SENATE AMENDMENT

Bill No. CS/HBs 1927 & 961, 1st Eng.

Amendment No. ___

CHAMBER ACTION

Senate	House
. . . . . .	

Senator Clary moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause,

and insert:

Section 1. Paragraph (a) of subsection (5) of section 408.05, Florida Statutes, 1998 Supplement, is amended to read:

408.05 State Center for Health Statistics.--

(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.--The center shall provide for the widespread dissemination of data which it collects and analyzes. The center shall have the following publication, reporting, and special study functions:

(a) The center shall publish and make available periodically to agencies and individuals health statistics publications of general interest, including HMO report cards; publications providing health statistics on topical health policy issues;~~,~~ publications that ~~which~~ provide health status profiles of the people in this state;~~,~~ and other topical health statistics publications.

Section 2. Subsections (2) and (11) of section

408.7056, Florida Statutes, 1998 Supplement, are amended to read:

408.7056 Statewide Provider and Subscriber Assistance Program.--

(2) The agency shall adopt and implement a program to provide assistance to subscribers and providers, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The program shall consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to the agency or the department any actions that should be taken concerning individual cases heard by the panel. The panel shall hear every grievance filed by subscribers and providers on behalf of subscribers, unless the grievance:

(a) Relates to a managed care entity's refusal to accept a provider into its network of providers;

(b) Is part of an internal grievance in a Medicare managed care entity or a reconsideration appeal through the Medicare appeals process which does not involve a quality of care issue;

(c) Is related to a health plan not regulated by the state such as an administrative services organization, third-party administrator, or federal employee health benefit program;

(d) Is related to appeals by in-plan suppliers and providers, unless related to quality of care provided by the plan;

(e) Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

(f) Is the basis for an action pending in state or

federal court;

(g) Is related to an appeal by nonparticipating providers, unless related to the quality of care provided to a subscriber by the managed care entity and the provider is involved in the care provided to the subscriber;

(h) Was filed before the subscriber or provider completed the entire internal grievance procedure of the managed care entity, the managed care entity has complied with its timeframes for completing the internal grievance procedure, and the circumstances described in subsection (6) do not apply;

(i) Has been resolved to the satisfaction of the subscriber or provider who filed the grievance, unless the managed care entity's initial action is egregious or may be indicative of a pattern of inappropriate behavior;

(j) Is limited to seeking damages for pain and suffering, lost wages, or other incidental expenses, including accrued interest on unpaid balances, court costs, and transportation costs associated with a grievance procedure;

(k) Is limited to issues involving conduct of a health care provider or facility, staff member, or employee of a managed care entity which constitute grounds for disciplinary action by the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and the agency or department has reported these grievances to the appropriate professional licensing board or to the health facility regulation section of the agency for possible investigation; or

(l) Is withdrawn by the subscriber or provider. Failure of the subscriber or the provider to attend the hearing shall be considered a withdrawal of the grievance.

(11) The panel shall consist of members employed by the agency and members employed by the department, chosen by their respective agencies; a consumer appointed by the Governor; a physician appointed by the Governor, as a standing member; and physicians who have expertise relevant to the case to be heard, on a rotating basis. The agency may contract with a medical director and a primary care physician who shall provide additional technical expertise to the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida.

Section 3. Present subsection (5) of section 627.6471, Florida Statutes, is redesignated as subsection (6) and a new subsection (5) is added to that section to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.--

(5) Any policy issued under this section which does not provide direct patient access to a dermatologist must conform to the requirements of s. 627.6472(16). This subsection shall not be construed to affect the amount the insured or patient must pay as a deductible or coinsurance amount authorized under this section.

Section 4. Subsection (36) is added to section 641.31, Florida Statutes, 1998 Supplement, to read:

641.31 Health maintenance contracts.--

(36)(a) Notwithstanding any other provision of this part, a health maintenance organization that meets the requirements of paragraph (b) may, through a point-of-service rider to its contract providing comprehensive health care services, include a point-of-service benefit. Under such a rider, a subscriber or other covered person of the health

maintenance organization may choose, at the time of covered service, a provider with whom the health maintenance organization does not have a health maintenance organization provider contract. The rider may not require a referral from the health maintenance organization for the point-of-service benefits.

