S., which provides no similar exceptions.

Section 26. Amends s. 641.316, F.S., related to fiscal intermediary services. This section was created in 1997 to require a $10 million fidelity bond to all persons or entities engaged in the business of providing fiduciary or fiscal intermediary services to any contracted health care provider or provider panel. The term "fiscal intermediary services" is defined to include patient and provider accounting, financial reporting and auditing, receipts and collections management, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with HMOs. Organizations owned, operated, or controlled by a hospital, authorized insurer, licensed third-party administrator, prepaid limited health organization, HMO, or physician group practice is exempt from the statute's requirements. The $10 million fidelity bond must provide coverage against misappropriation of funds by the fiscal intermediary or its officers, agents, or employees, and must be posted with the department for the benefit of managed care plans, subscribers, and providers. It appears that surety insurers do not generally make available the $10 million fidelity bond currently required for fiscal intermediary service organizations.

The bill deletes the $10 million fidelity bond requirement and replaces it with two separate, but lower, bond requirements. The fiscal intermediary service organization would be required to obtain a fidelity bond in the minimum amount of 10 percent of the funds handled by the intermediary in connection with its fiscal services during the prior year, or $1 million, whichever is less, subject to a minimum bond amount of $50,000. This fidelity bond must protect the intermediary from loss caused by the dishonesty of its employees.

The organization would also be required to maintain a surety bond on file with the department, with a penal sum of not less than 5 percent of the funds handled by the intermediary in connection with its fiscal services during the prior year, or $250,000, whichever is less, subject to a minimum bond amount of $10,000. The condition of the bond must be that the intermediary register with the department and not misappropriate funds within its control or custody. The bond may be terminated by the surety upon its giving 30 days' written notice to the department.

The bill also incorporates technical revisions regarding reference to prepaid limited health *service* organizations licensed under ch. 636, F.S., and physician group practices licensed under s. 455.654(3)(f), F.S.

Section 27. Amends s. 641.3922(7)(a), F.S., relating to eligibility for conversion health maintenance organization policies, to make the same changes to the HMO conversion law as made to the group health conversion law in Section 11, above, as follows:

Subsection (3): Currently, the maximum premium for HMO conversion contracts is set at 200 percent of the standard risk rate, as determined by the FCHA. The bill requires the Department of Insurance, rather than the FCHA, to annually establish the standard risk rate, pursuant to s. 627.6675, F.S. (See Section 11, above.)

Subsection (7): Revising the grounds for non-renewal of a conversion contract to be consistent with HIPAA law, by: (1) changing "fraud or material misrepresentation" to "fraud or intentional misrepresentation" in applying for benefits under the contract, and (2) deleting as a ground, eligibility of the insured for Medicare or any other state or federal law providing similar benefits to the conversion contract.

Subsection (14): Requiring HMOs to mail to individuals who are eligible for a conversion contract, an election and premium notice form, including an outline of coverage, within 14 days of request or notice to the HMO that an individual is considering applying for a conversion contract.

Section 28. Amends s. 641.495(11), F.S., relating to requirements for issuance and maintenance of a certificate, to insert a provision which exempts from licensure under chapter 395, F.S., certain beds of a health maintenance organization. The provision was inadvertently deleted by the Legislature in 1996.

Section 25. Provides an effective date of January 1, 1999.

IV. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

According to Milliman and Roberts, Actuaries and Consultants, the provisions of the Federal Mental Parity Act of 1996 will result in increased costs to the State Self-Insured plan of approximately $3 million in fiscal year 1998-99, or slightly less than one percent of total paid claims.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

$3 million in fiscal year 1998-99.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

Indeterminate.

2. Recurring Effects:

Indeterminate.

3. Long Run Effects Other Than Normal Growth:

Indeterminate.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

HMOs will experienced increased costs associated with meeting the higher surplus and solvency requirements. Insurance and HMO premiums may increase to pay for mental health benefits.

2. Direct Private Sector Benefits:

Florida consumers will have recourse through the Florida Department of Insurance for violations of the federal “Mental Health Parity Act of 1996". Moneys paid into or taken out of an MSA or a Roth IRA will not be available to creditors of the entity which established the MSA or the beneficiary of the MSA or IRA. The financial soundness of HMOs will be enhanced.

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

   None.

D. FISCAL COMMENTS:

   None.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill may require counties and municipalities to spend funds or to take an action requiring the expenditure of funds related to the provision of employee health benefits. However, two constitutional exemptions apply: all similarly situated persons are required to comply; and the mental health parity component of this bill is required to comply with a federal requirement.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

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

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

VI. COMMENTS:

There are two technical concerns regarding this bill. First, the bill amends three sections of statutes relating to insurance coverage of newborn children from the moment of birth or coverage of adopted or foster children from the date of placement. Current law specifies that the insurer must cover such children if notified by the insured, without specifing a time period for the notification. Since no time period is specified in law, the department has interperted the time period to extend until the child reaches age 18 years. This bill specifies a 60 day time period from the moment of birth or placement, and applies the time period to group health policies for newborn children (s. 627.6575, F.S.), and to individual health insurance policies and group health insurance policies for adopted and foster children (ss. 627.6415, and 627.6578, F.S., respectively), but not to newborn children in individual policies (s. 627.641, F.S.). Senate staff indicates that the failure to make this 60 day requirement applicable to individual health insurance policies for newborns was probably an oversight since these changes were made by floor amendment in the Senate.

