1983

Session Law 83-198

Florida Senate & House of Representatives

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<th>Year</th>
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### Committee Records

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### Senate/House Journals

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### Tape Recordings

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### Other Documentation

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# LEGISLATIVE SUPPLEMENT "B" - SESSION LAW ABSTRACT

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Documentation List 1983
Laws of Florida, 1983, Chapter 83-189, Section 9
Amending Florida Statutes §641.28
"An Act Relating to Health Maintenance Organizations"

Researcher's Note: This legislation appears to be a "clean-up" bill for the comprehensive Insurance Code Revision of 1982, Laws of Florida, 1982, Chapter 82-243. In the legislative committee files there is a copy of an Ad Hoc committee report of 1981 that seems to address some of the issues raised in the 1982 session (see Item 2 below). Additionally there is an undated copy of a model HMO Act, which is not included here as it had no provisions for civil remedies. The language of FS §641.28 is in the earliest versions of the bills and was not modified during the remainder of the legislative process.

1. Joint Legislative Management Committee. Division of Legislative Information. History of Legislation, 1992 Regular Session. HB 1176 (pp.362-3630 [passed bill] and SB 593 (p. 197) [substituted bill].


3. House Commerce Committee Proposed Committee Bill (PCB) 83-84, 1st Draft, 4/12/83, Section , pp. 1-2, 12. (Later filed as HB 1176).


5. House Bill (HB) 1176 (1983), Section and , pp. 1-2, 12, 18.

6. House. Committee on Commerce. Final Staff Summary of HB 1176, June 20, 1983. (See p. 2, "Effect of Changes", item no. ) [note: previous staff summaries of the PCB did not refer to the proposed amendment to FS §741.28]

7. Senate Bill (SB) 593 (1983), Section and , pp. 1, 10-11, 15


83.1983

1. 450.000

2. 322.500

3. 9/28/53

4. 2.67

5. 2.12

6. 9/12/53

7. 500.000

8. 40.000
Florida Legislature

History of Legislation
1983 Regular Session
1983 Special Sessions A, B, C
1982 Special Session H

prepared by:

Joint Legislative Management Committee
Legislative Information Division
Capitol Building, Room 826—488-4371
H 1174  GENERAL BILL BY REGULATED INDUSTRIES & LICENSING (SIMILAR S 0781)
PUBLIC SERVICE COMMISSION: EXEMPTS AUDITING TECHNIQUES OF COMMISSION FROM PUBLIC RECORDS LAW; AUTHORIZES COMMISSION TO ESTABLISH CHARGES FOR DOCUMENT COPYING & RELATED SERVICES. EFFECTIVE DATE: 10/01/83.
04/27/83 HOUSE FILED; INTRODUCED, REFERRED TO JUDICIARY -HJ 00245
05/02/83 HOUSE SUBREFEREED TO SUBCOMMITTEE ON OPEN GOVERNMENT LAWS; ON COMMITTEE AGENDA—SUBCOMM., JUDICIARY, 317 C, 8:00 AM, 05/04/83
05/06/83 HOUSE SUBREFEREED TO SUBCOMMITTEE ON OPEN GOVERNMENT LAWS; ON COMMITTEE AGENDA—SUBComm., JUDICIARY, 317 C, 8:00 AM, 05/10/83; ON COMMITTEE AGENDA: PENDING SUBCOMMITTEE ACTION—JUDICIARY, 317 C, 9:30 AM, 05/10/83
06/03/83 HOUSE INDEFINITELY POSTPONED & W/D (SCR 1209); WAS IN COMMITTEE ON JUDICIARY

H 1175  GENERAL BILL BY NATURAL RESOURCES (SIMILAR CS/S 0111)
ELECTRICAL TRANSMISSION LINES: PROVIDES POWERS & DUTIES OF ENVIRONMENTAL REGULATION DEPT.; PROVIDES FOR DETERMINATION OF APPLICATION COMPLETENESS & SUFFICIENCY; PROVIDES FOR REPORTS & STUDIES OF PROPOSED TRANSMISSION LINE OR CORRIDOR; PROVIDES FOR LOCAL PUBLIC HEARINGS; ETC. AMENDS CH. 403, 380.00. EFFECTIVE DATE: 10/01/83.
04/27/83 HOUSE FILED; INTRODUCED, REFERRED TO APPROPRIATIONS -HJ 00245
05/03/83 HOUSE ON COMMITTEE AGENDA—APPROPRIATIONS, 21 HOB, 1:00 PM, 05/05/83
05/27/83 HOUSE ON COMMITTEE AGENDA—APPROPRIATIONS, 21 HOB, 8:00 AM, 05/30/83
05/31/83 HOUSE COMM. REPORT: FAVORABLE, PLACED ON CALENDAR BY APPROPRIATIONS—HJ 00874
06/02/83 HOUSE PLACED ON SPECIAL ORDER CALENDAR
06/03/83 HOUSE IDEN./SIM. SENATE BILL SUBSTITUTED; LAID ON TABLE UNDER RULE, IDEN./SIM./COMPARE BILL PASSED, REFER TO C/S SB 111 (CH. 83-222) -HJ 01072

H 1176  GENERAL BILL BY COMMERCE (SIMILAR S 0593)
HEALTH MAINTENANCE ORGANIZATIONS: DEFINES VARIOUS TERMS RE HEALTH MAINTENANCE ORGANIZATIONS; REQUIRES FINANCIAL STATEMENT; PROVIDES FOR REQUIRED MINIMUM SURPLUS FOR HEALTH MAINTENANCE ORGANIZATIONS; REQUIRES SAID ORGANIZATIONS TO FILE REINSURANCE CONTRACTS, ETC. AMENDS CH. 641. EFFECTIVE DATE: 10/01/83.
04/27/83 HOUSE FILED; INTRODUCED, PLACED ON CALENDAR -HJ 00245
05/19/83 HOUSE PLACED ON SPECIAL ORDER CALENDAR
05/25/83 HOUSE READ SECOND TIME; AMENDMENTS ADOPTED —HJ 00599
05/26/83 HOUSE READ THIRD TIME; PASSED AS AMENDED; YEAS 115 NAYS 0 —HJ 00642
05/26/83 SENATE IN MESSAGES
05/30/83 SENATE RECEIVED, REFERRED TO HEALTH AND REHABILITATIVE SERVICES, APPROPRIATIONS—SJ 00486
05/31/83 SENATE EXTENSION OF TIME GRANTED COMMITTEE HEALTH AND REHABILITATIVE SERVICES
06/02/83 SENATE WITHDRAWN FROM HEALTH AND REHABILITATIVE SERVICES, CONTINUED ON NEXT PAGE
06/02/83 APPROPRIATIONS; SUBSTITUTED FOR SB 593; PASSED; YEA 34 NAYS 0 - SJ 00717
06/02/83 HOUSE ORDERED ENROLLED
06/09/83 HOUSE SIGNED BY OFFICERS AND PRESENTED TO GOVERNOR
06/22/83 HOUSE APPROVED BY GOVERNOR CHAPTER NO. 83-198

H 1177 GENERAL BILL BY COMMERCE
MEDICAL FACILITIES; RESTRICTS DENIAL OF ADMISSION TO PERSONS SOLELY BECAUSE SUCH PERSON IS A MEDICAID OR MEDICARE RECIPIENT; DIRECTS STATEWIDE HEALTH COUNCIL TO STUDY ISSUE OF BED DECRIFICATION. CREATES 395.0147. EFFECTIVE DATE: 10/01/83.
04/27/83 HOUSE FILED; INTRODUCED, REFERRED TO APPROPRIATIONS
05/16/83 HOUSE SUBREFERRED TO SUBCOMMITTEE ON MRS/CRIMINAL JUSTICE (SUB. I)
06/03/83 HOUSE INDEFINITELY POSTPONED & W/O (SCR 1209); WAS IN COMMITTEE ON APPROPRIATIONS

H 1178 GENERAL BILL BY ETHICS & ELECTIONS (SIMILAR CS/S 0950, COMPARE CS/ H 0770, ENG/S 0256)
FINANCIAL DISCLOSURE: REDEFINES CERTAIN TERMS; CHANGES DATE FOR FILING FINANCIAL DISCLOSURE STATEMENTS; REQUIRED LOCAL OFFICERS TO FILE STATEMENTS WITH SUPERVISIONS OF ELECTIONS IN COUNTY IN WHICH THEY PERMANENTLY RESIDE; PROVIDES FOR INVESTIGATION OF DELINQUENT FINDINGS, ETC. AMENDS 112.312, 314. EFFECTIVE DATE: 10/01/83.
04/27/83 HOUSE FILED; INTRODUCED, REFERRED TO APPROPRIATIONS
05/06/83 HOUSE WITHDRAWN FROM APPROPRIATIONS -HJ 00350; PLACED ON CALENDAR
05/25/83 HOUSE PLACED ON SPECIAL ORDER CALENDAR
06/01/83 HOUSE READ SECOND TIME; AMENDMENTS ADOPTED; ENG./SIM. SENATE BILL SUBSTITUTED; LAID ON TABLE UNDER RULE; ENG./SIM./COMPARE BILL PASSED, REFER TO SB 256 (CH. 83-282) & C/S HB 770 (CH. 83-128) -HJ 00889

H 1179 GENERAL BILL BY NATURAL RESOURCES (SIMILAR S 0703, COMPARE H 1210, S 0704)
WATER MANAGEMENT DISTRICT; INCREASES MILLAGE CAP FOR NORTHWEST FLORIDA WATER MANAGEMENT DISTRICT. AMENDS 373.503. EFFECTIVE DATE: CONTINGENT.
04/27/83 HOUSE FILED; INTRODUCED, REFERRED TO FINANCE & TAXATION, APPROPRIATIONS -HJ 00246
05/02/83 HOUSE ON COMMITTEE AGENDA— FOR SUBREFERRAL, 21 HOB, 1:30 PM, 05/04/83
05/04/83 HOUSE SUBREFERRED TO SUBCOMMITTEE ON AD VALOREM TAX AND LOCAL GOVERNMENT
05/24/83 HOUSE ON COMMITTEE AGENDA— F. & T., 413 C, AFTER HOUSE ADJ., 05/25/83
06/03/83 HOUSE INDEFINITELY POSTPONED & W/O (SCR 1209); WAS IN COMMITTEE ON FINANCE & TAXATION

H 1180 MEMORIAL BY NATURAL RESOURCES
ENVIRONMENTAL PROGRAMS; REQUESTS OF THE PRESIDENT & CONGRESS OF UNITED STATES THAT FEDERAL SUPPORT FOR ENVIRONMENTAL PROGRAMS BE MAINTAINED.
04/27/83 HOUSE FILED; INTRODUCED, PLACED ON CALENDAR -HJ 00246
06/03/83 HOUSE INDEFINITELY POSTPONED & W/O (SCR 1209); WAS ON CALENDAR

H 1181 GENERAL BILL BY TOURISM & ECONOMIC DEVELOPMENT AND OTHERS (IDENTICAL CS/S 1156, SIMILAR ENG/S 1050, COMPARE H 0483, S 0507)
COMMUNITY REDEVELOPMENT: PROVIDES THAT CONSIDERATION BE GIVEN TO USE OF FLA. ENTERPRISE ZONE ACT OF 1982 & ITS INCENTIVES IN COMMUNITY REDEVELOPMENT AREAS; PROVIDES THAT COMMUNITY REDEVELOPMENT PLANS APPLY TO SAID AREAS; PROVIDES FOR USES OF COMM. DEVELOPMENT TRUST FUNDS, ETC. AMENDS CH. 163. EFFECTIVE DATE: 10/01/83.
04/27/83 HOUSE FILED; INTRODUCED, REFERRED TO FINANCE & TAXATION -HJ 00246
05/02/83 HOUSE ON COMMITTEE AGENDA— FOR SUBREFERRAL, 21 HOB, 1:30 PM, 05/04/83
06/03/83 HOUSE INDEF. POSTPONED & W/O (SCR 1209); WAS IN COMMITTEE ON NEXT PAGE
05/31/83 SENATE EXTENSION OF TIME GRANTED COMMITTEE HEALTH AND
REHABILITATIVE SERVICES
06/03/83 SENATE INDEFINITELY POSTPONED & W/O (SCR 1209); WAS IN
COMMITTEE ON HEALTH AND REHABILITATIVE SERVICES

S 592 GENERAL BILL BY GORDON (IDENTICAL H 0756)
EFFECTIVE DATE: 10/01/83
04/07/83 SENATE FILED
04/12/83 SENATE INTRODUCED, REFERRED TO HEALTH AND REHABILITATIVE
SERVICES - SJ 00076
05/11/83 SENATE EXTENSION OF TIME GRANTED COMMITTEE HEALTH AND
REHABILITATIVE SERVICES
05/19/83 SENATE EXTENSION OF TIME GRANTED COMMITTEE HEALTH AND
REHABILITATIVE SERVICES
05/31/83 SENATE EXTENSION OF TIME GRANTED COMMITTEE HEALTH AND
REHABILITATIVE SERVICES
06/03/83 SENATE INDEFINITELY POSTPONED & W/O (SCR 1209); WAS IN
COMMITTEE ON HEALTH AND REHABILITATIVE SERVICES

S 593 GENERAL BILL BY CHILDERS, DUN AND OTHERS (SIMILAR ENG/H 1176)
HEALTH MAINTENANCE ORGANIZATIONS; REQUIRES FINANCIAL STATEMENT &
ACTUARIALY SOUND RATES; PROVIDES SURPLUS REQUIREMENTS; REQUIRES FILING
OF REINSURANCE CONTRACTS; PROVIDES FOR REVOCATION OF CERTIFICATE OF
AUTHORITY, ETC. AMENDS 641.21-23, 25-28, 285, 315.19, 31; CREATES
641.225. EFFECTIVE DATE: UPON BECOMING LAW.
04/07/83 SENATE FILED
04/12/83 SENATE INTRODUCED, REFERRED TO HEALTH AND REHABILITATIVE
SERVICES, APPROPRIATIONS - SJ 00153
04/14/83 SENATE ON COMMITTEE AGENDA - HRS, 04/20/83, 9:00 AM; RM. A
04/20/83 SENATE COMM. REPORT: FAVORABLE WITH AMEND. BY HEALTH AND
REHABILITATIVE SERVICES - SJ 00153
04/21/83 SENATE NOW IN APPROPRIATIONS - SJ 00153
05/04/83 SENATE EXTENSION OF TIME GRANTED COMMITTEE APPROPRIATIONS
05/16/83 SENATE EXTENSION OF TIME GRANTED COMMITTEE APPROPRIATIONS
05/29/83 SENATE WITHDRAWN FROM APPROPRIATIONS - SJ 00337; PLACED ON
CALENDAR
06/02/83 SENATE PLACED ON CONSENT CALENDAR; IDEN./SIM. HOUSE BILL
SUBSTITUTED; LAID ON TABLE UNDER RULE, IDEN./SIM./COMPARE: BILL PASSED, REFER TO HB 1176 (CH.
1981-83) - SJ 00770

S 594 GENERAL BILL/CJS BY COMMERCE, GERSTEN, MYERS (COMPARE S 0389)
PUGILISTIC EXHIBITIONS: CREATES STATE ATHLETIC COMMISSION WITHIN
GOVERNOR'S OFFICE; PROVIDES FOR MEMBERS' COMPENSATION & TERMS OF OFFICE;
REGULATES BOXING IN STATE; GRANTS EXCLUSIVE JURISDICTION OVER ALL BOXING
MATCHES TO COMMISSION, ETC. CREATES 14.27, 548.041-.49; REPEALS
§48.01-.04. EFFECTIVE DATE: 10/01/83.
04/07/83 SENATE FILED
04/11/83 SENATE INTRODUCED, REFERRED TO COMMERCE, GOVERNMENTAL
OPERATIONS, APPROPRIATIONS - SJ 00076
04/26/83 SENATE EXTENSION OF TIME GRANTED COMMITTEE COMMERCE
05/12/83 SENATE EXTENSION OF TIME GRANTED COMMITTEE COMMERCE; ON
COMMITTEE AGENDA -- COMMERCE, 05/17/83, 9:00 AM; RM. A
05/17/83 SENATE CJS COMBINES THIS BILL AND SB 389; COMM. REPORT: CJS
BY COMMERCE - SJ 00303; CJS READ FIRST TIME 05/19/83
05/19/83 SENATE NOW IN GOVERNMENTAL OPERATIONS - SJ 00303; WITHDRAWN
FROM GOVERNMENTAL OPERATIONS - SJ 00326; NOW IN FINANCE, TAXATION AND CLAIMS
05/27/83 SENATE ON COMMITTEE AGENDA -- FINANCE, TAX & CLAIMS, 05/30/83,
12 NOON, RM. IC - SJ 00451
CONTINUED ON NEXT PAGE
Dear Tom:

Enclosed is the approved and accepted version by the Ad Hoc Committee. It also reflects the industry thinking. When testimony comes up please let me know.

Sincerely,

Gary Jacobs
President

Enclosures:
1) Final Recommendations on HMO's Approved by the Ad Hoc Study Committee, August 12, 1981
2) Solvency Amendment to NAIC Model HMO Act

cc: Mr. Dale Hazlet, Committee on Insurance

P.S. Please see the final approved report of August 12, 1981, especially those sections which are highlighted and which contrast with the corresponding sections in the new report of September 22, 1981.
TO: All Interested Parties

FROM: Representative Tom Gustafson
Chairman, House Insurance Committee

RE: PRELIMINARY DRAFT OF THE INSURANCE CODE

Earlier this month the preliminary draft of the Insurance Code was made available to you. Members of the House of Representatives were asked to review this draft bill and mail their comments to the committee staff by October 21, 1981. Other interested parties were asked to review the document and comment no later than October 16, 1981.

This is a second notice to remind you to please comply with these dates so that any additional alternatives you may have can be considered during upcoming committee meetings.

The remaining parts of the code will be made available for your review as soon as those sections are completed.

TG:1f
Insurance Committee
Florida House of Representatives

Final Recommendations on HMO's

Approved by the Ad Hoc Study Committee, August 12, 1981

The Committee recommends the centralization of the state HMO program into a new and distinct bureau within the Insurance Department. The new bureau shall be called the Bureau of HMO's, and shall be the sole state agency responsible for implementing Section 641, Part II of the Code. Further, in promulgating new rules to implement the suggested revisions, the Committee would like the opportunity to work with the Department of Insurance and the new Bureau to ensure that the Committee's intent is being carried out.

Section 641, Part II

641.18, Declaration of Legislative Intent:

In this paragraph, it should be noted that HMO's should operate on an equal footing with fee-for-service medicine in terms of quality of health services offered to the public, and that both systems should be subject to quality assurance programs and peer review mechanisms to ensure said quality.

641.19, Minimum Services Definition:

This paragraph should remain the same. It is the intent of the Committee to reserve the HMO's freedom to deliver said benefits in a manner which preserves quality, and appropriate care within a responsible fiscal environment. No services should be introduced into the minimum services definition which could jeopardize the fiscal soundness of the HMO, or which would affect the HMO's ability to control the delivery of health services in a manner consistent with its plan's purpose. Care should be available after the . . .
641.20:

Accept the Commissioner's recommendations.

641.21:

In applying for a Certificate of Authority, an HMO must provide to the Commissioner a sound plan to protect its members from the risk of insolvency. A plan suggested for the Commissioner's review would be the National Association of Insurance Commissioners' Model HMO Insolvency Act.

641.22:

A statutory definition of working capital was not recommended. However, the Committee recommended language similar to the National Association of Insurance Commissioners' proposal cited above.

641.23:

This requires the HMO to maintain its insolvency plan and applicable reserves or policies in effect at all times. If a change is requested to the approved plan, it must be re-approved by the Commissioner.

641.24:

Direct oversight and responsibility for HMO's should be centralized within a new and separate Bureau of HMO's, within the Insurance Department. In assessing quality of care, the Bureau should seek recommendations from the Secretary of Health & Rehabilitative Services.