(b) A health maintenance organization offering a point-of-service rider under this subsection must have a valid certificate of authority issued under the provisions of the chapter, must have been licensed under this chapter for a minimum of 3 years, and must at all times that it has riders in effect maintain a minimum surplus of $5 million.

(c) Premiums paid in for the point-of-service riders may not exceed 15 percent of total premiums for all health plan products sold by the health maintenance organization offering the rider. If the premiums paid for point-of-service riders exceed 15 percent, the health maintenance organization must notify the department and, once this fact is known, must immediately cease offering such a rider until it is in compliance with the rider premium cap.

(d) Notwithstanding the limitations of deductibles and copayment provisions in this part, a point-of-service rider may require the subscriber to pay a reasonable copayment for each visit for services provided by a noncontracted provider chosen at the time of the service. The copayment by the subscriber may either be a specific dollar amount or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider upon receipt of covered services. The point-of-service rider may require that a reasonable annual deductible for the expenses associated with the

point-of-service rider be met and may include a lifetime maximum benefit amount. The rider must include the language required by s. 627.6044 and must comply with copayment limits described in s. 627.6471. Section 641.315(2) and (3) does not apply to a point-of-service rider authorized under this subsection.

(e) The term "point of service" may not be used by a health maintenance organization except with riders permitted under this section or with forms approved by the department in which a point-of-service product is offered with an indemnity carrier.

(f) A point-of-service rider must be filed and approved under ss. 627.410 and 627.411.

Section 5. Subsection (4) is added to section 641.3155, Florida Statutes, 1998 Supplement, to read:

641.3155 Provider contracts; payment of claims.--

(4) Any retroactive reductions of payments or demands for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.

Section 6. The Director of the Agency for Health Care Administration shall establish an advisory group composed of eight members, with three members from health maintenance organizations licensed in Florida, one representative from a not-for-profit hospital, one representative from a for-profit

hospital, one representative who is a licensed physician, one representative from the Office of the Insurance Commissioner, and one representative from the Agency for Health Care Administration. The advisory group shall study and make recommendations concerning:

(1) Trends and issues relating to legislative, regulatory, or private-sector solutions for timely and accurate submission and payment of health claims.

(2) Development of electronic billing and claims processing for providers and health care facilities that provide for electronic processing of eligibility requests; benefit verification; authorizations; precertifications; business expensing of assets, including software, used for electronic billing and claims processing; and claims status, including use of models such as those compatible with federal billing systems.

(3) The form and content of claims.

(4) Measures to reduce fraud and abuse relating to the submission and payment of claims.

The advisory group shall be appointed and convened by July 1, 1999, and shall meet in Tallahassee. Members of the advisory group shall not receive per diem or travel reimbursement. The advisory group shall submit its recommendations in a report, by January 1, 2000, to the President of the Senate and the Speaker of the House of Representatives.

Section 7. Subsections (8), (9), and (10) of section 641.51, Florida Statutes, are amended to read:

641.51 Quality assurance program; second medical opinion requirement.--

(8) Each organization shall release to the agency data

that ~~which~~ are indicators of access and quality of care. The agency shall develop rules specifying data-reporting requirements for these indicators. The indicators shall include the following characteristics:

(a) They must relate to access and quality of care measures.

(b) They must be consistent with data collected pursuant to accreditation activities and standards.

(c) They must be consistent with frequency requirements under the accreditation process.

(d) They must include measures of the management of chronic diseases.

(e) They must include preventive health care for adults and children.

(f) They must include measures of prenatal care.

(g) They must include measures of health checkups for children.

The agency shall develop by rule a uniform format for publication of the data for the public which shall contain explanations of the data collected and the relevance of such data. The agency shall publish such data no less frequently than every 2 years.