The second technical concern involves the effective date of the bill, which is January 1, 1999. However, section 20 of the bill requires an HMO to increase its minimum surplus, effective September 30, 1998, from $200,000 to $800,000. Given the effective date, it is assumed this increased minimum surplus requirement will take effect on January 1, 1999.

History of HB 4495

03/26/98 H Filed
03/31/98 H Introduced -HJ 00376
04/06/98 H Referred to Civil Justice & Claims (JC); Finance & Taxation (FRC); General Government Appropriations -HJ 00463
04/14/98 H Withdrawn from Civil Justice & Claims (JC) -HJ 00571; Now in Finance & Taxation (FRC)
04/20/98 H On Committee agenda-- Finance & Taxation (FRC), 04/21/98, 10:15 am, Morris Hall
04/21/98 H Comm. Action: Unanimously Favorable by Finance & Taxation (FRC) -HJ 00999
04/22/98 H Now in General Government Appropriations -HJ 00999; On Committee agenda-- General Government Appropriations, 04/23/98, 4:30 pm, 214C
04/23/98 H Comm. Action:-Favorable with 1 amendment(s) by General Government Appropriations -HJ 01368
04/24/98 H Placed on General Calendar -HJ 01368; Read second time -HJ 01119; Amendment(s) adopted -HJ 01119

04/28/98 H Senate Bill substituted; Laid on Table, Iden./Sim./Compare Bill(s) passed, refer to CS/CS/SB 1800 -HJ 01489

History of SB 1800

03/03/98 S Filed
03/11/98 S Introduced, referred to Banking and Insurance; Health Care; Ways and Means -SJ 00159
03/18/98 S On Committee agenda-- Banking and Insurance, 03/23/98, 3:00 pm, Room-EL
03/23/98 S Comm. Action: CS by Banking and Insurance -SJ 00304; CS read first time on 03/25/98 -SJ 00317
03/25/98 S Now in Health Care -SJ 00304
03/26/98 S On Committee agenda-- Health Care, 03/31/98, 9:00 am, Room-EL
03/31/98 S Comm. Action: CS/CS by Health Care -SJ 00375; CS read first time on 04/02/98 -SJ 00381
04/02/98 S Now in Ways and Means -SJ 00375
04/10/98 S On Committee agenda-- Ways and Means, 04/15/98, 2:00 pm, Room-EL --Withdrawn
04/13/98 S Withdrawn from Ways and Means -SJ 00433; Placed on Calendar
04/17/98 S Placed on Special Order Calendar -SJ 00528
04/21/98 S Placed on Special Order Calendar -SJ 00528
04/22/98 S Placed on Special Order Calendar -SJ 00741; Read second time -SJ 00782; Amendment(s) adopted -SJ 00782; Ordered engrossed -SJ 00784
04/23/98 S Read third time -SJ 00860; Amendment(s) adopted -SJ 00860; CS passed as amended; YEAS 37 NAYS 0 -SJ 00860; Immediately certified -SJ 00860
04/23/98 H In Messages
04/28/98 H Received -HJ 01431; In Government Services Council, pending ranking -HJ 01432; Substituted for HB 4495 -HJ 01489; Read second and third times -HJ 01489; CS passed; YEAS 114 NAYS 0 -HJ 01490
04/28/98 S Ordered enrolled -SJ 01098
05/06/98 Signed by Officers and presented to Governor
05/22/98 Became Law without Governor's Signature; Chapter No. 98-159

VII. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

This bill was discussed at the January 5, 1998, meeting of the Health Care Services Committee which adopted 4 amendments as follows:

Amendment 1 specifies that funds in a medical savings account are liable to attachment, garnishment, or legal process.

Amendment 2 reinserts in statute a provision which was inadvertently repealed to permit HMOs to have up to 10 outpatient holding beds.

Amendments 3 and 4 were technical in nature.

On March 3, 1998, the Health Care Services Committee adopted an amendment relating to Medicare Supplement policies to make changes necessary to conform to federal law. Specifically, the amendment requires that rules adopted by the department must be no less comprehensive or beneficial to insureds than federal law. Further, the amendment revises standards for the issuance of Medicare supplement policies. Current Florida Law requires insurers to guaranty the issuance of coverage to any individual during the first 6 months after they reach age 65 and who enrolls in Part B, and to any individual who is 65 or older during the 2 month period following termination of coverage under a group plan. This amendment provides that if any such individual has at least 6 months of prior creditable coverage, the Medicare supplement policy may not exclude benefits based on a pre-existing condition. Credit must be given towards a pre-existing condition exclusion for time covered under a previous Medicare supplement policy or a group policy.