641.25:

As there is no documentation of the need for deletion of the language which the Insurance Department has proposed, the Ad Hoc Committee recommends that the language should be retained. An HMO cited by the Insurance Department should have a reasonable period of time to correct any deficient, defective administrative actions or at time be levied.
The Ad Hoc Committee proposes that language be developed to stipulate that the Annual Report submitted to the U. S. Dept. of Health & Human Services should be in compliance with the reporting requirements under this section of the state statute. Thus, the problem of dual reporting would be eliminated and, therefore, reduce the HMO's administrative costs.

Accept the Insurance Commissioner's recommendation.

Remove the personal liability responsibility for the boards of directors of not-for-profit HMO's, as this restriction is not placed on other health insurers. This provision as currently written may prohibit developing HMO's from attracting high-caliber board members. The Committee felt that HMO boards should encompass providers from the field if the HMO extends coverage (e.g. if dental benefits are provided, a dentist should be involved with the board of directors).

Remove the Dept. of Health & Rehabilitative Services provision.

Accept the recommendations of the Insurance Commissioner.

Accept the recommendations of the Insurance Commissioner.
641.33:

Accept the recommendations of the Insurance Commissioner.

641.34:

Revise the open enrollment provision to be consistent with the Federal HMO Act. A 30-day open enrollment period is required of an HMO when one of the following conditions has been met: One year after it has been operating in such a manner whereby revenues exceed expenses, or, the HMO has been in operation for five years, or the HMO has 50,000 members. This revision permits HMO's to develop a fiscally sound presence in the marketplace before it must open its doors to all who seek membership. No other insurer is required to extend membership to anyone who seeks it, and it was felt that an HMO needs to develop a successful track record before it should be required to offer open enrollment.

641.35:

Accept the Insurance Commissioner's recommendation.

641.36:

The Dept. of Health & Penulitative Services' role is in the capacity of an advisor to the Commissioner on matters related to quality of care.

641.37:

Accept the Insurance Commissioner's recommendation.

641.38:

Accept the Insurance Commissioner's recommendation.

641.39:

Accept the Insurance Commissioner's recommendation.
MEMORANDUM

TO: MEMBER HEALTH PLANS
ASSOCIATED HEALTH PLANS
DEVELOPING HEALTH PLANS

FROM: ERLING HANSEN, COUNSEL

DATE: OCTOBER 1, 1981

RE: SOLVENCY AMENDMENT TO NAIC MODEL HMO ACT

On October 19, 1981, the HMO Task Force of the National Association of Insurance Commissioners (NAIC) will vote to recommend certain amendments to the NAIC Model HMO Act. The most critical and most controversial of these amendments is an insolvency provision which would establish reserve deposits for HMOs based on the estimated dollar value of their uncovered health care expenditures. The proposed final version of this solvency amendment, including a proposed drafter's comment, is enclosed for your review and comment. A summary of the amendment follows:

The proposed amendment to Section 14 of the NAIC Model HMO Act now requires an initial deposit (for initial operation) to be the greater of (1) five percent of the HMO's estimated annual premium revenues; or (2) the value of two months of average uncovered liabilities; or (3) $100,000. After the first year, the initial deposit would be augmented by an annual deposit at the rate of four percent of uncovered liabilities to a maximum of two months of uncovered liabilities.

Existing HMOs would initially deposit the larger of one percent of uncovered liabilities for the preceding year or $100,000, and would phase in the annual deposit at the rate of one percent a year for the subsequent 3 years.
The annual deposit requirement would no longer apply when the organization has deposited amounts equal to either 25% of the HMO's estimated annual uncovered expenditures for the next calendar year or to the capital and surplus requirements of accident and health insurers, whichever amount is less.

The annual deposit requirements would not apply to HMOs who have either been (1) operating for five years and have one million dollars net worth (liquid assets), or (2) operating for ten years and have five million dollars in total plan-related assets. The annual deposit would also not apply to guaranteeing or sponsoring organizations meeting the same net worth requirements except that the net worth requirement would increase by a multiple equal to the number of HMOs sponsored by such organizations if they sponsored more than one.

Finally, HMOs and their guaranteeing or sponsoring organizations not required to make an annual deposit would be entitled to lower the amount of their initial (as opposed to annual) deposit by $100,000 for each $250,000 of net worth in excess of $1 million, excluding plant and equipment, or $5 million, including plant-related land, buildings and equipment. All interest from cash or securities on deposit with the commissioner shall belong to the depositing organization and shall be paid to it as it becomes available.

The likelihood is great that this proposal will be adopted by the NAIC in December and be introduced in many state legislatures next year as an amendment to state HMO legislation.

Please review the proposal (e.g., calculate the amount of money your organization would be required to deposit) and communicate your concerns -- either philosophical or technical -- to me (202-737-4311) or to Jim Lane (415-271-6306). We must have your comments by October 16, 1981, if you want your concerns expressed to the NAIC HMO Task Force at the October 19 meeting.
Section 2. Definitions

(10) "Uncovered expenditures" means the costs of those services that are covered under the organization's health care plans, but that are not guaranteed, insured or assumed by a person or organization other than the health maintenance organization, or that a provider has not agreed to hold not bill enrollees harmless if the provider is not paid by the health maintenance organization.

Section 14. Protection Against Insolvency

Unless otherwise provided below and except as is required in Section-8 (4) (f) of this Act, each health maintenance organization shall deposit with the Commissioner (Director/Superintendent) or with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, for cash, securities, or any combination of these or other measures that is acceptable to him in the amount set forth in this Section.
(1) The amount for an organization that is beginning operation shall be the greater of: (a) five percent (5%) of its estimated expenditures for health care services for its first year of operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation or (c) $100,000.

At the beginning of each succeeding year, unless not applicable, such an organization shall deposit with the Commissioner (Director/Superintendent), or organization or trustee, cash, securities, or any combination of these or other measures acceptable to the Commissioner (Director/Superintendent), in an amount equal to four percent (4%) of its estimated annual uncovered expenditures for that year.

(2) Unless not applicable, an organization that is in operation on the effective of this section shall make a deposit equal to the larger of; (a) one percent (1%) of the preceding 12 months of uncovered expenditures, or (b) $100,000, on the first day of the first fiscal year beginning six (6) months or more after the effective date of this Section.

In the second fiscal year, if applicable, the amount of the additional deposit shall be equal to two percent (2%) of its estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit shall be equal to three percent (3%) of its estimated annual uncovered expenditures for that year, and in the fourth fiscal year and subsequent years, if applicable, the additional deposit shall be equal to an amount of four percent (4%) of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation shall reasonably reflect the prior years operating experience and delivery arrangements.

(3) The Commissioner (Director/Superintendent) may waive any of the deposit requirements as set forth in subsections (1) and (2) above, whenever
satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, (hospital or medical service corporation), governments or other organizations are sufficient to reasonably assure the performance of its obligations.

(4) When an organization has achieved a net worth not including land, buildings, and equipment, of at least $1 million or has achieved a net worth including plan-related land, buildings, and equipment of at least $5 million, the annual deposit requirement shall not apply.

The annual deposit requirement shall not apply to an organization if the total amount of the deposit with the Commissioner (Director/Superintendent) of each, securities or any combination of these or other measures is equal to 25% of the HMO's estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation for admittance of an accident and health insurer in this state, whichever is less.

If the organization has a guaranteeing organization which has been in operation for at least five (5) years and has a net worth not including land, buildings, and equipment of at least $1 million or which has been in operation for at least ten (10) years and has a net worth including plan-related land, buildings, and equipment of at least $5 million, the annual deposit requirement shall not apply; provided, however, that if the guaranteeing organization is sponsoring more than the one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall
not apply during any time that the guaranteeing organization maintains a net worth at least equal to the capital and surplus requirements for an accident and health insurer for each organization it sponsors.

(5) All income from securities-on deposits with the Commissioner (Director, Superintendent) shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit with the Commissioner (Director, Superintendent) may, at its option, withdraw the securities deposit or any part thereof, first having deposited, in lieu thereof, a deposit of cash, securities, or any combination of these or other measures of equal amount and value to that withdrawn. Any securities shall be approved by the Commissioner (Director, Superintendent) before being substituted.

(6) In any year in which an annual deposit is not required of an organization, at its request, the Commissioner shall lower its required deposit by $100,000 for each $250,000 of net worth not including land, buildings and equipment it or a guaranteeing organization on its behalf and not for another organization, has in excess of $1 million, or in excess of $5 million of net worth, including only HMO plan-related land, buildings and equipment contributing to the delivery of health care services. If the net worth of an organization or guaranteeing organization no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction, provided that its total deposit does not exceed the maximum required under this section.
Introduction

The purpose of this report is to propose amendments to the National Association of Insurance Commissioners (NAIC) Model Health Maintenance Organization Act.

The initial concern of the Task Force was with developing means of assuring the solvency of health maintenance organizations (HMOs). Since the Model Act was developed, a small number of HMOs have become insolvent and in a few cases, their enrollees have been faced with claims from providers for services that were covered by the HMO, but that it was unable to pay.

In addition, the Task Force has examined the entire Model Act and has determined that there are a number of provisions that may be costly to HMOs and thus affect their competitive position and long-term growth. This report recommends that such provisions be deleted or amended.

The Task Force has concluded that it is not possible to solve the problem of continued insurability of enrollees in HMOs that fail on a state basis. It is believed that there will be a limited number of such persons because most HMO enrollees are members of groups with dual or multiple choice programs under which they have an option of being covered by another carrier without medical review. Even so, for those few enrollees, the loss of insurability while enrollees of the failed HMO can create a substantial problem.

One approach to the problem the Task Force considered was to require other HMOs in the state to assume the responsibility for continued coverage of the enrollees of failed HMOs. However, there may be only a few other
HMOs and they may not operate in the same area so that it is impossible or unreasonable to impose such an obligation upon them.

There are other possible solutions to this problem, but they are beyond the scope of this report. They include: 1) the establishment of a continued insurability program for enrollees of federally qualified HMOs under the HMO Act. This would require federal legislation and would only apply to approximately one-half the HMOs in the country; 2) the establishment of a continued insurability program for persons covered by all health benefits carriers in a state. This would broaden the base for bearing the costs of continued coverage, but it would also increase the persons eligible and thus could be costly for an HMO; 3) the establishment of a state pool for uninsurables as set forth in the NAIC Model Comprehensive Health Insurance and Health Care Cost Containment Act. This proposal has been advanced by the NAIC to solve a broader health insurance problem, but its enactment would be an ideal solution to the problem of continued insurability for enrollees of failed HMOs.

The Task Force realizes that the best protection against the problem created by an HMO's insolvency is the continued solvency of all HMOs. However, the means for assuring such solvency are imperfect. They include high financial entry requirements and stringent financial monitoring that characterize insurance regulation. Many insurance regulations are not applicable to HMOs, but of more importance, they may be of little value in detecting problems. For example, HMOs have failed recently because their membership grew too fast and because they lost the services of a medical group or individual practice association. Because of this and because of the
constraints traditional insurance regulation can place upon HMO development, the Task Force has concentrated on protecting the HMO enrollees from claims of providers for services for which the failed HMO was liable.

Protection Against HMO Insolvency

Section 4(2) of the Model Act provides that the Commissioner shall issue a certificate of authority to an HMO if the Commissioner is satisfied that, among other things, the HMO is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. The section then sets forth a number of factors that the Commissioner may consider in determining that an HMO is financially responsible, but does not provide specific guidance on how the factors are to be applied. The relevant note to the section provides:

Under Subsection (2)(d), to grant a certificate of authority, the Commissioner should be satisfied that the health maintenance organization will have the financial resources to provide the health care services for which it is obligated to its enrollees. However, it is recognized that requiring an HMO to have a specified minimum capitalization might prevent the organization or implementation of an otherwise viable HMO. Furthermore, with various possible insurance and surety arrangements available to back up the HMO's promise of performance, reserve requirements such as those found in the insurance laws are not deemed necessary.

In addition, Section 14 of the Model Act provides that each HMO shall furnish a surety bond or deposit of cash or securities with the Commissioner
in an amount satisfactory to the Commissioner that the HMO's obligations to the enrollees will be performed. The Commissioner may waive this requirement whenever satisfied that the assets of the organization, or its contracts with insurers, governments, or other organizations are sufficient to reasonably assure the performance of its obligations.

The Task Force believes that these provisions provide an adequate statutory base for protecting HMO members from the problems created by the insolvency of an HMO. However, they require the exercise of considerable judgement on the part of Commissioners and no guidance has been provided to assist a Commissioner in deciding the amount of a surety bond or deposit. Therefore, the Task Force is recommending the following guidelines. They are presented in the form of an amendment to Section 14, but could also be adopted as a regulation under Section 14 as it now exists, or used as guidelines in implementing the existing section.

Section 14 should be amended to read:

Section 14. Protection Against Insolvency

Insert Proposed Section

The comment for Section 14 should be amended to read:

Comment. Fiscal control of health maintenance organizations in a manner comparable to that applied to insurance companies appears inappropriate in view of the service nature of such organizations. However, very serious problems can arise if a health maintenance organization defaults on its contracts, whether the reasons are fiscal or not.
The best protection for the enrollees is a financially sound organization that generates net income. However, beginning health maintenance organizations are often small businesses with limited financial resources that will sustain operating losses in their early years. Unreasonably high starting capital or reserve requirements may prevent some organizations from starting or may unreasonably tie up the capital of those that do. Some enrollees may be unable to obtain care thereafter if an HMO defaults, even because of their insolvency or for other reasons. This Section provides for a structured but flexible approach to protecting against insolvency. It requires the maintenance of a minimum capital account and a deposit of cash or securities or other measures in an amount satisfactory to and requires the organization to generate additional amounts annually for deposit the Commissioner as a guarantee that source of funds to meet the organization’s contractual obligations to the enrollees in the event of insolvency. will be performed or at least that money will be available to purchase such services. Alternatively, the

The Commissioner may waive this requirement all or part of these requirements when satisfied that the organization has sufficient net worth or an adequate history of generating net income to assure its viability. The requirements may also be waived if the health maintenance organization’s performance is guaranteed by another financially strong organization.

The section relates the deposit requirements to the amount of uncovered liability the health maintenance organization has. This amount will vary depending upon the type of organization and the nature of its arrangements.
with providers. For example, the physicians of the staff of the organization or a contracting medical group or individual practice association may agree to look only to the organization for payment for services provided to the organization's enrollees and agree not to bill them in the event of insolvency.* An organization could have insurance for all or part of its hospitalization expense or another organization could agree to guarantee that the liabilities of the health maintenance organization are met. In all such cases, it is recommended that the contractual provision require the provider or guarantor to notify the Commissioner if the provision or insurance is modified or no longer in effect or if payment on the contract or policy has not been made in a reasonable period of time (Section 3(5) requires prior notification of cancellation of any reinsurance.) This can provide an early warning of possible adverse changes in the health maintenance organization's financial position. In addition, the status of such provisions or policies should be covered in annual interrogatories to the organization. It is believed that these provisions and the related provisions of Section 4(2) (d), including possible insurance backup arrangements, provide adequate assurances. The failure to provide assurances as required would subject the health maintenance organization to suspension or revocation of its certificate of authority under Section 19.

*A provision to accomplish this might read:

ABC Medical Group and its physicians will look solely to XYZ HMO for compensation for medical services and other services incident thereto rendered by ABC Medical Group to enrollees of XYZ HMO, and will not assert any claim for compensation (other than collection of
Supplemental charges on XYZ HMO's behalf) against enrollees of XYZ HMO for medical services. Any modification or deletion of this provision shall be reported within 15 days to the State Commissioner of Insurance.
which annuity contracts may be purchased under the program, and shall approve the form and content of the optional retirement program contracts.

(c) The provisions of each contract applicable to a participant in the optional retirement program shall be contained in a written program description which shall include a report of pertinent financial and actuarial information on the solvency and actuarial soundness of the program and the benefits applicable to the participant. Such description shall be furnished by the companies to each participant in the program and to the division upon commencement of participation in the program, and thereafter on an annual basis.

(d) The division shall ensure that each participant in the optional retirement program is provided an accounting of the total contributions and the annual contributions made by and on behalf of the participant.

Section 2. The introductory paragraph of section 121.23, Florida Statutes, is amended to read:

121.23 Disability retirement and special risk membership applications, Retirement Commission; powers and duties; judicial review.—The provisions of this section shall apply to all proceedings respecting applications for disability retirement, reexamination of retired members receiving disability benefits, and applications for special risk membership in the Florida Retirement System, and applications for eligibility for the State University System optional retirement program as provided in s. 121.35.

Section 3. This act shall take effect July 1, 1983.

Approved by the Governor June 22, 1983.

Filed in Office Secretary of State June 23, 1983.

CHAPTER 83-198

House Bill No 1176

An act relating to health maintenance organizations; adding subsections (9)-(13) to s. 641.19, Florida Statutes, 1982 Supplement, defining "surplus," "guaranteeing organization," "uncovered expenditures," "insolvent" or "insolvency" and "surplus notes"; amending s. 641.21(7), Florida Statutes, 1982 Supplement, relating to applications for certificates; requiring a financial statement; amending s. 641.22, Florida Statutes, 1982 Supplement, relating to issuance of certificates of authority; providing for required minimum surplus for health maintenance organizations; requiring health maintenance organizations to file reinsurance contracts with the department; creating s. 641.225, Florida Statutes, relating to surplus requirements; amending s. 641.23, Florida Statutes, 1982 Supplement, relating to revocation of certificates; providing a time period for order of compliance; amending s. 641.25, Florida Statutes, 1982 Supplement, providing for administrative penalties in lieu of revocation; amending s. 641.26,
Be it enacted by the Legislature of the State of Florida.

Section 1. Subsections (9), (10), (11), (12) and (13) are added to section 641.19, Florida Statutes, 1982 Supplement, to read:

641.19 Definitions.--As used in this part, the term:

(9) "Surplus" means total unencumbered assets in excess of total liabilities. Surplus shall include capital stock, capital in excess of par, retained earnings and may include surplus notes.

(10) "Guaranteeing organization" is an organization which is domiciled in the United States, which has authorized service of process against it, and which has appointed the Insurance Commissioner as Treasurer as its Agent for Service of Process upon any cause of action arising in this state, based upon any guarantee entered into under this part.

(11) "Uncovered expenditures" means the cost of health care services that are covered by a health maintenance organization, for which a subscriber would also be liable in the event of the organization's insolvency.

(12) "Insolvent" or "insolvency" means the inability of the health maintenance organization to discharge its liabilities as they become due in the normal course of business.

(13) "Surplus notes" means debt which has been guaranteed by the U.S. Government or its agencies, or debt which has been subordinated to all claims of subscribers and general creditors of the organization.

Section 2. Subsection (7) of section 641.21, Florida Statutes, 1982 Supplement, is amended to read:

641.21 Application for certificate.--Before any entity may operate a health maintenance organization, it shall obtain
Chapter 83-198, Laws of Florida Certificate of Authority from the Department Each application for a certificate shall be on such form as the department shall prescribe and shall be accompanied by the following:

(7) A financial statement prepared on the basis of generally accepted accounting principles, except that surplus notes acceptable to the department and meeting the requirements of this act may be included in its calculation of surplus. A statement of the assets and liabilities of the entity.

Section 3. Section 641.22, Florida Statutes, 1982 Supplement, is amended to read

641.22 Issuance of certificate of authority.--The department shall issue a certificate of authority within 60 days of the filing of a properly completed the application to any entity filing a completed application in conformity with s. 641.21, upon payment of the prescribed fees and upon being satisfied that:

(1) The entity proposes to establish and operate a bona fide health maintenance organization having the capability to provide comprehensive health care services in the geographic area proposed, as certified by the Department of Health and Rehabilitative Services as a condition precedent to the issuance of any certificate.