~~(9) Each organization shall conduct a standardized customer satisfaction survey, as developed by the agency by rule, of its membership at intervals specified by the agency. The survey shall be consistent with surveys required by accrediting organizations and may contain up to 10 additional questions based on concerns specific to Florida. Survey data shall be submitted to the agency, which shall make comparative findings available to the public.~~

(9)~~(10)~~ Each organization shall adopt recommendations for preventive pediatric health care which are consistent with the ~~early periodic screening, diagnosis, and treatment~~ requirements for health checkups for children developed for the Medicaid program. Each organization shall establish goals to achieve 80-percent compliance by July 1, 1998, and 90-percent compliance by July 1, 1999, for their enrolled pediatric population.

Section 8. Subsection (4) of section 641.58, Florida Statutes, is amended to read:

641.58 Regulatory assessment; levy and amount; use of funds; tax returns; penalty for failure to pay.--

(4) The moneys ~~so~~ received and deposited into the Health Care Trust Fund shall be used to defray the expenses of the agency in the discharge of its administrative and regulatory powers and duties under this part, including conducting an annual survey of the satisfaction of members of health maintenance organizations; contracting with physician consultants for the Statewide Provider and Subscriber Assistance Panel;~~the~~ maintaining ~~of~~ offices and necessary supplies, essential equipment, and other materials, salaries and expenses of required personnel;~~,~~ and discharging ~~all other legitimate expenses relating to the discharge of~~ the administrative and regulatory powers and duties imposed under this ~~such~~ part.

Section 9. Subsections (4) and (7) of section 409.910, Florida Statutes, 1998 Supplement, are amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.--

(4) After the department has provided medical assistance under the Medicaid program, it shall seek recovery

of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid, as to:

(a) Claims for which the department has a waiver pursuant to federal law; or

(b) Situations in which the department learns of the existence of a liable third party or in which third-party benefits are discovered or become available after medical assistance has been provided by Medicaid. Nothing in this subsection shall limit the authority of the state or any agency thereof to bring or maintain actions seeking recoveries in excess of the amount paid as Medicaid benefits under alternative theories of liability in conjunction with an action filed pursuant to this section.

(7) The department shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits.

(a) Recovery of such benefits shall be collected directly from:

1. Any third party;

2. The recipient or legal representative, if he or she has received third-party benefits;

3. The provider of a recipient's medical services if third-party benefits have been recovered by the provider; notwithstanding any provision of this section, to the contrary, however, no provider shall be required to refund or pay to the department any amount in excess of the actual third-party benefits received by the provider from a third-party payor for medical services provided to the recipient; or

4. Any person who has received the third-party benefits.

(b) Upon receipt of any recovery or other collection pursuant to this section, the department shall distribute the amount collected as follows:

1. To itself, an amount equal to the state Medicaid expenditures for the recipient plus any incentive payment made in accordance with paragraph (14)(a).

2. To the Federal Government, the federal share of the state Medicaid expenditures minus any incentive payment made in accordance with paragraph (14)(a) and federal law, and minus any other amount permitted by federal law to be deducted.

3. To the recipient, after deducting any known amounts owed to the department for any related medical assistance or to health care providers, any remaining amount. This amount shall be treated as income or resources in determining eligibility for Medicaid.

The provisions of this subsection do not apply to any proceeds received by the state, or any agency thereof, pursuant to a final order, judgment, or settlement agreement, in any matter in which the state asserts claims brought on its own behalf, and not as a subrogee of a recipient, or under other theories of liability. The provisions of this subsection do not apply to any proceeds received by the state, or an agency thereof, pursuant to a final order, judgment, or settlement agreement, in any matter in which the state asserted both claims as a subrogee and additional claims, except as to those sums specifically identified in the final order, judgment, or settlement agreement as reimbursements to the recipient as

expenditures for the named recipient on the subrogation claim.

Section 10. The amendments to section 409.910, Florida Statutes, 1998 Supplement, made by this act are intended to clarify existing law and are remedial in nature. As such, they are specifically made retroactive to October 1, 1990, and shall apply to all causes of action arising on or after October 1, 1990.