On March 9, 1998, the Health Care Services Committee adopted an amendment relating to coverage for contraceptives. The amendment creates the Equity in Contraceptive Coverage Act of 1998, which requires certain health insurance policies and health maintenance contracts to provide coverage for prescription oral contraceptives approved by the federal Food and Drug Administration and prescribed by an authorized practitioner. This section does not require an insurer to provide coverage for prescription oral contraceptives if the insurer or policy holder objects on religious or moral grounds, nor does this section apply to any prescription medications which are abortifacient in nature.

On March 11, 1998, the Committee on Health Care Services adopted two amendments to the bill. The first amendment revises ch. 641, F.S., relating to HMO surplus and solvency requirements, to increase minimum surplus requirements from $.5 million to $1.5 million, to require a deposit of cash or securities with the department of $300,000 (or up to $2 million based on financial conditions), and to require HMOs to file a report on internal control in conjunction with its CPA report. The second amendment exempts policies which provide for expanded coverage, written in conjunction with comprehensive medical policies, from the requirements of the small group law.

On March 18, 1998, the Committee on Health Care Services adopted 4 additional amendments. The first two were technical in nature. The third removed from the bill the enhanced reporting requirements for HMOs amended in the previous week. And the fourth amendment requires reporting to DOI of any claim or action for damages for personal injuries claimed to have been caused by negligence in the performance of professional services by a physician, podiatrist, or dentist who obtains professional liability insurance through the Board of Regents.

On April 23, 1998, the Committee on General Government Appropriations adopted one amendment that removes provisions relating to coverage for prescription oral contraceptives from the bill.

As passed, CS/CS/SB 1800 does the following things which are not in HB 4495.

> Expands eligibility for guarantee-issue of an individual health insurance policy to include persons with 18 months of prior coverage under an <u>individual plan</u>, if the prior insurance coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO. (Current law requires that the most recent coverage must be <u>group</u> coverage.)

Requires the Department of Insurance to annually establish the standard risk premium which serves as the benchmark for establishing maximum premiums for the FCHA and for individual conversion policies.

Requires insurers to mail to individuals who are eligible for a conversion policy, an election and premium notice form, including an outline of coverage, within 14 days of request.

Provides that moneys paid into Roth IRAs are protected from creditors.

Revises the requirements for an HMO to provide a 1 2-month extension of benefits for persons who are totally disabled, to apply the requirement to any termination of an HMO contract, including termination by a group contract holder, but limiting such requirement to group HMO contracts;

Revises the bond requirements that must be met by fiscal intermediary organizations;

Specifies that the current 1 80-day notice requirement that an insurer is required to provide to individual or group policyholders if the insurer discontinues offering all health insurance coverage in the individual or group market in the state, must be 180 days prior to nonrenewal of each policyholder's coverage. This clarifies that an insurer cannot cancel a policy mid-term.

Provides that an individual is not eligible for guarantee-issue of coverage if the individual is eligible for a conversion policy under an insured plan or a self-insured plan. However, the conversion policy would have to be issued by a Florida authorized insurer or HMO that issues the conversion policy under the requirements of Florida law. In other words, the insurer or HMO would be required to have the policy approved by the Department of Insurance, must offer the standard benefit plan, and must limit premiums to 200 percent of the standard risk rate, as currently required for all conversion policies.

Provides that an insurer may not deny coverage for a late enrolled child if notice is given within 60 days of the birth of the child. Current law has been interpreted to allow a policyholder to enroll a child under a policy anytime after birth until age 18, and to obtain retroactive coverage back to the date of birth, if the policyholder pays the past due premiums. This is the literal interpretation of the current law, but all parties agree that it is not reasonable to allow enrollment of a child years after the child is born and obtain coverage back to the date of birth.

Reinserts certain exceptions to the requirement that HMO contracts provide for an extension of benefits for at least 12 months for a person who is totally disabled at the time an HMO contract is terminated. The provision reinserts only 3 of the current exceptions: (1) fraud or material misrepresentation in applying for benefits; (2) disenrollment for cause, after the HMO follows specified procedures; and (3) the subscriber has moved out of the geographic service area of the HMO.

Only one item in the HB is not in the SB. That item is the reporting of malpractice claims by health care providers who obtain professional liability through the Board of Regents.

VIII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Legislative Research Director:
Michael P. Hansen	Michael P. Hansen

AS FURTHER REVISED BY THE COMMITTEE ON FINANCE AND TAXATION:

Prepared by:	Legislative Research Director:
Kama D.S. Monroe, Esq.	Keith G. Baker, Ph.D.

AS FURTHER REVISED BY THE COMMITTEE ON GENERAL GOVERNMENT APPROPRIATIONS:

Prepared by:	Legislative Research Director:
Jenny Underwood Dietzel	Cynthia P. Kelly

FINAL RESEARCH PREPARED BY COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Legislative Research Director:
Michael P. Hansen	Michael P. Hansen