(2) The proposed rates are sound actuarially sound for the benefits provided, including administrative costs, and the health maintenance organization has and will continue to have adequate working capital in a minimum amount of $100,000 each or working capital sufficient to carry all operating expenses for a period of at least 3 months; whichever is the greater amount. A reasonable sufficiency of working capital shall be determined by the department by taking into account the area to be served, the anticipated number of subscribers, and the type of services to be rendered.

(3) Prior to December 31, 1985, the health maintenance organization must have a minimum surplus of $100,000. After December 31, 1985, the health maintenance organization must have a minimum surplus as follows:

(a) As of December 31, 1986, $150,000;
(b) As of December 31, 1987, $200,000;
(c) As of December 31, 1988, $250,000.

In lieu of having any minimum surplus there may exist a written guarantee to insure payment of covered subscriber claims provided by an entity which has been in operation for at least 3 years and has a surplus, not including land, buildings, and equipment, equal to two times the statutory surplus deficiency or two times the statutory requirement, whichever is the greater amount. Such guaranteeing organization and the written guarantee must be acceptable to and approved by the Department of Insurance.

(4) The health maintenance organization has made acceptable arrangements to provide all health care services offered.

(5) The terms of the contracts such entity proposes to offer to subscribers will in fact assure that the comprehensive health care
services required by such subscribers will be rendered under reasonable standards of quality of care, as certified by the Department of Health and Rehabilitative Services.

(6) The procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, health, or economic status. However, this section shall not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor shall it prohibit experience rating.

(7) The entity furnishes evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of comprehensive health care.

(8) The entity has provided, through contract or otherwise, for periodic review of its medical facilities and services.

(9) The ownership, control, or management of the entity is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The department shall not grant or continue authority to transact the business of a health maintenance organization in this state at any time during which it has good reason to believe that the ownership, control, or management of the organization is under the control of any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors; by the improper manipulation of assets or of accounts; or by bad faith.

(10) The entity has a blanket fidelity bond in the amount of $25,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with such funds. All employees handling such funds shall be covered by the blanket fidelity bond. An agent licensed under the provisions of the Florida Insurance Code may either directly or indirectly represent the health maintenance organization's contract or collect or forward any consideration paid by the subscriber to the health maintenance organization; and such agent shall not be required to post the bond required by this subsection.

(11) The entity has filed with and obtained approval from the department all reinsurance contracts as provided in § 641.225, Florida Statutes, is created to read 641.225 Surplus requirements --

(1) Each health maintenance organization licensed prior to October 1, 1983, must have by December 31, 1985, a minimum surplus of $100,000. After December 31, 1985, each health maintenance organization must have a minimum surplus as follows:

(a) As of December 31, 1986, $150,000.

(b) As of December 31, 1987, $200,000.
(c) As of December 31, 1988, $250,000.

(2) In lieu of having a minimum surplus, there may exist for a health maintenance organization a written guarantee of the type and subject to the same provisions as outlined in s. 641.22.

Section 5 Section 641.23, Florida Statutes, 1982 Supplement, is amended to read:

641.23 Revocation of certificate of authority.--The department may revoke any certificate issued to a health maintenance organization, or order compliance within 60 days, if it finds that any of the following conditions exists:

(1) The organization is not operating in compliance with this part;

(2) The organization is in substantial violation of its health maintenance contracts, as certified by the Department of Health and Rehabilitative Services;

(3) The organization is unable to fulfill its obligations under outstanding health maintenance contracts entered into with its subscribers, as certified by the Department of Health and Rehabilitative Services;

(4) The plan is no longer actuarially sound or the organization does not have the minimum surplus as required by this part adequate working capital;

(5) The existing contract rates are excessive, inadequate, or unfairly discriminatory, or

(6) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising; or

(7) The organization is insolvent.

Section 6. Section 641.25, Florida Statutes, 1982 Supplement, is amended to read:

641.25 Administrative penalty in lieu of revocation.--The department may, in lieu of revocation, levy an administrative penalty in an amount not less than $100 or more than $10,000.

Section 7 Section 641.26, Florida Statutes, 1982 Supplement, is amended to read:

641.26 Annual report.--

(1) Every health maintenance organization shall, annually on or before April 1, or within 3 months of the end of the fiscal year for health maintenance organizations operating under a valid certificate of authority as of the effective date of this section, or within such extension of time therefor as the department, for good cause, may grant, on forms prescribed by the department, file a report with the department, verified by the oath of two executive officers of the organization, or, if not a corporation, of two
persons who are principal managing directors of the affairs of the organization, showing its condition on the last day of the preceding calendar year. Such report shall include:

(a) A financial statement of the organization, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant;

(b) A list of the names and residence addresses of all persons responsible for the conduct of its affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the health maintenance organization, including any possible conflicts of interest;

(c) The number of health maintenance contracts issued and outstanding and the number of health maintenance contracts terminated and a compilation of the reasons for such terminations;

(d) A description by location and specialty of the providers retained or otherwise engaged by the organization to satisfy its contractual obligations with its subscribers;

(e) Such statistical information as is requested by the department reflecting the rates of the health maintenance organization for all comprehensive health care services provided under health maintenance contracts;

(f) The number and amount of damage claims for medical injury initiated against the health maintenance organization and any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim; and

(g) An actuarial certification that the health maintenance organization's rates are actuarially sound for the benefits provided, and

(h)(g) Such other information relating to the performance of health maintenance organizations as is required by the department.

(2) Any health maintenance organization which is unable to provide to the department an audited financial statement within the time required shall annually file, on or before March 1 next following each calendar year, the annual report required by subsection (1) with an unaudited financial statement of the organization, and certification of such financial statement by an independent certified public accountant shall be received by the department by the following May 1.

(3) Any health maintenance organization which neglects to file the annual report in the form and within the time required by this section shall forfeit $100 for each day during which the neglect continues, and, upon notice by the department to that effect, its authority to do business in this state shall cease while such default continues. The department shall deposit all sums collected by it under this section to the credit of the Insurance Commissioner's Regulatory Trust Fund.

Section 8. Section 641.27, Florida Statutes, 1982 Supplement, is amended to read:
641.27 Examination by the department.--The department shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 3 years. The Department of Health and Rehabilitative Services may conduct periodic examinations regarding the quality of health care services being provided by the organization. Every health maintenance organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. However, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the respective departments may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The expenses of examination of each health maintenance organization by the department shall be subject to the same terms and conditions as apply to insurers under part II of chapter 624 of the Florida Insurance Code. The expenses of examination of each health maintenance organization by the Department of Health and Rehabilitative Services shall be paid by the organization. In no event shall expenses of all examinations exceed a maximum of $15,000 per year. Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation, liquidation, conservation, or dissolution of life insurance companies.

Section 9 Section 641.28, Florida Statutes, 1982 Supplement, is amended to read:

641.28 Civil remedy.--In any civil action brought to enforce the terms and conditions of a health maintenance organization contract, the prevailing party shall be entitled to recover reasonable attorney's fees and court costs. Any person damaged by a breach of a subscriber contract may bring a civil action against a person breaching such contract. Upon adverse adjudication at trial or upon appeal the defendant shall be liable for damages, together with court costs and reasonable attorney's fees incurred by the plaintiff. This section shall not be construed to authorize a civil action against the department, its employees, or the Insurance Commissioner or the Department of Health and Rehabilitative Services, its employees, or the secretary of the department.

Section 10. Section 641.285, Florida Statutes, 1982 Supplement, is amended to read:

641.285 Insolvency protection.--

641.285 Insolvency protection.--Every health maintenance organization shall comply with one of the following:

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the department securities of the type eligible for deposit by insurers under s. 625.52, which securities shall have at all times a market value in the amount set forth in this section.
(a) The amount for an organization that is beginning operation shall be the greater of:

1. Five percent of its estimated expenditures for health care services for its first year of operation;

2. Twice its estimated average monthly uncovered expenditures for its first year of operation; or

3. $100,000.

On or before January 1 of each succeeding year, unless not applicable, the organization shall deposit with the department cash, securities, or any combination of these or other measures acceptable to the department in an amount equal to 4 percent of the preceding 12 months' uncovered expenditures or 4 percent of its estimated annual uncovered expenditures for the succeeding year, whichever is greater.

(b) Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to 1 percent of the preceding 12 months' uncovered expenditures or $100,000, on the first day of the first calendar year beginning 6 months or more after the effective date of this section. In the second calendar year, if applicable, the amount of the additional deposit shall be equal to 2 percent of its estimated annual uncovered expenditures. In the third calendar year, if applicable, the additional deposit shall be equal to 3 percent of its estimated annual uncovered expenditures for that year, and in the fourth and subsequent years, if applicable, the additional deposit shall be equal to 4 percent of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.

(2) The department may waive any of the deposit requirements set forth in subsection (1) whenever satisfied that the organization has sufficient surplus and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient surplus and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, hospitals or medical service corporations, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

(3) Post a surety bond executed by the health maintenance organization and by a surety company authorized to do business in this state payable to the Governor in the sum of $75,000. The bond shall be conditioned that the health maintenance organization shall faithfully and truly perform all of the conditions of any health maintenance contract, if such performance so not forthwith, any affected subscriber may maintain an action in his own name upon the bond in any court having jurisdiction of the amount claimed. In no event shall the aggregate insufficiency of the surety to all such subscribers exceed the amount of the bond. Any remedy thus authorized shall not be exclusive of any other remedy which would otherwise exist. The bond posted shall be in full force and effect.
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during all periods and in all places and areas in which the entity is doing business as a health maintenance organization.

(3) When an organization has achieved a surplus, not including land, buildings, and equipment, of at least $1 million or has achieved a surplus, including organization-related land, buildings, and equipment, of at least $5 million, the annual deposit requirement shall not apply. The annual deposit requirement shall not apply to an organization if the total amount of the accumulated deposit is equal to 25 percent of its estimated annual uncovered expenditures for the next calendar year, or $1,500,000, whichever is less. If the organization has a guaranteeing organization which has been in operation for 5 years or more and has a surplus, not including land, buildings, and equipment, of at least $1 million, or which has been in operation for 10 years or more and has a surplus, including organization-related land, buildings, and equipment, of at least $5 million, the annual deposit requirement shall not apply; provided, however, that if the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of $1 million shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a surplus at least equal to $1,500,000.

(4) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit, or any part thereof, after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the department.

(5) In any year in which an annual deposit is not required of an organization, at the organization's request the department shall reduce the required, previously accumulated deposit to $100,000 for each $250,000 of surplus in excess of the amount that allows the organization not to make the annual deposit. If the amount of surplus no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in surplus, provided that its total deposit shall not exceed the maximum required under this section.

(6) The requirements of this section shall not apply to an applying or licensed health maintenance organization which has on file with the department contracts of insurance or reinsurance to protect subscribers in the event the organization is unable to meet its obligations. All such agreements between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All such agreements and any modifications thereto must be filed with and approved by the department. All such agreements shall remain in full force and effect until replaced or for at least 90 days following written notification to the department by registered mail of cancellation by either party.

Section 11. Subsections (8) and (9) are added to section 641.31, Florida Statutes, 1982 Supplement, to read:

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641 31 Health maintenance contracts.--

(8) Health maintenance organizations are entitled to coordinate benefits on the same basis as insurers under s. 627.4235 of the Insurance Code.

(9) Health maintenance organizations providing medical benefits or payments to subscribers who suffer injury, disease or illness by virtue of the negligent act or omission of a third party shall be entitled to reimbursement from the subscriber, on a fee-for-service basis, for the reasonable value of the benefits or payments provided. However, the health maintenance organization shall not be entitled to reimbursement in excess of the subscriber's monetary recovery for medical expenses rendered, from the third party.

Section 12. Section 641.315, Florida Statutes, 1982 Supplement, is amended to read

641.315 Provider contracts --Whenever a contract exists between a health maintenance organization and a provider and the organization fails becomes unable to meet its obligations to pay fees for services already rendered to subscribers, the health maintenance organization shall be liable for such fee or fees rather than the subscriber; and the contract shall so state.

Section 13. This act shall take effect October 1, 1983, except that the amendments to subsection (1) of section 641.26, Florida Statutes, 1982 Supplement, shall take effect upon becoming a law.

Approved by the Governor June 22, 1983.

Filed in Office Secretary of State June 23, 1983.

CHAPTER 83-199

House Bill No 1198

An act relating to the Department of Law Enforcement; adding subsection (4) to s 943.054, Florida Statutes; authorizing the department to exchange criminal history records with the Florida Board of Bar Examiners and to accept fingerprints of applicants for admission to the Florida Bar; providing an effective date.

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

Section 1. Subsection (4) is added to section 943.054, Florida Statutes, to read:

943.054 Exchange of federal criminal history records and information.--

(4) The Department of Law Enforcement is authorized to accept fingerprints of applicants for admission to the Florida Bar and, to the extent provided for by federal law, to exchange state, multi-state, and federal criminal history records with the Florida Board of Bar Examiners for licensing purposes.

Section 2. This act shall take effect upon becoming a law.
A bill to be entitled
An act relating to health maintenance
organizations; adding subsections (9)-(13) to
s. 641.19, Florida Statutes, 1982 Supplement,
defining "surplus," "guaranteeing
organization," "uncovered expenditures,"
"insolvent" or "insolvency" and "surplus
notes"; amending s. 641.21(7), Florida
Statutes, 1982 Supplement, relating to
applications for certificates; requiring a
financial statement; amending s. 641.22,
Florida Statutes, 1982 Supplement, relating to
issuance of certificates of authority;
providing for required minimum surplus for
health maintenance organizations; requiring
health maintenance organizations to file
reinsurance contracts with the department;
creating s. 641.225, Florida Statutes, relating
to surplus requirements; amending s. 641.23,
Florida Statutes, 1982 Supplement, relating to
revocation of certificates; providing a time
period for order of compliance; amending s.
641.25, Florida Statutes, 1982 Supplement,
providing for administrative penalties in lieu
of revocation; amending s. 641.26, Florida
Statutes, 1982 Supplement, providing for filing
of an annual report; providing for requirements
for filing annual reports and financial
statements; amending s. 641.27, Florida
Statutes, 1982 Supplement, relating to
examinations by the department; providing terms

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and conditions for expenses of examination of each health maintenance organization by the department; amending s. 641.28, Florida Statutes, 1982 Supplement, relating to civil actions and remedies; providing for recovery of attorney's fees and court costs; amending s. 641.285, Florida Statutes, 1982 Supplement, relating to insolvency protection; providing for deposits of securities with the department; providing amounts of security deposits; providing exceptions; providing for withdrawal of deposits; providing for reduction of deposits; providing for application of section; adding subsections (8) and (9) to s. 641.31, Florida Statutes, 1982 Supplement, providing for coordinating and limiting contract benefits; providing that benefits provided by health maintenance organizations under certain circumstances shall not be considered collateral source under the provisions of s. 627.7372, Florida Statutes, 1982 Supplement; amending s. 641.315, Florida Statutes, 1982 Supplement, relating to provider contracts; providing that the health maintenance organization shall be liable for fees when the organization fails to meet its obligation to pay such fees; providing effective dates.

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

CODING: Words in struck through type are deletions from existing law, words underlined are additions.
Section 1. Subsections (9), (10), (11), (12) and (13) are added to section 641.19, Florida Statutes, 1982 Supplement, to read:

641.19 Definitions.--As used in this part, the term:

(9) "Surplus" means total unencumbered assets in excess of total liabilities. Surplus shall include capital stock, capital in excess of par, retained earnings and may include surplus notes.

(10) "Guaranteeing organization" is an organization which is domiciled in the United States, which has authorized service of process against it, and which has appointed the Insurance Commissioner as Treasurer as its Agent for Service of Process issuing upon any cause of action arising in this state, based upon any guarantee entered into under this part.

(11) "Uncovered expenditures" means the cost of health care services that are covered by a health maintenance organization, for which a subscriber would also be liable in the event of the organization's insolvency.

(12) "Insolvent" or "insolvency" means the inability of the health maintenance organization to discharge its liabilities as they become due in the normal course of business.

(13) "Surplus notes" means debt which has been guaranteed by the U.S. Government or its agencies, or debt which has been subordinated to all claims of subscribers and general creditors of the organization.

Section 2. Subsection (7) of section 641.21, Florida Statutes, 1982 Supplement, is amended to read:

641.21 Application for certificate.--Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the department. Each
application for a certificate shall be on such form as the
department shall prescribe and shall be accompanied by the
following:

(7) A financial statement prepared on the basis of
generally accepted accounting principles, except that surplus
notes acceptable to the department and meeting the
requirements of this act may be included in its calculation of
surplus. A statement of the assets and liabilities of the
entity.

Section 3. Section 641.22, Florida Statutes, 1982
Supplement, is amended to read:

641.22 Issuance of certificate of authority.--The
department shall issue a certificate of authority within 60
days of the filing of a properly completed the application to
any entity filing a completed an application in conformity
with s. 641.21, upon payment of the prescribed fees and upon
being satisfied that:

(1) The entity proposes to establish and operate a
bona fide health maintenance organization having the
capability to provide comprehensive health care services in
the geographic area proposed, as certified by the Department
of Health and Rehabilitative Services as a condition precedent
to the issuance of any certificate.

(2) The proposed rates are plan-is actuarially sound
for the benefits provided including administrative costs.?-and
the health maintenance organization has and will continue to
have adequate working capital in a minimum amount of $100,000
cash or working capital sufficient to carry all operating
expenditures for a period of at least 3 months, whichever is the
greater amount. A reasonable sufficiency of working capital
shall be determined by the department by taking into account

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the-area-to-be-served, the-anticipated-number-of-subscribers, and the-type-of-services-to-be-rendered.

(3) Prior to December 31, 1985, the health maintenance organization must have a minimum surplus of $100,000. After December 31, 1985, the health maintenance organization must have a minimum surplus as follows:

(a) As of December 31, 1986, $150,000;
(b) As of December 31, 1987, $200,000;
(c) As of December 31, 1988, $250,000;

unless there exists a written guarantee to insure payment of covered subscriber claims provided by an entity which has been in operation for at least three years and has a surplus, not including land, building, and equipment, equal to two times the statutory surplus deficiency or two times the statutory requirement, whichever is the greater amount. Such guaranteeing organization and the written guarantee must be acceptable to and approved by the Department of Insurance.

(4) The health maintenance organization has made acceptable arrangements to provide all health care services offered.

(5) The terms of the contracts such entity proposes to offer to subscribers will in fact assure that the comprehensive health care services required by such subscribers will be rendered under reasonable standards of quality of care, as certified by the Department of Health and Rehabilitative Services.

(6) The procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, health, or economic status. However, this section shall not prohibit reasonable underwriting
classifications for the purposes of establishing contract rates, nor shall it prohibit experience rating.

(7) The entity furnishes evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of comprehensive health care.

(8) The entity has provided, through contract or otherwise, for periodic review of its medical facilities and services.

(9) The ownership, control, or management of the entity is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The department shall not grant or continue authority to transact the business of a health maintenance organization in this state at any time during which it has good reason to believe that the ownership, control, or management of the organization is under the control of any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors; by the improper manipulation of assets or of accounts; or by bad faith.

(10) The entity has a blanket fidelity bond in the amount of $25,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with such funds. All employees handling such funds shall be covered by the blanket fidelity bond. An agent licensed under the provisions of the Florida Insurance Code may either directly or indirectly represent the health maintenance organization in the solicitation, negotiation,
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effectuation, procurement, receipt, delivery, or forwarding of any health maintenance organization subscriber's contract or collect or forward any consideration paid by the subscriber to the health maintenance organization; and such agent shall not be required to post the bond required by this subsection.

(11) The entity has filed with and obtained approval from the department all reinsurance contracts as provided in s. 641.285.

Section 4. Section 641.225, Florida Statutes, is created to read:

641.225 Surplus requirements.--

(1) Each health maintenance organization licensed prior to October 1, 1983, must have at December 31, 1985, a minimum surplus of $100,000. After December 31, 1985, each health maintenance organization must have a minimum surplus as follows:

(a) As of December 31, 1986, $150,000.
(b) As of December 31, 1987, $200,000.
(c) As of December 31, 1988, $250,000.