Section 11. Subsection (1) of section 627.6645, Florida Statutes, is amended and subsection (5) is added to that section to read:

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

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

(5) If cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the

insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due.

Section 12. Section 627.6675, Florida Statutes, 1998 Supplement, is 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 or her by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." A group insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the department under s. 627.410.An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(1) TIME LIMIT.--Written application for the converted

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

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

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

(a) The premium for the converted policy shall be determined in accordance with premium rates applicable to the 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 department, pursuant to this subsection.

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

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

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

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

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

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

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

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

(4) EFFECTIVE DATE OF COVERAGE.--The effective date of

the converted policy shall be the day following the termination of insurance under the group policy.

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

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

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

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 actually provided coverage, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

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

(b) If the benefits provided under the sources referred to in subparagraph (a)1. or the benefits provided or available under the sources referred to in subparagraphs (a)2. and 3., together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the

area in which the insured lives at the time of conversion and must be filed with the department prior to their use in denying coverage.

(7) INFORMATION REQUESTED BY INSURER.--

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

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

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

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

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

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

3. Fraud or intentional misrepresentation in applying

for any benefits under the converted policy.

4. Other reasons approved by the department.

(8) BENEFITS OFFERED.--

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

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

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

(9) PREEXISTING CONDITION PROVISION.--The converted policy shall not exclude a preexisting condition not excluded by the group policy. However, the converted policy may provide that any hospital, surgical, or medical benefits payable under the converted policy may be reduced by the amount of any such benefits payable under the group policy after the termination of covered under the group policy. The converted policy may also provide that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force.

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

(a) A maximum benefit equal to the lesser of the policy limit of the group policy from which the individual

converted or $500,000 per covered person for all covered medical expenses incurred during the covered person's lifetime.

(b) Payment of benefits at the rate of 80 percent of covered medical expenses which are in excess of the deductible, until 20 percent of such expenses in a benefit period reaches $2,000, after which benefits will be paid at the rate of 90 percent during the remainder of the contract year unless the insured is in the insurer's case management program, in which case benefits shall be paid at the rate of 100 percent during the remainder of the contract year. For the purposes of this paragraph, "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 insurer. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50 percent.

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

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

(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 required by this section.

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

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

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

(a) The surviving spouse, if any, at the death of the employee or member, with respect to the spouse and the children whose coverages under the group policy terminate by reason of the death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents' coverages following the employee's or member's death, at the end of such continuation.

(b) 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) The spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group

policy, with respect to the spouse and the children whose coverages under the group policy terminate at the same time.

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

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

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

(17) NOTIFICATION.--A notification of the conversion privilege shall be included in each certificate of coverage. The insurer shall mail an election and premium notice form, including an outline of coverage, on a form approved by the department, within 14 days after an individual who is eligible for a converted policy gives notice to the insurer that the individual is considering applying for the converted policy or otherwise requests such information. The outline of coverage must contain a description of the principal benefits and coverage provided by the policy and its principal exclusions and limitations, including, but not limited to, deductibles and coinsurance.

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

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

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

Section 13. Section 641.3108, Florida Statutes, is amended to read:

641.3108 Notice of cancellation of contract.--

(1) Except for nonpayment of premium or termination of eligibility, no health maintenance organization may cancel or otherwise terminate or fail to renew a health maintenance contract without giving the subscriber at least 45 days' notice in writing of the cancellation, termination, or nonrenewal of the contract. The written notice shall state the reason or reasons for the cancellation, termination, or nonrenewal. All health maintenance contracts shall contain a clause which requires that this notice be given.

(2) If cancellation is due to nonpayment of premium, the health maintenance organization may not retroactively cancel the contract to a date prior to the date that notice of cancellation was provided to the subscriber unless the organization mails notice of cancellation to the subscriber prior to 45 days after the date the premium was due. Such notice must be mailed to the subscriber's last address as

shown by the records of the organization and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due.