(2) In lieu of having a minimum surplus, there may exist for a health maintenance organization a written guarantee of the type and subject to the same provisions as outlined in s. 641.22.

Section 5. Section 641.23, Florida Statutes, 1982 Supplement, is amended to read:

641.23 Revocation of certificate of authority.--The department may revoke any certificate issued to a health maintenance organization, or order compliance within 60 days, if it finds that any of the following conditions exists:

(1) The organization is not operating in compliance with this part;

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(2) The organization is in substantial violation of its health maintenance contracts, as certified by the Department of Health and Rehabilitative Services;

(3) The organization is unable to fulfill its obligations under outstanding health maintenance contracts entered into with its subscribers, as certified by the Department of Health and Rehabilitative Services;

(4) The plan is no longer actuarially sound or the organization does not have the minimum surplus as required by this part adequate working capital;

(5) The existing contract rates are excessive, inadequate, or unfairly discriminatory; or

(6) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising; or-

(7) The organization is insolvent.

Section 6. Section 641.25, Florida Statutes, 1982 Supplement, is amended to read:

641.25 Administrative penalty fine in lieu of revocation.--The department may, in lieu of revocation, levy an administrative penalty in an amount not less than $100 or more than $10,000.

Section 7. Section 641.26, Florida Statutes, 1982 Supplement, is amended to read:

641.26 Annual report.--

(1) Every health maintenance organization shall, annually on or before April 1, or within three months of the end of the fiscal year for health maintenance organizations operating under a valid certificate of authority

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as of the effective date of this section, or within such
extension of time therefor as the department, for good cause,
may grant, on forms prescribed by the department, file a
report with the department, verified by the oath of two
executive officers of the organization, or, if not a
corporation, of two persons who are principal managing
directors of the affairs of the organization, showing its
condition on the last day of the preceding calendar year.
Such report shall include:

(a) A financial statement of the organization,
including its balance sheet and a statement of operations for
the preceding year certified by an independent certified
public accountant;

(b) A list of the names and residence addresses of all
persons responsible for the conduct of its affairs, together
with a disclosure of the extent and nature of any contracts or
arrangements between such persons and the health maintenance
organization, including any possible conflicts of interest;

(c) The number of health maintenance contracts issued
and outstanding and the number of health maintenance contracts
terminated and a compilation of the reasons for such
terminations;

(d) A description by location and specialty of the
providers retained or otherwise engaged by the organization to
satisfy its contractual obligations with its subscribers;

(e) Such statistical information as is requested by
the department reflecting the rates of the health maintenance
organization for all comprehensive health care services
provided under health maintenance contracts;

(f) The number and amount of damage claims for medical
injury initiated against the health maintenance organization
and any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim; and

(g) An actuarial certification that the health maintenance organization's rates are actuarially sound for the benefits provided; and

(h) Such other information relating to the performance of health maintenance organizations as is required by the department.

(2) Any health maintenance organization which is unable to provide to the department an audited financial statement within the time required shall annually file, on or before March 1 next following each calendar year, the annual report required by subsection (1) of this section with an unaudited financial statement of the organization, and certification of such financial statement by an independent certified public accountant shall be received by the department by the following May 1.

(3) Any health maintenance organization which neglects to file the annual report in the form and within the time required by this section shall forfeit $100 for each day during which the neglect continues; and, upon notice by the department to that effect, its authority to do business in this state shall cease while such default continues. The department shall deposit all sums collected by it under this section to the credit of the Insurance Commissioner's Regulatory Trust Fund.

Section 8. Section 641.27, Florida Statutes, 1982 Supplement, is amended to read:

641.27 Examination by the department.—The department shall examine the affairs, transactions, accounts, business
records, and assets of any health maintenance organization as
often as it deems it expedient for the protection of the
people of this state, but not less frequently than once every
3 years. The Department of Health and Rehabilitative Services
may conduct periodic examinations regarding the quality of
health care services being provided by the organization.

Every health maintenance organization shall submit its books
and records and take other appropriate action as may be
necessary to facilitate an examination. However, medical
records of individuals and records of physicians providing
service under contract to the health maintenance organization
shall not be subject to audit, although they may be subject to
subpoena by court order upon a showing of good cause. For the
purpose of examinations, the respective departments may
administer oaths to and examine the officers and agents of a
health maintenance organization concerning its business and
affairs. The expenses of examination of each health
maintenance organization by the department shall be subject to
the same terms and conditions as apply to insurers under Part
II of chapter 624 of the Florida Insurance Code. The expenses
of examination of each health maintenance organization or by
the Department of Health and Rehabilitative Services shall be
paid by the organization. In no event shall expenses of all
examinations exceed a maximum of $15,000 per year. Any
rehabilitation, liquidation, conservation, or dissolution of a
health maintenance organization shall be conducted under the
supervision of the department, which shall have all power with
respect thereto granted to it under the laws governing the
rehabilitation, liquidation, conservation, or dissolution of
life insurance companies.

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Section 9. Section 641.28, Florida Statutes, 1982
Supplement, is amended to read:

641.28 Civil remedy.--In any civil action brought to
enforce the terms and conditions of a health maintenance
organization contract, the prevailing party shall be entitled
to recover reasonable attorney's fees and court costs. Any
person damaged by a breach of a subscriber-contract may bring
a civil action against a person breaching such contract. Upon
adverse adjudication at trial or upon appeal, the defendant
shall be liable for damages, together with court costs and
reasonable attorney's fees incurred by the plaintiff. This
section shall not be construed to authorize a civil action
against the department, its employees, or the Insurance
Commissioner or the Department of Health and Rehabilitative
Services, its employees, or the secretary of the department.

Section 10. Section 641.285, Florida Statutes, 1982
Supplement, is amended to read:

641.285 Insolvency protection.--

641.285--Insolvency protection. Every health
maintenance organization shall comply with one of the
following:

(1) Unless otherwise provided below, each health
maintenance organization shall deposit with the department
securities of the type eligible for deposit by insurers under
s. 625.52, which securities shall have at all times a market
value in the amount set forth in this section.

(a) The amount for an organization that is beginning
operation shall be the greater of: (a) five percent of its
estimated expenditures for health care services for its first
year of operation; (b) twice its estimated average monthly
uncovered expenditures for its first year of operation; or (c)
$100,000. On or before January 1 of each succeeding year, unless not applicable, the organization shall deposit with the department cash, securities, or any combination of these or other measures acceptable to the department in an amount equal to four percent of the preceding 12 months' uncovered expenditures or 4 percent of its estimated annual uncovered expenditures for the succeeding year, whichever is greater.

(b) Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to the larger of: (a) one percent of the preceding 12 months' uncovered expenditures, or (b) $100,000 on the first day of the first calendar year beginning six months or more after the effective date of this section. In the second calendar year, if applicable, the amount of the additional deposit shall be equal to two percent of its estimated annual uncovered expenditures. In the third calendar year, if applicable, the additional deposit shall be equal to three percent of its estimated annual uncovered expenditures for that year, and in the fourth and subsequent years, if applicable, the additional deposit shall be equal to four percent of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.

(2) The department may waive any of the deposit requirements set forth in subsection (1) of this section whenever satisfied that the organization has sufficient surplus and an adequate history of generating net income to...
assure its financial viability for the next year, or its
terms and obligations are guaranteed by an organization
with sufficient surplus and an adequate history of generating
net income, or the assets of the organization or its contracts
with insurers, (hospital or medical service corporations),
governments, or other organizations are reasonably sufficient
to assure the performance of its obligations.

(2) Post-a-surety-bond-executed-by-the-health
maintenance-organization-and-by-a-surety-company-authorized-to
do-business-in-this-state-payable-to-the-Governor-in-the-sum
of $75,000. The bond shall be conditioned that the health
maintenance-organization shall faithfully and truly perform
all of the conditions of any health maintenance contract; if
such performance is not forthcoming, any affected subscriber
may maintain an action in his own name upon the bond in any
court having jurisdiction of the amount claimed; in no event
shall the aggregate liability of the surety to all such
subscribers exceed the amount of the bond. Any remedy thus
authorized shall not be exclusive of any other remedy which
would otherwise exist. The bond posted shall be in full force
and effect during all periods and in all places and areas in
which the entity is doing business as a health maintenance
organization.

(3) When an organization has achieved a surplus not
including land, buildings, and equipment, or at least $1
million, or has achieved a surplus including organization-
related land, buildings, and equipment of at least $5 million,
the annual deposit requirement shall not apply. The annual
deposit requirement shall not apply to an organization if the
total amount of the accumulated deposit is equal to 25 percent
of its estimated annual uncovered expenditures for the next

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calendar year, or $1,500,000, whichever is less. If the organization has a guaranteeing organization which has been in operation for five years or more and has a surplus not including land, buildings and equipment of at least $1 million, or which has been in operation for 10 years or more and has a surplus including organization-related land, buildings and equipment of at least $5 million, the annual deposit requirement shall not apply; provided, however, that if the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of $1 million shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a surplus at least equal to $1,500,000.

(3) Deposit with the department—a cash deposit in the amount of $75,000 to guarantee that the obligations to the subscribers will be performed.

(4) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit, or any part thereof, after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the department.

(5) In any year in which an annual deposit is not required of an organization, at the organization's request the department shall reduce the required, previously accumulated deposit to $100,000 for each $250,000 of surplus in excess of the amount that allows the organization not to make the annual deposit.
deposit. If the amount of surplus no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in surplus, provided that its total deposit shall not exceed the maximum required under this section.

(6) The requirements of this section shall not apply to an applying or licensed health maintenance organization which has on file with the department contracts of insurance or reinsurance to protect subscribers in the event the organization is unable to meet its obligations. All such agreements between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All such agreements and any modifications thereto must be filed with and approved by the department. All such agreements shall remain in full force and effect until replaced or for at least 90 days following written notification to the department by registered mail of cancellation by either party.

Section 11. Subsections (8) and (9) are added to section 641.31, Florida Statutes, 1982 Supplement, to read:

641.31 Health maintenance contracts.--

(8) Health maintenance organizations are entitled to coordinate benefits on the same basis as insurers under s. 627.4235 of the Insurance Code.

(9) Health maintenance organizations providing medical benefits to subscribers who suffer injury, disease or illness by virtue of the negligent act or omission of a third party shall be entitled to reimbursement from the subscriber, on a fee-for-service basis, for the reasonable value of the benefits provided. However, the health maintenance organization shall not be entitled to reimbursement in excess of the subscriber's monetary recovery from the third party.
Health maintenance organizations providing benefits pursuant to this subsection shall direct providers of health care and shall not be considered collateral source subject to the provisions of s. 627.7372.

Section 12. Section 641.315, Florida Statutes, 1982 Supplement, is amended to read:

641.315 Provider contracts.--Whenever a contract exists between a health maintenance organization and a provider and the organization fails becomes—unable to meet its obligations to pay fees for services already rendered to subscribers, the health maintenance organization shall be liable for such fee or fees rather than the subscriber; and the contract shall so state.

Section 13. This act shall take effect October 1, 1983, except that the amendments to subsection (1) of section 641.26, Florida Statutes, 1982 Supplement, shall take effect upon becoming a law.
A bill to be entitled
An act relating to health maintenance organizations; adding subsections (9)-(13) to s. 641.19, Florida Statutes, 1982 Supplement, defining "surplus," "guaranteeing organization," "uncovered expenditures," "insolvent" or "insolvency" and "surplus notes"; amending s. 641.21(7), Florida Statutes, 1982 Supplement, relating to applications for certificates; requiring a financial statement; amending s. 641.22, Florida Statutes, 1982 Supplement, relating to issuance of certificates of authority; providing for required minimum surplus for health maintenance organizations; requiring health maintenance organizations to file reinsurance contracts with the department; creating s. 641.225, Florida Statutes, relating to surplus requirements; amending s. 641.23, Florida Statutes, 1982 Supplement, relating to revocation of certificates; providing a time period for order of compliance; amending s. 641.25, Florida Statutes, 1982 Supplement, providing for administrative penalties in lieu of revocation; amending s. 641.26, Florida Statutes, 1982 Supplement, providing for filing of an annual report; providing for requirements for filing annual reports and financial statements; amending s. 641.27, Florida Statutes, 1982 Supplement, relating to examinations by the department; providing terms

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and conditions for expenses of examination of each health maintenance organization by the department; amending s. 641.28, Florida Statutes, 1982 Supplement, relating to civil actions and remedies; providing for recovery of attorney's fees and court costs; amending s. 641.285, Florida Statutes, 1982 Supplement, relating to insolvency protection; providing for deposits of securities with the department; providing amounts of security deposits; providing exceptions; providing for withdrawal of deposits; providing for reduction of deposits; providing for application of section; adding subsections (8) and (9) to s. 641.31, Florida Statutes, 1982 Supplement, providing for coordinating and limiting contract benefits; providing that benefits provided by health maintenance organizations under certain circumstances shall not be considered collateral source under the provisions of s. 627.7372, Florida Statutes, 1982 Supplement; amending s. 641.315, Florida Statutes, 1982 Supplement, relating to provider contracts; providing that the health maintenance organization shall be liable for fees when the organization fails to meet its obligation to pay such fees; providing effective dates.

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

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Section 1. Subsections (9), (10), (11), (12) and (13) are added to section 641.19, Florida Statutes, 1982 Supplement, to read:

641.19 Definitions.--As used in this part, the term:

(9) "Surplus" means total unencumbered assets in excess of total liabilities. Surplus shall include capital stock, capital in excess of par, retained earnings and may include surplus notes.

(10) "Guaranteeing organization" is an organization which is domiciled in the United States, which has authorized service of process against it, and which has appointed the Insurance Commissioner as Treasurer as its Agent for Service of Process issuing upon any cause of action arising in this state, based upon any guarantee entered into under this part.

(11) "Uncovered expenditures" means the cost of health care services that are covered by a health maintenance organization, for which a subscriber would also be liable in the event of the organization's insolvency.

(12) "Insolvent" or "insolvency" means the inability of the health maintenance organization to discharge its liabilities as they become due in the normal course of business.

(13) "Surplus notes" means debt which has been guaranteed by the U.S. Government or its agencies, or debt which has been subordinated to all claims of subscribers and general creditors of the organization.

Section 2. Subsection (7) of section 641.21, Florida Statutes, 1982 Supplement, is amended to read:

641.21 Application for certificate.--Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the department. Each

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application for a certificate shall be on such form as the
department shall prescribe and shall be accompanied by the
following:

(7) A financial statement prepared on the basis of
generally accepted accounting principles, except that surplus
notes acceptable to the department and meeting the
requirements of this act may be included in its calculation of
surplus. A statement of the assets and liabilities of the
entity:

Section 3. Section 641.22, Florida Statutes, 1982
Supplement, is amended to read:

641.22 Issuance of certificate of authority.--The
department shall issue a certificate of authority within 60
days of the filing of a properly completed application to
any entity filing a completed application in conformity
with s. 641.21, upon payment of the prescribed fees and upon
being satisfied that:

(1) The entity proposes to establish and operate a
bona fide health maintenance organization having the
capability to provide comprehensive health care services in
the geographic area proposed, as certified by the Department
of Health and Rehabilitative Services as a condition precedent
to the issuance of any certificate.

(2) The proposed rates are plan-is actuarially sound
for the benefits provided including administrative costs, and
the health maintenance organization has and will continue to
have adequate working capital in a minimum amount of $100,000
cash or working capital sufficient to carry all operating
expenses for a period of at least 3 months, whichever is the
greater amount. A reasonable sufficiency of working capital
shall be determined by the department by taking into account

CODING Words in cursive type are deletions from existing law, words underlined are additions.
Prior to December 31, 1985, the health maintenance organization must have a minimum surplus of $100,000. After December 31, 1985, the health maintenance organization must have a minimum surplus as follows:

(a) As of December 31, 1986, $150,000;
(b) As of December 31, 1987, $200,000;
(c) As of December 31, 1988, $250,000;

unless there exists a written guarantee to insure payment of covered subscriber claims provided by an entity which has been in operation for at least three years and has a surplus, not including land, building, and equipment, equal to two times the statutory surplus deficiency or two times the statutory requirement, whichever is the greater amount. Such guaranteeing organization and the written guarantee must be acceptable to and approved by the Department of Insurance.

The health maintenance organization has made acceptable arrangements to provide all health care services offered.

The terms of the contracts such entity proposes to offer to subscribers will in fact assure that the comprehensive health care services required by such subscribers will be rendered under reasonable standards of quality of care, as certified by the Department of Health and Rehabilitative Services.

The procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, health, or economic status. However, this section shall not prohibit reasonable underwriting.
classifications for the purposes of establishing contract rates, nor shall it prohibit experience rating.

(7) The entity furnishes evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of comprehensive health care.

(8) The entity has provided, through contract or otherwise, for periodic review of its medical facilities and services.

(9) The ownership, control, or management of the entity is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The department shall not grant or continue authority to transact the business of a health maintenance organization in this state at any time during which it has good reason to believe that the ownership, control, or management of the organization is under the control of any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors; by the improper manipulation of assets or of accounts; or by bad faith.

(10) The entity has a blanket fidelity bond in the amount of $25,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with such funds. All employees handling such funds shall be covered by the blanket fidelity bond. An agent licensed under the provisions of the Florida Insurance Code may either directly or indirectly represent the health maintenance organization in the solicitation, negotiation,
effectuation, procurement, receipt, delivery, or forwarding of any health maintenance organization subscriber's contract or collect or forward any consideration paid by the subscriber to the health maintenance organization; and such agent shall not be required to post the bond required by this subsection.

(11) The entity has filed with and obtained approval from the department all reinsurance contracts as provided in s. 641.285.

Section 4. Section 641.225, Florida Statutes, is created to read:

641.225 Surplus requirements.--

(1) Each health maintenance organization licensed prior to October 1, 1983, must have at December 31, 1985, a minimum surplus of $100,000. After December 31, 1985, each health maintenance organization must have a minimum surplus as follows:

(a) As of December 31, 1986, $150,000.
(b) As of December 31, 1987, $200,000.
(c) As of December 31, 1988, $250,000.

(2) In lieu of having a minimum surplus, there may exist for a health maintenance organization a written guarantee of the type and subject to the same provisions as outlined in s. 641.22.

Section 5. Section 641.23, Florida Statutes, 1982 Supplement, is amended to read:

641.23 Revocation of certificate of authority.--The department may revoke any certificate issued to a health maintenance organization, or order compliance within 60 days, if it finds that any of the following conditions exists:

(1) The organization is not operating in compliance with this part;

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(2) The organization is in substantial violation of its health maintenance contracts, as certified by the Department of Health and Rehabilitative Services;

(3) The organization is unable to fulfill its obligations under outstanding health maintenance contracts entered into with its subscribers, as certified by the Department of Health and Rehabilitative Services;

(4) The plan is no longer actuarially sound or the organization does not have the minimum surplus as required by this part adequate-working-capital;

(5) The existing contract rates are excessive, inadequate, or unfairly discriminatory; or

(6) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising; or:

(7) The organization is insolvent.

Section 6. Section 641.25, Florida Statutes, 1982 Supplement, is amended to read:

641.25 Administrative penalty fine in lieu of revocation.—The department may, in lieu of revocation, levy an administrative penalty in an amount not less than $100 or more than $10,000.

Section 7. Section 641.26, Florida Statutes, 1982 Supplement, is amended to read:

641.26 Annual report.—

(1) Every health maintenance organization shall, annually on or before April 1, or within three months of the end of the fiscal year for health maintenance organizations operating under a valid certificate of authority

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as of the effective date of this section, or within such extension of time therefor as the department, for good cause, may grant, on forms prescribed by the department, file a report with the department, verified by the oath of two executive officers of the organization, or, if not a corporation, of two persons who are principal managing directors of the affairs of the organization, showing its condition on the last day of the preceding calendar year. Such report shall include:

(a) A financial statement of the organization, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant;

(b) A list of the names and residence addresses of all persons responsible for the conduct of its affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the health maintenance organization, including any possible conflicts of interest;

(c) The number of health maintenance contracts issued and outstanding and the number of health maintenance contracts terminated and a compilation of the reasons for such terminations;

(d) A description by location and specialty of the providers retained or otherwise engaged by the organization to satisfy its contractual obligations with its subscribers;

(e) Such statistical information as is requested by the department reflecting the rates of the health maintenance organization for all comprehensive health care services provided under health maintenance contracts;

(f) The number and amount of damage claims for medical injury initiated against the health maintenance organization.