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

Section 14. Subsection (1) of section 641.3922, Florida Statutes, 1998 Supplement, 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 days after such termination. However, if termination was the result of failure to pay any required premium or contribution and such nonpayment of premium was due to acts of an employer or group contract holder other than the employee or individual subscriber, written application for the contract must be made and the first premium must be paid not later than 63 days after notice of termination is mailed by the organization or the employer, whichever is earlier, to the employee's or

individual's last address as shown by the record of the organization or the employer, whichever is applicable. In such case of termination due to non-payment of premium by the employer or group contract holder, the premium for the converted contract may not exceed the rate for the prior group coverage for the period of coverage under the converted contract prior to the date notice of termination is mailed to the employee or individual subscriber. For the period of coverage after such date, the premium for the converted contract is subject to the requirements of subsection (3).

Section 15. Subsection (9) is added to section 20.41, Florida Statutes, to read:

20.41 Department of Elderly Affairs.--There is created a Department of Elderly Affairs.

(9) Area agencies on aging are subject to chapter 119, relating to public records, and, when considering any contracts requiring the expenditure of funds, are subject to ss. 286.011-286.012, relating to public meetings.

Section 16. There is appropriated to the Agency for Health Care Administration for fiscal year 1999-2000 $1,439,000 from the Health Care Trust Fund for 12 months of funding for the purpose of implementing this act.

Section 17. This act shall take effect upon becoming a law.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause,

and insert:

A bill to be entitled

An act relating to governmental agencies; amending s. 20.41, F.S.; providing that area agencies on aging are subject to ch. 119 and ss. 286.011-286.012, F.S., as specified; amending s. 408.05, F.S., relating to the State Center for Health Statistics; requiring the Agency for Health Care Administration to publish health maintenance organization report cards; amending s. 408.7056, F.S.; excluding certain additional grievances from consideration by a statewide provider and subscriber assistance panel; revising the membership of the panel; amending s. 627.6471, F.S.; requiring preferred provider organization policies which do not provide direct patient access for dermatological services to conform to certain requirements imposed on exclusive provider organization contracts; amending s. 627.6645, F.S.; revising the notice requirements for cancellation or nonrenewal of a group health insurance policy; specifying conditions under which the insurer may retroactively cancel coverage due to nonpayment of premium; amending s. 627.6675, F.S.; revising the time limits for an employee or group member to apply for an individual converted policy when termination of group coverage is due to failure of the employer to pay the premium; revising the requirements for the premium for the converted policy; allowing

a group insurer to contract with another insurer to issue an individual converted policy under certain conditions; amending s. 641.3108, F.S.; revising the notice requirements for cancellation or nonrenewal of a health maintenance organization contract; specifying conditions under which the organization may retroactively cancel coverage due to nonpayment of premium; amending s. 641.3922, F.S.; revising the time limits for an employee or group member to apply for a converted contract from a health maintenance organization when termination of group coverage is due to failure of the employer to pay the premium; revising the requirements for the premium for the converted contract; amending s. 641.31, F.S., relating to health maintenance contracts; providing for a point-of-service benefit rider on a health maintenance contract; providing requirements; providing restrictions; authorizing reasonable copayment and annual deductible; providing exceptions relating to subscriber liability for services received; amending s. 641.3155, F.S., relating to health maintenance organization provider contracts and payment of claims; requiring health maintenance organizations to reconcile retroactive reductions of payment to specific claims; requiring providers to reconcile retroactive demands for underpayment or nonpayment to specific claims; providing an exception;

providing for the contract to specify the look-back period; providing for an advisory group established in the Agency for Health Care Administration; requiring a report; amending s. 641.51, F.S.; requiring that health maintenance organizations provide additional information to the Agency for Health Care Administration indicating quality of care; removing a requirement that organizations conduct customer satisfaction surveys; revising requirements for preventive pediatric health care provided by health maintenance organizations; amending s. 641.58, F.S.; providing for moneys in the Health Care Trust Fund to be used for additional purposes; amending s. 409.910, F.S.; clarifying that the state may recover and retain damages in excess of Medicaid payments made under certain circumstances; providing for retroactive application; providing an appropriation; providing an effective date.