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and any of the providers engaged by it during the reporting
year, broken down into claims with and without formal legal
process, and the disposition, if any, of each such claim; and

(g) An actuarial certification that the health
maintenance organization's rates are actuarially sound for the
benefits provided; and

(h) Such other information relating to the
performance of health maintenance organizations as is required
by the department.

(2) Any health maintenance organization which is
unable to provide to the department an audited financial
statement within the time required shall annually file, on or
before March 1 next following each calendar year, the annual
report required by subsection (1) of this section with an
unaudited financial statement of the organization, and
certification of such financial statement by an independent
certified public accountant shall be received by the
department by the following May 1.

(3) Any health maintenance organization which
neglects to file the annual report in the form and within the
time required by this section shall forfeit $100 for each day
during which the neglect continues; and, upon notice by the
department to that effect, its authority to do business in
this state shall cease while such default continues. The
department shall deposit all sums collected by it under this
section to the credit of the Insurance Commissioner's
Regulatory Trust Fund.

Section 8. Section 641.27, Florida Statutes, 1982
Supplement, is amended to read:

641.27 Examination by the department.—The department
shall examine the affairs, transactions, accounts, business

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records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 3 years. The Department of Health and Rehabilitative Services may conduct periodic examinations regarding the quality of health care services being provided by the organization.

Every health maintenance organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. However, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the respective departments may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The expenses of examination of each health maintenance organization by the department shall be subject to the same terms and conditions as apply to insurers under Part II of chapter 624 of the Florida Insurance Code. The expenses of examination of each health maintenance organization by the Department of Health and Rehabilitative Services shall be paid by the organization. In no event shall expenses of all examinations exceed a maximum of $15,000 per year. Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation, liquidation, conservation, or dissolution of life insurance companies.
Section 9. Section 641.28, Florida Statutes, 1982 Supplement, is amended to read:

641.28 Civil remedy.--In any civil action brought to enforce the terms and conditions of a health maintenance organization contract, the prevailing party shall be entitled to recover reasonable attorney's fees and court costs. Any person damaged by a breach of a subscriber-contract may bring a civil action against a person breaching such contract; whereupon the defendant, by an adverse adjudication at trial or upon appeal, shall be liable for damages, together with court costs and reasonable attorney's fees incurred by the plaintiff. This section shall not be construed to authorize a civil action against the department, its employees, or the Insurance Commissioner or the Department of Health and Rehabilitative Services, its employees, or the secretary of the department.

Section 10. Section 641.285, Florida Statutes, 1982 Supplement, is amended to read:

641.285 Insolvency protection.--

641.285--Insolvency protection.--Every health maintenance organization shall comply with one of the following:

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the department securities of the type eligible for deposit by insurers under s. 625.52, which securities shall have at all times a market value in the amount set forth in this section.

(a) The amount for an organization that is beginning operation shall be the greater of: (a) five percent of its estimated expenditures for health care services for its first year of operation; (b) twice its estimated average monthly uncovered expenditures for its first year of operation; or (c) [Deleted through underlining].

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$100,000. On or before January 1 of each succeeding year, unless not applicable, the organization shall deposit with the department cash, securities, or any combination of these or other measures acceptable to the department in an amount equal to four percent of the preceding 12 months' uncovered expenditures or 4 percent of its estimated annual uncovered expenditures for the succeeding year, whichever is greater.

(b) Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to the larger of: (a) one percent of the preceding 12 months' uncovered expenditures, or (b) $100,000 on the first day of the first calendar year beginning six months or more after the effective date of this section. In the second calendar year, if applicable, the amount of the additional deposit shall be equal to two percent of its estimated annual uncovered expenditures. In the third calendar year, if applicable, the additional deposit shall be equal to three percent of its estimated annual uncovered expenditures for that year, and in the fourth and subsequent years, if applicable, the additional deposit shall be equal to four percent of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.

(1) Secure insurance or reinsurance to protect subscribers in the event the organization is unable to meet its obligations.

(2) The department may waive any of the deposit requirements set forth in subsection (1) of this section whenever satisfied that the organization has sufficient surplus and an adequate history of generating net income to
assure its financial viability for the next year, or its
performance and obligations are guaranteed by an organization
with sufficient surplus and an adequate history of generating
net income, or the assets of the organization or its contracts
with insurers, (hospital or medical service corporations),
governments, or other organizations are reasonably sufficient
to assure the performance of its obligations.

(2) Any surety bond executed by the health maintenance organization and
by a surety company authorized to do business in this state payable to the Governor in the sum
of $75,000.--The bond shall be conditioned that the health maintenance organization shall faithfully and truly perform all of the conditions of any health maintenance contract and if such performance is not forthcoming, any affected subscriber may maintain an action in his own name upon the bond in any court having jurisdiction of the amount claimed.--In no event shall the aggregate liability of the surety to all such subscribers exceed the amount of the bond. Any remedy thus authorized shall not be exclusive of any other remedy which would otherwise exist.--The bond posted shall be in full force and effect during all periods and in all places and areas in which the entity is doing business as a health maintenance organization.

(3) When an organization has achieved a surplus not
including land, buildings, and equipment, or at least $1
million, or has achieved a surplus including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement shall not apply. The annual deposit requirement shall not apply to an organization if the total amount of the accumulated deposit is equal to 25 percent of its estimated annual uncovered expenditures for the next

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calendar year, or $1,500,000, whichever is less. If the
organization has a guaranteeing organization which has been in
operation for five years or more and has a surplus not
including land, buildings and equipment of at least $1
million, or which has been in operation for 10 years or more
and has a surplus including organization-related land,
buildings and equipment of at least $5 million, the annual
deposit requirement shall not apply; provided, however, that
if the guaranteeing organization is sponsoring more than one
organization, the surplus requirement shall be increased by a
multiple equal to the number of such organizations. This
requirement to maintain a deposit in excess of $1 million
shall not apply during any time that the guaranteeing
organization maintains for each organization it sponsors a
surplus at least equal to $1,500,000.

(4) All income from deposits shall belong to the
depositing organization and shall be paid to it as it becomes
available. A health maintenance organization that has made a
securities deposit may withdraw that deposit, or any part
thereof, after making a substitute deposit of cash,
securities, or any combination of these or other measures of
equal amount and value. Any securities shall be approved by
the department.

(5) In any year in which an annual deposit is not
required of an organization, at the organization's request the
department shall reduce the required, previously accumulated
deposit to $100,000 for each $250,000 of surplus in excess of
the amount that allows the organization not to make the annual
deposit. If the amount of surplus no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in surplus, provided that its total deposit shall not exceed the maximum required under this section.

(6) The requirements of this section shall not apply to an applying or licensed health maintenance organization which has on file with the department contracts of insurance or reinsurance to protect subscribers in the event the organization is unable to meet its obligations. All such agreements between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All such agreements and any modifications thereto must be filed with and approved by the department. All such agreements shall remain in full force and effect until replaced or for at least 90 days following written notification to the department by registered mail of cancellation by either party.

Section 11. Subsections (8) and (9) are added to section 641.31, Florida Statutes, 1982 Supplement, to read:

641.31 Health maintenance contracts.--

(8) Health maintenance organizations are entitled to coordinate benefits on the same basis as insurers under s. 627.4235 of the Insurance Code.

(9) Health maintenance organizations providing medical benefits to subscribers who suffer injury, disease or illness by virtue of the negligent act or omission of a third party shall be entitled to reimbursement from the subscriber, on a fee-for-service basis, for the reasonable value of the benefits provided. However, the health maintenance organization shall not be entitled to reimbursement in excess...
of the subscriber's monetary recovery for medical expenses rendered, from the third party.

Section 12. Section 641.315, Florida Statutes, 1982 Supplement, is amended to read:

641.315 Provider contracts.--Whenever a contract exists between a health maintenance organization and a provider and the organization fails to meet its obligations to pay fees for services already rendered to subscribers, the health maintenance organization shall be liable for such fee or fees rather than the subscriber; and the contract shall so state.

Section 13. This act shall take effect October 1, 1983, except that the amendments to subsection (1) of section 641.26, Florida Statutes, 1982 Supplement, shall take effect upon becoming a law.

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THE MAJOR CHANGES IN THE HMO BILL INCLUDE:

1. RAISING THE MINIMUM SURPLUS THAT AN HMO MUST HAVE IN 1985 OF 100,000 TO 250,000 BY 1988 UNLESS REINSURED.

2. REQUIRING AN HMO TO PROVIDE ACTUARIAL CERTIFICATION THAT ITS RATES ARE SOUND.

3. REQUIRING A DEPOSIT BE PLACED WITH THE DEPARTMENT UNLESS THE DEPARTMENT WAIVES IT OR THE HMO IS REINSURED.

4. ALLOWING THE PREVAILING PARTY, INSTEAD OF JUST THE PLAINTIFF, TO RECOVER COURT COSTS AND REASONABLE ATTORNEY'S FEES IN AN ACTION TO ENFORCE THE HMO CONTRACT.

5. ALLOWING HMO's TO COORDINATE BENEFITS ON SAME BASIS AS HEALTH INSURERS. THE BILL FURTHER PROVIDES THAT AN HMO IS ENTITLED TO REIMBURSEMENT FOR REASONABLE VALUE OF SERVICES PROVIDED CAUSED BY NEGLIGENCE OF A THIRD PARTY.
I. SUMMARY AND PURPOSE

In 1982, the Health Maintenance Organization (HMO) section of the Florida Insurance Code went through major revisions in order to provide an effective way to control health care costs. This was achieved by strengthening the requirements under which an HMO can operate. Basically, an HMO member pays a flat monthly fee and a group of physicians provide for their medical care. The incentive to limit costs is induced by the physician receiving what remains from the lump sum. However, it has recently been brought to attention that the financial stability of HMO's may be in difficulty. Therefore, in order to protect members of HMO's from unpaid medical bills, new requirements for guaranteeing financial solvency have been proposed. To attain this end, more specific financial standards have been established in order to give the Department of Insurance concrete guidelines to determine the viability of an HMO.

II. CURRENT LAW AND EFFECT OF CHANGES

A. CURRENT LAW

The financial considerations presently required are:

(1) A statement of the assets and liabilities of the HMO.

(2) Actuarially sound rates.

(3) Adequate working capital of at least $100,000 or sufficient working capital to carry all operating expenses for a period of at least 3 months whichever is greater. Sufficiency in working capital are to be determined by taking into account the area to be served, the anticipated number of subscribers and type of services to be rendered.
(4) Compliance with one of the following:

(a) secure insurance or reinsurance
(b) post a surety bond of $75,000
(c) deposit a cash deposit of $75,000

B. EFFECT OF PROPOSED CHANGES

The guidelines used to define working capital were so vague as to not give the department an effective means of measuring financial solvency. The proposed bill remedies this situation by providing that:

(1) Prior to December 31, 1985, an HMO must have a minimum surplus of $100,000. After that date the surplus will increase yearly until 1988 when the minimum amount will be $250,000. However, if the HMO has been insured by a guaranteeing organization approved by the department, then the minimum surplus requirements after 1985 will not apply (s. 641.22).

For HMO's licensed prior to October 1, 1983, a minimum surplus of $100,000 is required by 1985. After 1985, HMO's licensed before October 1, 1983, will be subject to the same requirements as HMO's not licensed before this date (s. 641.225).

(2) The HMO must provide actuarial certification that their rates are actuarially sound for the benefits provided (s. 641.26 (1)(g)).

(3) A deposit is required to be placed with the department. This amount will be:

(a) for an organization beginning operation, the greater of;

(i) five percent of its estimated expenditures for health care services for the first year of operation;

(ii) twice its estimated average monthly uncovered expenditures for its first year of operation; or

(iii) $100,000;

on or before the beginning of each year, if applicable, the HMO will deposit 4% of the preceding 12 months' uncovered expenditures or estimated annual uncovered definitions, whichever is greater.

(b) for an HMO that is in operation on the effective date of this section, a deposit of the larger of:

(i) one percent of preceding 12 months' uncovered expenditures, or

(ii) $100,000.

Through the next four years thereafter, if applicable, an additional deposit will be required, increasing yearly by 1% the amount of its estimated annual uncovered expenditures.

(c) Waived by the department if the HMO has sufficient surplus or guaranteed by a financially solvent organization.

(d) Inapplicable when an HMO has reached a surplus of $1 million or $5 million including land, buildings and equipment, or if the total amount of the accumulated deposit is equal to 25% of
its estimated annual uncovered expenditures for the calendar year or $1.5 million, whichever is less.

(e) Inapplicable if the HMO has a guaranteeing organization which meets specific requirements.

(f) Inapplicable if the HMO has contracts of insurance or reinsurance to protect subscribers.

The bill amends s. 641.31, Florida Statutes, 1982 Supplement, to provide that HMO's may coordinate benefits on the same basis as health insurers. Further, the bill provides through the referenced section that an HMO is entitled to reimbursement from a member for the reasonable value of services provided due to injury, disease or illness caused by the negligence of a third party. Reimbursement is limited to the member's monetary recovery from the third party.

Benefits provided pursuant to a subscriber contract with an HMO shall not be considered collateral source subject to the provisions of s. 627.7372, collateral sources of indemnity. Section 627.7372 provides that in any action for personal injury or wrongful death arising out of ownership, use or maintenance of an automobile, the court shall admit into evidence the total amount of all payments to the claimant such as health insurance. The court instructs the jury to deduct from its verdict the value of all benefits received by an injured party from any collateral source. The effect of this bill is to provide that the benefits provided to an HMO subscriber will not be disclosed to the jury, nor will the judgment be reduced by the amount of such benefits.

III. ECONOMIC IMPACT CONSIDERATIONS

A. PRIVATE SECTOR CONSIDERATIONS

The economic impact to HMO's will be substantial due to the new surplus and deposit requirements.

(1) Under present law the working capital is the greater of $100,000 or operating expenses for the first three months. This amount will be raised to $250,000 by 1988 under the proposed law unless the HMO is reinsured.

(2) Under present law, insurance, reinsurance or a bond or deposit of $75,000 is required. Under the proposed law, for an HMO beginning operation the amount to be deposited will be the greater of:

(a) five percent of estimated expenditures for health care services for its first year of operation;

(b) twice estimated average monthly uncovered expenditures for first year of operation;

(c) $100,000.

In addition, unless if not applicable, the HMO shall deposit an amount equal to 4% of preceding 12 months uncovered expenditures or estimated annual uncovered expenditures for the succeeding year.

For an organization in operation on the effective date of this section, the deposit shall be the greater of:

(a) one percent preceding 12 months uncovered expenditures or

(b) $100,000.
This amount will be increased by one percent each year for the following 4 years, measured by the estimated annual uncovered expenditures.

However, if reinsurance has been obtained or the department is satisfied that the HMO is generating net income sufficient to assure its financial viability, then the deposit requirement will not apply.

B. PUBLIC SECTOR CONSIDERATIONS

None.

IV. COMMENTS

None.

V. AMENDMENTS

Prepared by: ________________________________

Staff Director: ________________________________
I. SUMMARY AND PURPOSE

In 1982, the Health Maintenance Organization (HMO) section of the Florida Insurance Code went through major revisions in order to provide an effective way to control health care costs. This was achieved by strengthening the requirements under which an HMO can operate. Basically, an HMO member pays a flat monthly fee and a group of physicians provide for their medical care. The incentive to limit costs is induced by the physician receiving what remains from the lump sum. However, it has recently been brought to attention that the financial stability of HMO’s may be in difficulty. Therefore, in order to protect members of HMO’s from unpaid medical bills, new requirements for guaranteeing financial solvency have been proposed. To attain this end, more specific financial standards have been established in order to give the Department of Insurance concrete guidelines to determine the viability of an HMO.

II. CURRENT LAW AND EFFECT OF CHANGES

A. CURRENT LAW

The financial considerations presently required are:

1. A statement of the assets and liabilities of the HMO.

2. Actuarially sound rates.

3. Adequate working capital of at least $100,000 or sufficient working capital to carry all operating expenses for a period of at least 3 months whichever is greater. Sufficiency in working capital are to be determined by taking into account the area to be served, the anticipated number of subscribers and type of services to be rendered.
(4) Compliance with one of the following:
(a) secure insurance or reinsurance
(b) post a surety bond of $75,000
(c) deposit a cash deposit of $75,000

B. EFFECT OF PROPOSED CHANGES

The guidelines used to define working capital were so vague as to not give the department an effective means of measuring financial solvency. The proposed bill remedies this situation by providing that:

(1) Prior to December 31, 1985, an HMO must have a minimum surplus of $100,000. After that date the surplus will increase yearly until 1988 when the minimum amount will be $250,000. However, if the HMO has been insured by a guaranteeing organization approved by the department, then the minimum surplus requirements after 1985 will not apply (s. 641.22).

For HMO's licensed prior to October 1, 1983, a minimum surplus of $100,000 is required by 1985. After 1985, HMO's licensed before October 1, 1983, will be subject to the same requirements as HMO's not licensed before this date (s. 641.225).

(2) The HMO must provide actuarial certification that their rates are actuarially sound for the benefits provided (s. 641.26 (1)(g)).

(3) In a civil action brought to enforce the terms of the contract, the prevailing party, instead of just the plaintiff, may recover reasonable attorney's fees and court costs.

(4) A deposit is required to be placed with the department. This amount will be:
(a) for an organization beginning operation, the greater of:
   (i) five percent of its estimated expenditures for health care services for the first year of operation;
   (ii) twice its estimated average monthly uncovered expenditures for its first year of operation; or
   (iii) $100,000;

on or before the beginning of each year, if applicable, the HMO will deposit 4% of the preceding 12 months' uncovered expenditures or estimated annual uncovered definitions, whichever is greater.

(b) for an HMO that is in operation on the effective date of this section, a deposit of the larger of:
   (i) one percent of preceding 12 months' uncovered expenditures, or
   (ii) $100,000.

Through the next four years thereafter, if applicable, an additional deposit will be required, increasing yearly by 1% the amount of its estimated annual uncovered expenditures.

(c) Waived by the department if the HMO has sufficient surplus or guaranteed by a financially solvent organization.
(d) Inapplicable when an HMO has reached a surplus of $1 million or $5 million including land, buildings and equipment, or if the total amount of the accumulated deposit is equal to 25% of its estimated annual uncovered expenditures for the calendar year or $1.5 million, whichever is less.

(e) Inapplicable if the HMO has a guaranteeing organization which meets specific requirements.

(f) Inapplicable if the HMO has contracts of insurance or reinsurance to protect subscribers.

The bill amends s. 641.31, Florida Statutes, 1982 Supplement, to provide that HMO's may coordinate benefits on the same basis as health insurers. Further, the bill provides through the referenced section that an HMO is entitled to reimbursement from a member for the reasonable value of services provided due to injury, disease or illness caused by the negligence of a third party. Reimbursement is limited to the member's monetary recovery for medical expenses rendered from the third party.

III. ECONOMIC IMPACT CONSIDERATIONS

A. PRIVATE SECTOR CONSIDERATIONS

The economic impact to HMO's will be substantial due to the new surplus and deposit requirements.

(1) Under present law the working capital is the greater of $100,000 or operating expenses for the first three months. This amount will be raised to $250,000 by 1988 under the proposed law unless the HMO is reinsured.

(2) Under present law, insurance, reinsurance or a bond or deposit of $75,000 is required. Under the proposed law, for an HMO beginning operation the amount to be deposited will be the greater of:

(a) five percent of estimated expenditures for health care services for its first year of operation;

(b) twice estimated average monthly uncovered expenditures for first year of operation;

(c) $100,000.

In addition, unless if not applicable, the HMO shall deposit an amount equal to 4% of preceding 12 months uncovered expenditures or estimated annual uncovered expenditures for the succeeding year.

For an organization in operation on the effective date of this section, the deposit shall be the greater of:

(a) one percent preceding 12 months uncovered expenditures or

(b) $100,000.

This amount will be increased by one percent each year for the following 4 years, measured by the estimated annual uncovered expenditures.

However, if reinsurance has been obtained or the department is satisfied that the HMO is generating net income sufficient to assure its financial viability, then the deposit requirement will not apply.
B. PUBLIC SECTOR CONSIDERATIONS

None.

IV. COMMENTS

None.

V. AMENDMENTS

Prepared by: [Signature]

Staff Director: [Signature]
A bill to be entitled
An act relating to health maintenance
organizations; adding subsections (9)-(13) to
s. 641.19, Florida Statutes, 1982 Supplement,
defining "surplus," "guaranteeing
organization," "uncovered expenditures,"
"insolvent" or "insolvency" and "surplus
notes"; amending s. 641.21(7), Florida
Statutes, 1982 Supplement, relating to
applications for certificates; requiring a
financial statement; amending s. 641.22,
Florida Statutes, 1982 Supplement, relating to
issuance of certificates of authority;
providing for required minimum surplus for
health maintenance organizations; requiring
health maintenance organizations to file
reinsurance contracts with the department;
creating s. 641.225, Florida Statutes, relating
to surplus requirements; amending s. 641.23,
Florida Statutes, 1982 Supplement, relating to
revocation of certificates; providing a time
period for order of compliance; amending s.
641.25, Florida Statutes, 1982 Supplement,
providing for administrative penalties in lieu
of revocation; amending s. 641.26, Florida
Statutes, 1982 Supplement, providing for filing
of an annual report; providing for requirements
for filing annual reports and financial
statements; amending s. 641.27, Florida
Statutes, 1982 Supplement, relating to
examinations by the department; providing terms
and conditions for expenses of examination of each health maintenance organization by the department; amending s. 641.28, Florida Statutes, 1982 Supplement, relating to civil actions and remedies; providing for recovery of attorney's fees and court costs; amending s. 641.285, Florida Statutes, 1982 Supplement, relating to insolvency protection; providing for deposits of securities with the department; providing amounts of security deposits; providing exceptions; providing for withdrawal of deposits; providing for reduction of deposits; providing for application of section; adding subsections (8) and (9) to s. 641.31, Florida Statutes, 1982 Supplement, providing for coordinating and limiting contract benefits; providing that benefits provided by health maintenance organizations under certain circumstances shall not be considered collateral source under the provisions of s. 627.7372, Florida Statutes, 1982 Supplement; amending s. 641.315, Florida Statutes, 1982 Supplement, relating to provider contracts; providing that the health maintenance organization shall be liable for fees when the organization fails to meet its obligation to pay such fees; providing effective dates.
Section 1. Subsections (9), (10), (11), (12) and (13) are added to section 641.19, Florida Statutes, 1982 Supplement, to read:

641.19 Definitions.--As used in this part, the term:

(9) "Surplus" means total unencumbered assets in excess of total liabilities. Surplus shall include capital stock, capital in excess of par, retained earnings and may include surplus notes.

(10) "Guaranteeing organization" is an organization which is domiciled in the United States, which has authorized service of process against it, and which has appointed the Insurance Commissioner as Treasurer as its Agent for Service of Process issuing upon any cause of action arising in this state, based upon any guarantee entered into under this part.

(11) "Uncovered expenditures" means the cost of health care services that are covered by a health maintenance organization, for which a subscriber would also be liable in the event of the organization's insolvency.

(12) "Insolvent" or "insolvency" means the inability of the health maintenance organization to discharge its liabilities as they become due in the normal course of business.

(13) "Surplus notes" means debt which has been guaranteed by the U.S. Government or its agencies, or debt which has been subordinated to all claims of subscribers and general creditors of the organization.

Section 2. Subsection (7) of section 641.21, Florida Statutes, 1982 Supplement, is amended to read:

641.21 Application for certificate.--Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the department. Each

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application for a certificate shall be on such form as the
department shall prescribe and shall be accompanied by the
following:

(7) A financial statement prepared on the basis of
generally accepted accounting principles, except that surplus
notes acceptable to the department and meeting the
requirements of this act may be included in its calculation of
surplus. A statement of the assets and liabilities of the
entity.

Section 3. Section 641.22. Florida Statutes, 1982
Supplement, is amended to read:

641.22 Issuance of certificate of authority.--The
department shall issue a certificate of authority within 60
days of the filing of a properly completed the application to
any entity filing a completed an application in conformity
with s. 641.21, upon payment of the prescribed fees and upon
being satisfied that:

(1) The entity proposes to establish and operate a
bona fide health maintenance organization having the
capability to provide comprehensive health care services in
the geographic area proposed, as certified by the department
of Health and Rehabilitative Services as a condition precedent
to the issuance of any certificate.

(2) The proposed rates are plans actuarially sound
for the benefits provided, including administrative costs,
and the health maintenance organization has and will continue
to have adequate working capital in a minimum amount of
$1,500,000 cash or working capital sufficient to carry all
operating expenses for a period of at least 3 months.

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taking into account the area to be served, the anticipated number of subscribers, and the type of services to be rendered.

(3) Prior to December 31, 1985, the health maintenance organization must have a minimum surplus of $100,000. After December 31, 1985, the health maintenance organization must have a minimum surplus as follows:

(a) As of December 31, 1986, $150,000;
(b) As of December 31, 1987, $200,000;
(c) As of December 31, 1988, $250,000;

unless there exists a written guarantee to insure payment of covered subscriber claims provided by an entity which has been in operation for at least 3 years and has a surplus, not including land, buildings, and equipment, equal to two times the statutory surplus deficiency or two times the statutory requirement, whichever is the greater amount. Such guaranteeing organization and the written guarantee must be acceptable to and approved by the Department of Insurance.

(4) The health maintenance organization has made acceptable arrangements to provide all health care services offered.

(5) The terms of the contracts such entity proposes to offer to subscribers will in fact assure that the comprehensive health care services required by such subscribers will be rendered under reasonable standards of quality of care, as certified by the Department of Health and Rehabilitative Services.

(6) The procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of
age, sex, race, health, or economic status. However, this section shall not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor shall it prohibit experience rating.

The entity furnishes evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of comprehensive health care.

The entity has provided, through contract or otherwise, for periodic review of its medical facilities and services.

The ownership, control, or management of the entity is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The department shall not grant or continue authority to transact the business of a health maintenance organization in this state at any time during which it has good reason to believe that the ownership, control, or management of the organization is under the control of any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors; by the improper manipulation of assets or of accounts; or by bad faith.

The entity has a blanket fidelity bond in the amount of $25,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with such funds. All employees handling such funds shall be covered by the blanket fidelity bond. An agent licensed under the provisions of the Florida Insurance Code
may either directly or indirectly represent the health maintenance organization in the solicitation, negotiation, effectuation, procurement, receipt, delivery, or forwarding of any health maintenance organization subscriber's contract or collect or forward any consideration paid by the subscriber to the health maintenance organization; and such agent shall not be required to post the bond required by this subsection.

(11) The entity has filed with and obtained approval from the department all reinsurance contracts as provided in s. 641.285.

Section 4. Section 641.225, Florida Statutes, is created to read:

641.225 Surplus requirements.—

(1) Each health maintenance organization licensed prior to October 1, 1983, must have by December 31, 1985, a minimum surplus of $100,000. After December 31, 1985, each health maintenance organization must have a minimum surplus as follows:

(a) As of December 31, 1986, $150,000.
(b) As of December 31, 1987, $200,000.
(c) As of December 31, 1988, $250,000.

(2) In lieu of having a minimum surplus, there may exist for a health maintenance organization a written guarantee of the type and subject to the same provisions as outlined in s. 641.22.

Section 5. Section 641.23, Florida Statutes, 1982 Supplement, is amended to read:

641.23 Revocation of certificate of authority.—The department may revoke any certificate issued to a health maintenance organization, or order compliance within 60 days, if it finds that any of the following conditions exists:
(1) The organization is not operating in compliance with this part;
(2) The organization is in substantial violation of its health maintenance contracts, as certified by the Department of Health and Rehabilitative Services;
(3) The organization is unable to fulfill its obligations under outstanding health maintenance contracts entered into with its subscribers, as certified by the Department of Health and Rehabilitative Services;
(4) The plan is no longer actuarially sound or the organization does not have the minimum surplus as required by this part adequate-working-capital;
(5) The existing contract rates are excessive, inadequate, or unfairly discriminatory; or
(6) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising; or
(7) The organization is insolvent.

Section 6, Section 641.25, Florida Statutes, 1982 Supplement, is amended to read:

641.25 Administrative penalty fine in lieu of revocation.--The department may, in lieu of revocation, levy an administrative penalty in an amount not less than $100 or more than $10,000.

Section 7 Section 641.26, Florida Statutes, 1982 Supplement, is amended to read:

641.26 Annual report.--
(1) Every health maintenance organization shall, annually on or before April 1, or within 3 months of the.

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end of the fiscal year for health maintenance organizations operating under a valid certificate of authority as of the effective date of this section, or within such extension of time therefor as the department, for good cause, may grant, on forms prescribed by the department, file a report with the department, verified by the oath of two executive officers of the organization, or, if not a corporation, of two persons who are principal managing directors of the affairs of the organization, showing its condition on the last day of the preceding calendar year. Such report shall include:

(a) A financial statement of the organization, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant;

(b) A list of the names and residence addresses of all persons responsible for the conduct of its affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the health maintenance organization, including any possible conflicts of interest;

(c) The number of health maintenance contracts issued and outstanding and the number of health maintenance contracts terminated and a compilation of the reasons for such terminations;

(d) A description by location and specialty of the providers retained or otherwise engaged by the organization to satisfy its contractual obligations with its subscribers;

(e) Such statistical information as is requested by the department reflecting the rates of the health maintenance organization for all comprehensive health care services provided under health maintenance contracts;
(f) The number and amount of damage claims for medical
injury initiated against the health maintenance organization
and any of the providers engaged by it during the reporting
year, broken down into claims with and without formal legal
process, and the disposition, if any, of each such claim; and

(g) An actuarial certification that the health
maintenance organization's rates are actuarially sound for the
benefits provided; and

(h) Such other information relating to the
performance of health maintenance organizations as is required
by the department.

(2) Any health maintenance organization which is
unable to provide to the department an audited financial
statement within the time required shall annually file, on or
before March 1 next following each calendar year, the annual
report required by subsection (1) with an unaudited financial
statement of the organization, and certification of such
financial statement by an independent certified public
accountant shall be received by the department by the
following May 1.

(3) Any health maintenance organization which
neglects to file the annual report in the form and within the
time required by this section shall forfeit $100 for each day
during which the neglect continues; and, upon notice by the
department to that effect, its authority to do business in
this state shall cease while such default continues. The
department shall deposit all sums collected by it under this
section to the credit of the Insurance Commissioner's
Regulatory Trust Fund.

Section 8. Section 641 27, Florida Statutes, 1982

Supplement, is amended to read:

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641.27 Examination by the department.--The department shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 3 years. The Department of Health and Rehabilitative Services may conduct periodic examinations regarding the quality of health care services being provided by the organization.

Every health maintenance organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. However, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the respective departments may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The expenses of examination of each health maintenance organization by the department shall be subject to the same terms and conditions as apply to insurers under part II of chapter 624 of the Florida Insurance Code. The expenses of examination of each health maintenance organization or by the Department of Health and Rehabilitative Services shall be paid by the organization. In no event shall expenses of all examinations exceed a maximum of $15,000 per year. Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the

CODING Words in struck through type are deletions from existing law, words underlined are additions
Section 641.28, Florida Statutes, 1982

Supplement, as amended to read:

641.28 Civil remedy.--In any civil action brought to enforce the terms and conditions of a health maintenance organization contract, the prevailing party shall be entitled to recover reasonable attorney's fees and court costs. Any person injured by a breach of a subscriber contract may bring a civil action against a person breaching such contract. Upon adverse adjudication at trial or upon appeal, the defendant shall be liable for damages together with court costs and reasonable attorney's fees incurred by the plaintiff. This section shall not be construed to authorize a civil action against the Department, its employees, or the Insurance Commissioner of the Department of Health and Rehabilitative Services, its employees, or the secretary of the department.

Section 10. Section 641.285, Florida Statutes, 1982, is amended to read:

641.285 Insolvency protection.--

641.285-2 Insolvency protection--Every health maintenance organization shall comply with one of the following:

1. Unless otherwise provided below, each health maintenance organization shall deposit with the department security or the type eligible for deposit by insurers under s. 625.52, which securities shall have at all times a market value in the amount set forth in this section.

2. The amount for an organization that is beginning operations will be the greater of...

1:00 a.m.
1. Five percent of its estimated expenditures for health care services for its first year of operation;

2. Twice its estimated average monthly uncovered expenditures for its first year of operation; or

3. $100,000.

On or before January 1 of each succeeding year, unless not applicable, the organization shall deposit with the department cash, securities, or any combination of these or other measures acceptable to the department in an amount equal to 4 percent of the preceding 12 months' uncovered expenditures or 4 percent of its estimated annual uncovered expenditures for the succeeding year, whichever is greater.

(b) Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to the larger of 1 percent of the preceding 12 months' uncovered expenditures or $100,000, on the first day of the first calendar year beginning 6 months or more after the effective date of this section. In the second calendar year, if applicable, the amount of the additional deposit shall be equal to 2 percent of its estimated annual uncovered expenditures. In the third calendar year, if applicable, the additional deposit shall be equal to 3 percent of its estimated annual uncovered expenditures for that year, and in the fourth and subsequent years, if applicable, the additional deposit shall be equal to 4 percent of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.
(1) Secure insurance or reinsurance to protect subscribers in the event the organization is unable to meet its obligations.

(2) The department may waive any of the deposit required to be paid in subsection (1) whenever satisfied that the organization has sufficient surplus and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient surplus and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, (hospital or medical service corporations), governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

(2) Post a surety bond executed by the health maintenance organization and by a surety company authorized to do business in this state payable to the Governor in the sum of $75,000. The bond shall be conditioned that the health maintenance organization shall faithfully and truly perform all of the conditions of any health maintenance contract if such performance is not forthcoming, any affected subscriber may maintain an action in his own name upon the bond in any court having jurisdiction of the amount claimed. In no event shall the aggregate liability of the surety to all such authorized shall not be exclusive of any other remedy which would otherwise exist. The bond posted shall be in full force and effect during all periods and in all places and areas in which the entity is doing business as a health maintenance organization.

CODING: red or show through type or delete. new, form existing low words underlined are additions.
(3) When an organization has achieved a surplus, not including land, buildings, and equipment, of at least $1 million or has achieved a surplus, including organization-related land, buildings, and equipment, of at least $5 million, the annual deposit requirement shall not apply. The annual deposit requirement shall not apply to an organization if the total amount of the accumulated deposit is equal to 25 percent of its estimated annual uncovered expenditures for the next calendar year, or $1,500,000, whichever is less. If the organization has a guaranteeing organization which has been in operation for 5 years or more and has a surplus, not including land, buildings, and equipment, of at least $1 million, or which has been in operation for 10 years or more and has a surplus, including organization-related land, buildings, and equipment, of at least $5 million, the annual deposit requirement shall not apply; provided, however, that if the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of $1 million shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a surplus at least equal to $1,500,000.

(4) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit, or any part thereof, after making a substitute deposit of cash.
securities, or any combination of these or other measures of

equal amount and value. Any securities shall be approved by

the department.

(5) In any year in which an annual deposit is not

required of an organization, at the organization's request the
department shall reduce the required, previously accumulated

deposit to $10,000 for each $250,000 of surplus in excess of

the amount that allows the organization not to make the annual

gross. If the amount of surplus no longer supports a

reduction in the required deposit, the organization shall

reduce the deposit to $10,000 for each $250,000 of reduction

in surplus, provided that its total deposit shall not exceed

the maximum required under this section.

(6) The requirements of this section shall not apply

to an insurance - unrelated health maintenance organization

which has on file with the department contracts of insurance

reinsurance to protect subscribers in the event the

organization is unable to meet its obligations. All such

agreements between the organization and an insurer shall be

filed with and approved by the department. All such agreements

shall remain in full force and effect until replaced or for

30 days following written notification to the department

of cancellation by either party.

Sec. 11. Subsection (8) and (9) are added to

section 8-32, Florida Statutes, 1982 Supplement, to read:

11. Health maintenance contracts...

11. Health maintenance organizations are entitled to

construct or maintain on the same basis as insurers under s.

11.11 of the Insurance Code.

Am. 1985 c. 34.
(9) Health maintenance organizations providing medical benefits to subscribers who suffer injury, disease or illness by virtue of the negligent act or omission of a third party shall be entitled to reimbursement from the subscriber, on a fee-for-service basis, for the reasonable value of the benefits provided. However, the health maintenance organization shall not be entitled to reimbursement in excess of the subscriber's monetary recovery for medical expenses rendered, from the third party.

Section 12. Section 641.315, Florida Statutes, 1982 Supplement, is amended to read:

641.315 Provider contracts.—Whenever a contract exists between a health maintenance organization and a provider and the organization fails becomes unable to meet its obligations to pay fees for services already rendered to subscribers, the health maintenance organization shall be liable for such fee or fees rather than the subscriber; and the contract shall so state.

Section 13. This act shall take effect October 1, 1983, except that the amendments to subsection (l) of section 641.26, Florida Statutes, 1982 Supplement, shall take effect upon becoming a law.
**HOUSE SUMMARY**

Defines “surplus,” “guaranteeing organization,” “uncovered expenditures,” “insolvent,” and “surplus notes” for purposes of provisions relating to health maintenance organizations (HMO). Changes financial disclosure requirements for certification as an HMO by the Department of Insurance.

Provides for scheduled increases in the minimum surplus requirements for an HMO beginning in 1985. Exempts an HMO which has a certain written guarantee to insure payment of covered subscriber claims. Requires an HMO to file with the Department and obtain department approval of all reinsurance contracts. Requires HMO's certified prior to October 1, 1983, to have a minimum surplus of $100,000 by the end of calendar year 1985, and requires such HMO's to meet the scheduled increases thereafter. Provides an exemption to such HMO's which have the written guarantee of payment of covered subscriber claims.

Authorizes the Department to order an HMO to comply with regulatory provisions in lieu of revocation of the certificate. Provides for insolvency as a ground for the issuance of such order or for revocation.

Changes the date by which HMO's must file annual reports with the Department, and includes certification of the actuarial soundness of the HMO's rates within the report. Provides an alternative procedure for meeting audited financial statement reporting requirements. Provides that certain provisions of the Florida Insurance Code shall apply with respect to the payment by an HMO of the expenses of the Department incurred in the examination of the HMO Entitles the prevailing party in certain civil actions involving an HMO to recover court costs and reasonable attorney's fees.

Substantially changes HMO insolvency protection provisions. Authorizes an HMO to deposit securities in amount to be determined as provided in the act. Authorizes the Department to waive such requirement under specified circumstances. Provides that the annual deposit requirement shall not apply to an HMO achieving a specified level of surplus or accumulated deposit or if the HMO has a guaranteeing organization meeting specified requirements. Provides for the withdrawal and reduction of deposits and for departmental approval of securities. Prempts from deposit requirements any HMO which files with the department certain contracts of insurance or reinsurance.

Authorizes HMO's to coordinate benefits on the same basis as insurers. Authorizes HMO's to obtain reimbursement from all others for benefits received for injuries caused by third parties.
Bill Analysis

Florida House of Representatives

H. Lee Mofitt, Speaker
Steve Palermo, Speaker pro tempore
Committee on Commerce

FINAL STAFF SUMMARY

HB 1176 by Commerce
(as enacted by the Legislature)
relating to health
maintenance organizations
Committee Consideration:
House Commerce
Identical*/Similar Bills:
SB 593
Effective Date: October 1, 1983

I. SUMMARY AND PURPOSE

In 1982, the Health Maintenance Organization (HMO) section of the Florida Insurance Code went through major revisions in order to provide an effective way to control health care costs. This was achieved by strengthening the requirements under which an HMO can operate. Basically, HMO members pay a flat monthly fee, and a group of physicians provide for their medical care. However, it was brought to the Legislature's attention that the financial stability of some HMO's was in doubt. Therefore, in order to protect members of HMO's from unpaid medical bills, new requirements for guaranteeing financial solvency were proposed. To attain this end, more specific financial standards have been established in order to give the Department of Insurance concrete guidelines to determine the viability of an HMO.

II. CURRENT LAW AND EFFECT OF CHANGES

A. CURRENT LAW

The financial considerations presently required are:

(1) A statement of the assets and liabilities of the HMO.

(2) Actuarially sound rates.

(3) Adequate working capital of at least $100,000 or sufficient working capital to carry all operating expenses for a period of at least 3 months whichever is greater. Sufficiency of working capital is to be determined by taking into account the area to be served, the anticipated number of subscribers and type of services to be rendered.

Wyn T. Martin Staff Director
322 The Capitol, Tallahassee, Florida 32301 (904) 488-7824
(4) An HMO must also:
   (a) secure insurance or reinsurance;
   (b) post a surety bond of $75,000; or
   (c) deposit a cash deposit of $75,000.

B. EFFECT OF CHANGES

The guidelines used to define working capital were so vague as not to give the department an effective means of measuring financial solvency. The bill remedies this situation by providing that:

(1) Prior to December 31, 1985, an HMO must have a minimum surplus of $100,000. After that date the surplus will increase yearly until 1988 when the minimum amount will be $250,000. However, if the HMO has been insured by a guaranteeing organization approved by the department, then the minimum surplus requirements after 1985 will not apply (s. 641.22).

For HMO's licensed prior to October 1, 1983, a minimum surplus of $100,000 is required by 1985. After 1985, HMO's licensed before October 1, 1983, will be subject to the same requirements as HMO's not licensed before this date (s. 641.225).

(2) The HMO must provide actuarial certification that its rates are actuarially sound for the benefits provided (s. 641.76(1)(g)).

(3) In a civil action brought to enforce the terms of the contract, the prevailing party, instead of just the plaintiff, may recover reasonable attorney's fees and court costs.

(4) Except in specified circumstances, each HMO must deposit securities with the department as a protection against insolvency.
   (a) For an organization beginning operation, the required deposit is the greater of:
      (i) five percent of its estimated expenditures for health care services for the first year of operation;
      (ii) twice its estimated average monthly uncovered expenditures for its first year of operation; or
      (iii) $100,000.
   
   Additionally, on or before the beginning of each year, the HMO must deposit 4% of the preceding 12 months' uncovered expenditures or estimated annual uncovered expenditures, whichever is greater.
   (b) For an HMO that is in operation on the effective date of this section, the required deposit is the larger of:
      (i) one percent of preceding 12 months' uncovered expenditures; or
      (ii) $100,000.

In succeeding years an additional deposit, increasing by 1% each year to a maximum of 4% of estimated annual uncovered expenditures, is required.
(c) The deposit may be waived by the department if the HMO has sufficient surplus or is guaranteed by a financially solvent organization.

(d) The deposit requirement does not apply if:

(i) the HMO has reached a surplus of $1 million, or $5 million including land, buildings and equipment;

(ii) the total amount of the accumulated deposit is equal to 25% of its estimated annual uncovered expenditures for the calendar year or $1.5 million, whichever is less;

(iii) the HMO has a guaranteeing organization which meets specific requirements; or

(iv) the HMO has contracts of insurance or reinsurance to protect subscribers.

The bill amends s. 641.31, Florida Statutes, 1982 Supplement, to provide that HMO's may coordinate benefits on the same basis as health insurers. Further, the bill provides through the referenced section that an HMO is entitled to reimbursement from a member for the reasonable value of services provided due to injury, disease or illness caused by the negligence of a third party. Reimbursement is limited to the member's monetary recovery for medical expenses rendered from the third party.

III. ECONOMIC IMPACT

A. PRIVATE SECTOR CONSIDERATIONS

The economic impact on HMO's will be substantial due to the new surplus and deposit requirements.

(1) Under present law the working capital is the greater of $100,000 or operating expenses for the first three months. This amount will be raised to $250,000 by 1988 unless the HMO is reinsured.

(2) Under present law, insurance, reinsurance or a bond or deposit of $75,000 is required. Under the new law, the deposit requirements outlined above will apply.

B. PUBLIC SECTOR CONSIDERATIONS

None.

IV. COMMENTS

None.

V. LEGISLATIVE HISTORY

A. ENACTED BILL

The bill originated as Proposed Committee Bill 83-34 in the Commerce Committee and was first heard in the Subcommittee on Health Care and Life and Health Insurance on April 12, 1983. The subcommittee passed the bill with two amendments, one of which was technical. The other removed a provision which excluded HMO's from the collateral source provision of s. 627.7372. The bill then passed as amended out of full committee on April 19 and was introduced as HB 1176. The bill then passed the House as amended on the floor by a vote of 115-0 on May 26 (HJ 642). (The amendments were technical.) In the Senate, the bill passed 34-0 on June 2, 1983 (SJ 717).
B. DISPOSITION OF COMPANION

In the Senate, SB 593 was referred to HRS and passed by the committee on April 20, 1983. On May 20 it was placed on the Calendar. On June 2, 1983 it was laid on the table, the Senate having passed HB 1176.

Prepared by: Hala Ayoub

Staff Director: Wyatt T. Martin
AMENDMENTS TO HB 1176 (HMO’s)

#1 and #2: These clarify that an HMO does not have to meet the minimum surplus requirements if an organization (such as Blue Cross or an insurer) has guaranteed to the Department of Insurance that the obligations of an HMO will be fulfilled.

#3: This clarifies that one of the benefits of an HMO is payment for medical expenses.

#4: Title amendment.
A bill to be entitled

An act relating to health maintenance
organizations; amending ss. 641.21(7), 641.22, 641.23, 641.25, 641.26, 641.27, 641.28, 641.285, 641.315, Florida Statutes, 1982
Supplement, adding ss. 641.19(9)-(13), 641.31(8), Florida Statutes, 1982 Supplement;
creating ss. 641.225, Florida Statutes;
providing definitions; requiring a financial statement; requiring actuarially sound rates;
providing surplus requirements; requiring filing of reinsurance contracts; providing for revocation of certificate of authority;
providing for administrative penalty; requiring annual report; providing for examination;
providing for attorney fees and costs;
requiring annual deposit of securities;
providing for coordination of benefits;
providing an effective date.

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

Section 1. Subsections (9), (10), (11), (12), and (13) are added to section 641.19, Florida Statutes, 1982
Supplement, to read:

641.19 Definitions.--As used in this part, the term:

(9) "Surplus" means total unencumbered assets in excess of total liabilities. Surplus includes capital stock,
capital in excess of par, and retained earnings and may include surplus notes.

CODING: Words in struck through type are deletions from existing law, words underlined are additions.
(10) "Guaranteeing organization" is an organization which is domiciled in the United States, which has authorized service of process against it, and which has appointed the Insurance Commissioner and Treasurer as its agent for service of process issuing upon any cause of action arising in this state, based upon any guarantee entered into under this part.

(11) "Uncovered expenditures" means the cost of health care services that are covered by a health maintenance organization, for which a subscriber would also be liable in the event of the organization's insolvency.

(12) "Insolvency" means the inability of the health maintenance organization to discharge its liabilities as they become due in the normal course of business.

(13) "Surplus notes" means debt which has been guaranteed by the Federal Government or its agencies, or debt which has been subordinated to all claims of subscribers and general creditors of the organization.

Section 2. Subsection (7) of section 641.21, Florida Statutes, 1982 Supplement, is amended to read:

641.21 Application for certificate.--Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the department. Each application for a certificate shall be on such form as the department shall prescribe and shall be accompanied by the following:

(7) A financial statement prepared on the basis of generally accepted accounting principles, except that surplus notes acceptable to the department and meeting the requirements of this act may be included in its calculation of surplus. A statement of the assets and liabilities of the entity.
Section 3. Section 641.22, Florida Statutes, 1982 Supplement, is amended to read:

641.22 Issuance of certificate of authority.--The department shall issue a certificate of authority within 60 days of the filing of a properly completed application to any entity filing an application in conformity with s. 641.21, upon payment of the prescribed fees and upon being satisfied that:

(1) The entity proposes to establish and operate a bona fide health maintenance organization having the capability to provide comprehensive health care services in the geographic area proposed, as certified by the Department of Health and Rehabilitative Services as a condition precedent to the issuance of any certificate.

(2) The proposed rates are planned as actuarially sound for the benefits provided, including administrative costs, and the health maintenance organization has and will continue to have adequate working capital in a minimum amount of $200,000 cash or working capital sufficient to carry all operating expenses for a period of at least 3 months, whichever is the greater amount. A reasonable sufficiency of working capital shall be determined by the department by taking into account the area to be served; the anticipated number of subscribers; and the type of services to be rendered.

(3) Prior to December 31, 1985, the health maintenance organization shall have a minimum surplus of $100,000. After December 31, 1985, the health maintenance organization shall have a minimum surplus as follows:

(a) As of December 31, 1986, $150,000;

(b) As of December 31, 1987, $200,000.
(c) As of December 31, 1988, $250,000; unless there exists a written guarantee to insure payment of covered subscriber claims provided by an entity acceptable to the department which has been in operation for at least 3 years and has a surplus, not including land, building, and equipment, equal to 2 times the statutory surplus deficiency or 2 times the statutory requirement, whichever is the greater amount.

(4) The health maintenance organization has made acceptable arrangements to provide all health care services offered.

(5) The terms of the contracts such entity proposes to offer to subscribers will in fact assure that the comprehensive health care services required by such subscribers will be rendered under reasonable standards of quality of care, as certified by the Department of Health and Rehabilitative Services.

(6) The procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, health, or economic status. However, this section shall not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor shall it prohibit experience rating.

(7) The entity furnishes evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of comprehensive health care.

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(8) The entity has provided, through contract or otherwise, for periodic review of its medical facilities and services.

(9) The ownership, control, or management of the entity is competent and trustworthy and possesses managerial experience that would make the proposed health maintenance organization operation beneficial to the subscribers. The department shall not grant or continue authority to transact the business of a health maintenance organization in this state at any time during which it has good reason to believe that the ownership, control, or management of the organization is under the control of any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors; by the improper manipulation of assets or of accounts; or by bad faith.

(10) The entity has a blanket fidelity bond in the amount of $25,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with such funds. All employees handling such funds shall be covered by the blanket fidelity bond. An agent licensed under the provisions of the Florida Insurance Code may either directly or indirectly represent the health maintenance organization in the solicitation, negotiation, effectuation, procurement, receipt, delivery, or forwarding of any health maintenance organization subscriber's contract or collect or forward any consideration paid by the subscriber to the health maintenance organization; and such agent shall not be required to post the bond required by this subsection.

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(11) The entity has filed with the department all
reinsurance contracts as provided in s. 641.285.

Section 4. Section 641.225, Florida Statutes, is
created to read:

641.225 Surplus requirements.--

(1) Each health maintenance organization licensed
prior to October 1, 1983, shall have at December 31, 1985, a
minimum surplus of $100,000. After December 31, 1985, each
health maintenance organization must have a minimum surplus as
follows:

(a) As of December 31, 1986, $150,000;
(b) As of December 31, 1987, $200,000;
(c) As of December 31, 1988, $250,000.

(2) In lieu of having a minimum surplus, there may
exist for a health maintenance organization a written
guarantee of the type and subject to the same provisions as
outlined in s. 641.22.

Section 5. Section 641.23, Florida Statutes, 1982
Supplement, is amended to read:

641.23 Revocation of certificate of authority.--The
department may revoke any certificate issued to a health
maintenance organization or order compliance within 60 days if
it finds that any of the following conditions exists:

(1) The organization is not operating in compliance
with this part;

(2) The organization is in substantial violation of
its health maintenance contracts, as certified by the
Department of Health and Rehabilitative Services;

(3) The organization is unable to fulfill its
obligations under outstanding health maintenance contracts

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entered into with its subscribers, as certified by the
Department of Health and Rehabilitative Services;

(4) The plan is no longer actuarially sound or the
organization does not have the minimum surplus as required by
this part, adequate working capital;

(5) The existing contract rates are excessive,
inadequate, or unfairly discriminatory; or

(6) The organization has advertised, merchandised, or
attempted to merchandise its services in such a manner as to
misrepresent its services or capacity for service or has
engaged in deceptive, misleading, or unfair practices with
respect to advertising or merchandising; or-

(7) The organization is insolvent.

Section 6. Section 641.25, Florida Statutes, 1982
Supplement, is amended to read:

641.25 Administrative penalty in lieu of
revocation.--The department may, in lieu of revocation, levy
an administrative penalty in an amount not less than $100 or
more than $10,000.

Section 7. Section 641.26, Florida Statutes, 1982
Supplement, is amended to read:

641.26 Annual report.--

(1) Every health maintenance organization shall,
annually on or before April 1 or within 3 months of the end of
the fiscal year for health maintenance organizations operating
under a valid certificate of authority as of the effective
date of this part, March 1, or within such extension of time
thereof as the department, for good cause, may grant, on
forms prescribed by the department, file a report with the
department, verified by the oath of two executive officers of
the organization, or, if not a corporation, of two persons who

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are principal managing directors of the affairs of the
organization, showing its condition on the last day of the
preceding calendar year. Such report shall include:

(a) A financial statement of the organization,
including its balance sheet and a statement of operations for
the preceding year certified by an independent certified
public accountant;

(b) A list of the names and residence addresses of all
persons responsible for the conduct of its affairs, together
with a disclosure of the extent and nature of any contracts or
arrangements between such persons and the health maintenance
organization, including any possible conflicts of interest;

(c) The number of health maintenance contracts issued
and outstanding and the number of health maintenance contracts
terminated and a compilation of the reasons for such
terminations;

(d) A description by location and specialty of the
providers retained or otherwise engaged by the organization to
satisfy its contractual obligations with its subscribers;

(e) Such statistical information as is requested by
the department reflecting the rates of the health maintenance
organization for all comprehensive health care services
provided under health maintenance contracts;

(f) The number and amount of damage claims for medical
injury initiated against the health maintenance organization
and any of the providers engaged by it during the reporting
year, broken down into claims with and without formal legal
process, and the disposition, if any, of each such claim; and

(g) An actuarial certification or other evidence
satisfactory to the department that the health maintenance

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organization's rates are actuarially sound for the benefits provided, and

(h) Such other information relating to the performance of health maintenance organizations as is required by the department.

(2) A health maintenance organization which is unable to provide to the department an audited financial statement within the time required shall, annually, file on or before April 1 next following each calendar year, the annual report required by subsection (1) with an unaudited financial statement by an independent certified public accountant to be received by the department by the following May 1.

(3) Any health maintenance organization which neglects to file the annual report in the form and within the time required by this section shall forfeit $100 for each day during which the neglect continues; and, upon notice by the department to that effect, its authority to do business in this state shall cease while such default continues. The department shall deposit all sums collected by it under this section to the credit of the Insurance Commissioner's Regulatory Trust Fund.

Section 8. Section 641.27, Florida Statutes, 1982 Supplement, is amended to read:

641.27 Examination by the department.--The department shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 3 years. The Department of Health and Rehabilitative Services may conduct periodic examinations regarding the quality of health care services being provided by the organization.
Every health maintenance organization shall submit its books and records and take other appropriate action as may be necessary to facilitate an examination. However, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the respective departments may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The expenses of examination of each health maintenance organization by the department shall be subject to the same terms and conditions as applies to insurers under part II of chapter 624 or by the Department of Health and Rehabilitative Services shall be paid by the organization. In no event shall expenses of all examinations exceed a maximum of $15,000 per year. Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation, liquidation, conservation, or dissolution of life insurance companies.

Section 9. Section 641.28, Florida Statutes, 1982 Supplement, is amended to read:

641.28 Civil remedy.--In any civil action brought to enforce the terms and conditions of a health maintenance organization contract the prevailing party shall be entitled to recover a reasonable attorney fee and court costs. Any person damaged by a breach of a subscriber contract may bring a civil action against a person breaching such contract. Upon

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adverse adjudication at trial or upon appeal, the defendant shall be liable for damages, together with court costs and reasonable attorney's fees incurred by the plaintiff. This section shall not be construed to authorize a civil action against the department, its employees, or the insurance commissioner or the Department of Health and Rehabilitative Services, its employees, or the secretary of the department.

Section 10. Section 641.285, Florida Statutes, 1982 Supplement, is amended to read:

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the department securities of the type eligible for deposit by insurers under s. 625.52, which securities shall have at all times a market value in the amount set forth in this section.

(a) The amount for an organization that is beginning operation shall be the greater of 5 percent of its estimated expenditures for health care services for its first year of operation, twice its estimated average monthly uncovered expenditures for its first year of operation, or $100,000. On or before January 1 of each succeeding year, unless not applicable, the organization shall deposit with the department cash, securities, or any combination of these or other measures acceptable to the department in an amount equal to 4 percent of the preceding 12 months uncovered expenditures or 4 percent of its estimated annual uncovered expenditures for the succeeding year, whichever is greater.

(b) 1. Unless not applicable, an organization that is in operation on the effective date of this section shall make

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a deposit equal to the larger of 1 percent of the preceding 12
months' uncovered expenditures or $100,000 on the first day of
the first calendar year beginning 6 months or more after the
effective date of this section.

2. In the second calendar year, if applicable, the
amount of the additional deposit shall be equal to 2 percent
of its estimated annual uncovered expenditures.

3. In the third calendar year, if applicable, the
additional deposit shall be equal to 3 percent of its
estimated annual uncovered expenditures for that year.

4. In the fourth year and subsequent years, if
applicable, the additional deposit shall be equal to 4 percent
of its estimated annual uncovered expenditures for each year.

Each year's estimate, after the first year of operation shall
reasonably reflect the prior year's operating experience and
delivery arrangements.

(2) The department may waive any of the deposit
requirements set forth in subsection (1) whenever satisfied
that the organization has sufficient surplus and an adequate
history of generating net income to assure its financial
viability for the next year, or its performance and
obligations are guaranteed by an organization with sufficient
surplus and an adequate history of generating net income, or
the assets of the organization or its contracts with insurers,
hospital or medical service corporations, governments, or
other organizations are reasonably sufficient to assure the
performance of its obligations.

(3)(a) When an organization has achieved a surplus not
including land, buildings, and equipment or at least $1
million or has achieved a surplus including organization-
related land, buildings, and equipment of at least $5 million, the annual deposit requirement shall not apply.

(b) The annual deposit requirement shall not apply to an organization if the total amount of the accumulated deposit is equal to 25 percent of its estimated annual uncovered expenditures for the next calendar year, or $1,500,000 whichever is less.

(c) If the organization has a guaranteeing organization which has been in operation for at least 5 years and has a surplus not including land, buildings and equipment of at least $1 million or which has been in operation for a least 10 years and has a surplus including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement shall not apply, but if the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of $1 million shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a surplus at least equal to $1,500,000.

(4) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the department.

(5) In any year in which an annual deposit is not required of an organization, at the organization's request the

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department shall reduce the required, previously accumulated
deposit to $100,000 for each $250,000 of surplus in excess of
the amount that allows the organization not to make the annual
deposit. If the amount of surplus no longer supports a
reduction of its required deposit, the organization shall
immediately redeposit $100,000 for each $250,000 of reduction
in surplus, provided that its total deposit shall not exceed
the maximum required under this section.

(6) The requirements of this section shall not apply
to an applying or licensed health maintenance organization
which has on file with the department contracts of insurance
or reinsurance to protect subscribers in the event the
organization is unable to meet its obligations. All such
agreements between the organization and an insurer shall be
subject to the laws of this state regarding reinsurance. All
such agreements and any modifications thereto must be filed
with and approved by the department. All such agreements
shall remain in full force and effect until replaced, or for
at least 90 days following written notification to the
department by registered mail of cancellation by either party.

Section 11. Subsection (8) is added to section 641.31,
Florida Statutes, 1982 Supplement, to read:

641.31 Health maintenance contracts.--

(8) Health maintenance organizations are entitled to
coordinate benefits on the same basis as insurers under s.
627.4235.

Section 12. Section 641.315, Florida Statutes, 1982
Supplement, is amended to read:

641.315 Provider contracts.--Whenever a contract
exists between a health maintenance organization and a
provider and the organization fails becomes unable to meet its
obligations to pay fees for services already rendered to
subscribers, the health maintenance organization shall be
liable for such fee or fees rather than the subscriber; and
the contract shall so state.

Section 13. This act shall take effect upon becoming a
law.

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SENATE SUMMARY

Revises financial requirements for health maintenance
organizations. Provides for revocation of certificate of
authority of insolvent organization. Provides for
coordination of benefits.

CODING. Words in strike through type are deletions from existing law, words underlined are additions.
I. SUMMARY:
A. Present Situation:

Chapter 641, Part II, Florida Statutes, regulates Health Maintenance Organizations (HMOs), which are health care organizations that provide, either directly or through arrangements with other providers, a comprehensive range of health and medical services based on a prepaid, fixed premium.

HMOs operating in Florida must have a certificate of authority from the Department of Insurance (DOI), issued in consultation with the Department of Health and Rehabilitative Services (HRS). To obtain a certificate of authority, the proposed HMO must meet criteria set forth in section 641.22, Florida Statutes, which requires, among other things, that the HMO have, and continue to have adequate working capital of at least $100,000 or an amount sufficient to cover operating expenses for 3 months.

HMOs must file an annual financial report with DOI by March 1st of each year. Section 641.28, Florida Statutes, provides for payment of court costs and attorneys' fees by an HMO when such HMO loses a civil action against it.

HMOs must provide insolvency protection in one of 3 ways. An HMO may secure insurance or reinsurance to protect subscribers, or it may post a surety bond of $75,000, or it may deposit $75,000 cash with DOI.

B. Effect of Proposed Changes:

This bill will strengthen the financial requirements placed upon HMOs by the Department of Insurance by requiring HMOs to maintain a minimum surplus of $100,000 by December 31, 1985, increasing to a minimum surplus of $250,000 by December 31, 1988. This surplus is not required if the HMO has a guarantor which has been in operation for at least 3 years and has a surplus of at least 2 times the HMO's surplus deficiency.

The bill provides definitions necessary for the surplus requirement and for new requirements for insolvency protection. Such new insolvency protection requirements are set forth in section 641.285. First, a new HMO is required to deposit at least $100,000 or a greater amount based on expected expenditures. After the first year of operation, the HMO must deposit an amount equal to 4 percent of its uncovered expenditures.
Existing HMOs must deposit at least $100,000 or a greater amount based on actual uncovered expenditures, increasing to 4 percent of such expenditures after 4 years from the effective date of this bill. The Department of Insurance may waive these requirements if the HMO has sufficient surplus and a history of generating adequate net income or an acceptable guarantor backing the HMO.

In addition, the insolvency protection deposit is not required when an HMO has a surplus of at least $1 million, or when such deposit would equal the lesser of 25 percent of the HMOs annual uncovered expenditures or $1.5 million. Also, the insolvency protection deposit is not required if the HMO has a guarantor which has a surplus of $1 million and has been in business for at least 5 years, or has a surplus of $5 million including land, buildings and equipment and has been in business for at least 10 years.

In addition, the insolvency protection requirement may be met by an HMO obtaining insurance or reinsurance to protect subscribers.

This bill would require an applicant for a certificate of authority to file a financial statement, and would require that proposed rates be actuarially sound. The bill would authorize DOI to order compliance within 60 days, as well as revoke a certificate of authority for, among other things, failing to have the required surplus, or becoming insolvent.

The bill changes the deadline for filing annual reports to allow HMOs to file by April 1st or within 3 months of the end of the HMO's fiscal year, and allows an extension to May 1st if an interim report is filed. The bill adds a requirement that such annual report contain an actuarial certification of the HMO's rates.

The bill amends section 641.28, Florida Statutes, to provide for attorneys' fees and court costs to the prevailing party in litigation involving HMOs.

This bill authorizes HMOs to coordinate benefits on the same basis as insurers do under section 627.4235, Florida Statutes.

II. ECONOMIC IMPACT AND FISCAL NOTE:

A. Public:

This bill may substantially increase deposits required of HMOs, as well as increase surplus required to be maintained by HMOs, both of which could increase rates paid by subscribers.

However, such deposits and surplus may result in more stable financial conditions in HMOs and provide greater protection to subscribers from HMO insolvency, thereby reducing the financial risk of subscribers.

B. Government:

None.

III. COMMENTS:

None.
IV. AMENDMENTS:

#1 and 2 by HRS
Amendments 1 and 2 amend the definition of "Health Maintenance Organization" by adding that HMO's provide the most cost effective means of treatment consistent with sound patient care.

#3 by HRS
Amendment 3 is a technical amendment clarifying the provision for late filing of an annual report by an HMO.
I. SUMMARY:

A. Present Situation:

Chapter 641, Part II, Florida Statutes, regulates Health Maintenance Organizations (HMOs), which are health care organizations that provide, either directly or through arrangements with other providers, a comprehensive range of health and medical services based on a prepaid, fixed premium.

HMOs operating in Florida must have a certificate of authority from the Department of Insurance (DOI), issued in consultation with the Department of Health and Rehabilitative Services (HRS). To obtain a certificate of authority, the proposed HMO must meet criteria set forth in section 641.22, Florida Statutes, which requires, among other things, that the HMO have, and continue to have adequate working capital of at least $100,000 or an amount sufficient to cover operating expenses for 3 months.

HMOs must file an annual financial report with DOI by March 1st of each year. Section 641.28, Florida Statutes, provides for payment of court costs and attorneys' fees by an HMO when such HMO loses a civil action against it.

HMOs must provide insolvency protection in one of 3 ways. An HMO may secure insurance or reinsurance to protect subscribers, or it may post a surety bond of $75,000, or it may deposit $75,000 cash with DOI.

B. Effect of Proposed Changes:

This bill will strengthen the financial requirements placed upon HMOs by the Department of Insurance by requiring HMOs to maintain a minimum surplus of $100,000 by December 31, 1985, increasing to a minimum surplus of $250,000 by December 31, 1988. This surplus is not required if the HMO has a guarantor which has been in operation for at least 3 years and has a surplus of at least 2 times the required surplus amount or 2 times the HMO's surplus deficiency.

The bill provides definitions necessary for the surplus requirement and for new requirements for insolvency protection. Such new insolvency protection requirements are set forth in section 641.285. First, a new HMO is required to deposit at least $100,000 or a greater amount based on expected expenditures. After the first year of operation, the HMO must deposit an amount equal to 4 percent of its uncovered expenditures.
Existing HMOs must deposit at least $100,000 or a greater amount based on actual uncovered expenditures, increasing to 4 percent of such expenditures after 4 years from the effective date of this bill. The Department of Insurance may waive these requirements if the HMO has sufficient surplus and a history of generating adequate net income or an acceptable guarantor backing the HMO.

In addition, the insolvency protection deposit is not required when an HMO has a surplus of at least $1 million, or when such deposit would equal the lesser of 25 percent of the HMO's annual uncovered expenditures or $1.5 million. Also, the insolvency protection deposit is not required if the HMO has a guarantor which has a surplus of $1 million and has been in business for at least 5 years, or has a surplus of $5 million including land, buildings and equipment and has been in business for at least 10 years.

In addition, the insolvency protection requirement may be met by an HMO obtaining insurance or reinsurance to protect subscribers.

This bill would require an applicant for a certificate of authority to file a financial statement, and would require that proposed rates be actuarially sound. The bill would authorize DOI to order compliance within 60 days, as well as revoke a certificate of authority for, among other things, failing to have the required surplus, or becoming insolvent.

The bill changes the deadline for filing annual reports to allow HMOs to file by April 1st or within 3 months of the end of the HMO's fiscal year, and allows an extension to May 1st if an interim report is filed. The bill adds a requirement that such annual report contain an actuarial certification of the HMO's rates.

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This bill authorizes HMOs to coordinate benefits on the same basis as insurers do under section 627.4235, Florida Statutes.

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This bill may substantially increase deposits required of HMOs, as well as increase surplus required to be maintained by HMOs, both of which could increase rates paid by subscribers.

However, such deposits and surplus may result in more stable financial conditions in HMOs and provide greater protection to subscribers from HMO insolvency, thereby reducing the financial risk of subscribers.

B. Government:

None.

III. COMMENTS:

None.
IV. AMENDMENTS:

#1 and 2 by HRS
Amendments 1 and 2 amend the definition of "Health Maintenance Organization" by adding that HMO's provide the most cost effective means of treatment consistent with sound patient care.

#3 by HRS
Amendment 3 is a technical amendment clarifying the provision for late filing of an annual report by an HMO.

Passed the Legislature as House Bill 1176, with clarifying amendments.
Journals of the Florida House of Representatives

Sessions commencing on
November 16, 1982 Organization
March 1, 1983 "A"
April 5, 1983 Regular
June 15, 1983 "B"
July 12, 1983 "C"

[Special Sessions are lettered from Organization Session for two-year term of House of Representatives.]
ed, relating to a report required by the Administration Commission with respect to budgets for sheriffs, repealing s. 121.135, Florida Statutes, relating to reports and surveys relative to state and local retirement systems, repealing s. 165.092, Florida Statutes, relating to local government service delivery studies, repealing s. 236.023, Florida Statutes, relating to cost of delivering equivalent educational services and the development of a Cost-of-Education Index; repealing s. 257.06, Florida Statutes, relating to an annual report of the Division of Library Services of the Department of State; repealing s. 420.407 (2), Florida Statutes, as amended, relating to certain reports required of the Executive Office of the Governor with respect to the "Farmworker Housing Assistance Act", repealing s. 533.01, Florida Statutes, as amended, relating to an annual report required by the Department of Veteran and Community Affairs under the "Florida Manufactured Building Act of 1979", providing for the applicability of the act; providing an effective date.

—was read the second time by title and, under Rule 8 19, referred to the Engrossing Clerk.

Consideration of HB 1103 was temporarily deferred

HB 1176—A bill to be entitled An act relating to health maintenance organizations, adding subsections (9)(13)10 to s. 641.19, Florida Statutes, 1982 Supplement, defining "surplus," "guaranteed organization," "uncovered expenditures," "insolvent" or "insolvency" and "surplus notes"; amending s. 641.21 (7), Florida Statutes, 1982 Supplement, relating to applications for certificates, requiring a financial statement; amending s. 641.22, Florida Statutes, 1982 Supplement, relating to issuance of certificates of authority, providing for required minimum surplus for health maintenance organizations; requiring health maintenance organizations to file reinsurance contracts with the department, creating s. 641.225, Florida Statutes, relating to surplus requirements; amending s. 641.23, Florida Statutes, 1982 Supplement, relating to revocation of certificates; providing a time period for order of compliance, amending s. 641.25, Florida Statutes, 1982 Supplement, providing for administrative penalties in lieu of revocation; amending s. 641.26, Florida Statutes, 1982 Supplement, providing for filing of an annual report, providing for requirements for filing annual reports and financial statements; amending s. 641.27, Florida Statutes, 1982 Supplement, relating to examinations by the department, providing terms and conditions for expenses of examination of each health maintenance organization by the department; amending s. 641.28, Florida Statutes, 1982 Supplement, relating to civil actions and remedies, providing for recovery of attorney's fees and court costs; amending s. 641.285, Florida Statutes, 1982 Supplement, relating to insolvency protection; providing for deposits of securities with the department; providing amounts of security deposits, providing exceptions; providing for withdrawal of deposits; providing for reduction of deposits; providing for application of section, adding subsections (9) and (9) to s. 641.31, Florida Statutes, 1982 Supplement, providing for coordinating and limiting contract benefits; providing that benefits provided by health maintenance organizations under certain circumstances shall not be considered collateral source under the provisions of s. 627.7372, Florida Statutes, 1982 Supplement; amending s. 641.315, Florida Statutes, 1982 Supplement, relating to provider contracts, providing that the health maintenance organization shall be liable for fees when the organization fails to meet its obligation to pay such fees; providing effective dates.

—was read the second time by title.

Representative Lehtinen offered the following amendment:

Amendment 1—On page 5, line 12, strike "unless there exists" and insert: In lieu of having any minimum surplus there may exist

Rep. Lehtinen moved the adoption of the amendment, which was adopted without objection.

Representative Lehtinen offered the following amendment:

Amendment 2—On page 5, line 10, strike the semicolon and insert a period

Rep. Lehtinen moved the adoption of the amendment, which was adopted without objection.

Representative Lehtinen offered the following amendment.

Amendment 3—On page 17, lines 2 and 6, after the word "benefits" insert: or payments

Rep. Lehtinen moved the adoption of the amendment, which was adopted without objection.

Representative Lehtinen offered the following title amendment:

Amendment 4—On page 2, lines 17-21, strike all of said lines and insert, benefits,

Rep. Lehtinen moved the adoption of the amendment, which was adopted without objection.

Under Rule 8 19, the bill was referred to the Engrossing Clerk

HB 1302—A bill to be entitled An act relating to medical malpractice insurance; amending s. 627.351 (4), Florida Statutes, 1982 Supplement, requiring the Florida Medical Malpractice Joint Underwriting Association to make certain levels of coverage available to physicians, osteopaths, hospitals, and ambulatory surgical centers; increasing potential assessments against members, providing immunity from suit to certain persons relating to actions taken in performance of duties; providing for departmental approval of rates; deleting obsolete language; amending s. 768.54 (2) and (3), Florida Statutes, 1982 Supplement; permitting the Florida Patient's Compensation Fund to reject certain risks, changing liability limits of the fund; increasing financial responsibility limits for hospitals not participating in the fund; increasing the fund entry level; providing for reimbursement of board members; providing immunity from liability for certain actions of board members and others; granting certain powers to the fund; requiring approval of fund membership fees and assessments by the Insurance Commissioner, providing that fund members must pay protested assessment prior to filing suit; removing limitations on deficit assessments to fund members; prohibiting execution against the fund due to insufficient assets; providing for stay of execution absent posting of supersedeas bond; providing for a stay of execution against fund members; providing for termination of coverage by the fund under certain conditions and for cessation of coverage by the fund; providing effective dates.

—was read the second time by title.

Representative Lehtinen offered the following amendment.

Amendment 1—On page 25, lines 11-29, strike all of said lines and insert: later than 18 days prior to the beginning of the fiscal year. The fund shall determine, no later than 16 days prior to the beginning of each fiscal year, whether the total of the membership fees to be charged for the fiscal year to health care provider applicants other than hospitals exceeds $5 million and whether the total of the membership fees to be charged to hospital applicants exceeds $12.5 million. If the total of the membership fees to be charged to health care provider applicants other than hospitals does not exceed $5 million, the fund shall return the membership fees collected from such providers and shall, not later than 11 days prior to the beginning of the fiscal year, mail notices to all such providers, advising them that coverage will not be available from the fund. Thereafter, the fund may not issue coverage to any health care provider, including any hospital, for that fiscal year or for any future fiscal year. If the total of the membership fees to be charged to hospital applicants for the fiscal year does not exceed $12.5 million, the fund shall return the membership fees collected from the hospitals and shall, not later than 11 days prior to the beginning of the fiscal year, mail
Mr. Gary Walker  
Professional Staff  
Senate Health and Rehabilitation Services Committee  
State Capitol  
Tallahassee, Florida 32304

Dear Gary:

Enclosed are the materials we discussed. Chart 4 in the "Report to the Governor ..." contains information about HMO capital and reserve requirements in other states. The Model HMO Act draft I have included is more current than the one you have and, with the minutes of the December 14, 1981 Task Force meeting, is completely accurate. I hope these materials help.

Keep me posted on developments.

Sincerely,

Erling Hansen  
General Counsel

EH/va  
Enclosure
ATTACHMENT FIVE-A

Model Health Maintenance Organization Act

[Editor's Note — Attachment Five-A is a retyped copy of the model act which incorporates all editorial and task force changes]

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Section 30. Severability

Section 1 Short Title

This Act may be cited as the Health Maintenance Organization Act of (insert year).

Introductory Comment

The rising cost of health services in recent years has led government agencies, private organizations, and legislative bodies to seek alternatives to the traditional medical delivery system which will provide improved health care at a lower cost. The health maintenance organization is a concept which has received much attention as one means through which an improvement in delivery might be achieved.

Shortcomings of the Existing Health Care Delivery System

The health care delivery system as it is now constituted presents several problems. First, many people are unable to obtain health care when they need it and in the form they need it. This problem can be divided into three subareas: (a) In many areas of the country, the availability of health care in terms of the quantity of manpower and facilities is inadequate, (b) Even where physicians, nurses, clinics, and hospitals do exist, they may lack accessibility due to poor location, poor management, lack of transportation,
procedure to handle complaints should provide the mechanism through which enrollees receive a fair and proper opportunity to have their cases heard, including the use of binding arbitration as a means of resolving claims concerning coverage. For complaints regarding benefits over which the health maintenance organization has no direct control such as those portions of the benefit package which are covered by insurance, the health maintenance organization is responsible only for maintaining statistical information and transmitting the complaints to the persons responsible.

In establishing the format for records and reports pursuant to this Section, the commissioner may want to require disclosure similar to that provided for under the NAIC Model Unfair Trade Practices Act Section 4(10) of that Act requires, among other data, a record of total number of complaints since the last examination, the nature of each complaint, the disposition of the complaint, and the time it took to process each complaint. (See 1972 NAIC Proceedings I 443).

Section 12 Investments.

With the exception of investments made in accordance with Section 5(1)(a) and (b) and Section 5(2), the funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner (director, superintendent) may permit.

Comment  Life and health insurers are subject to statutory investment requirements designed to assure conservatism and liquidity in the handling of the insurer's funds. Sound financial management is an important element in the variable operation of an HMO. Furthermore, it is contrary to the intent of this bill to foster conditions which would enable an HMO to be used as a "front" for a speculative investment operation. At the same time, however, it is recognized that for an HMO to fulfill its expected functions, it may be both desirable and necessary for the HMO to invest a portion of its capital funds in facilities and services to better enable it to meet its obligations. Such investments may not conform to the traditional insurance law investment limitations. Consequently, this section excepts this type of investment when approved by the commissioner in accordance with the standards set out in Section 5(2).

Section 13. Protection Against Insolvency.

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner (director, superintendent) or with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to him in the amount set forth in this section.

(2) The amount for an organization that is beginning operation shall be the greater of: (a) five percent (5%) of its estimated expenditures for health care services for its first year of operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation or (c) $100,000. At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the commissioner (director, superintendent), or organization or trustee, cash, securities, or any combination of these or other measures acceptable to the commissioner (director, superintendent), in an amount equal to four percent (4%) of its estimated annual uncovered expenditures for that year.

(3) Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to the larger of: (a) one percent (1%) of the preceding 12 months uncovered expenditures, or (b) $100,000 on the first day of the first fiscal year beginning six (6) months or more after the effective date of this section. In the second fiscal year, if applicable, the amount of the additional deposit shall be equal to two percent (2%) of its estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit shall be equal to three percent (3%) of its estimated annual uncovered expen-
ditures for that year, and in the fourth fiscal year and subsequent years, if applicable, the additional deposit shall be equal to four percent (4%) of its estimated annual uncovered expenditures for each year. Each year’s estimate, after the first year of operation shall reasonably reflect the prior years’ operating experience and delivery arrangements.

(4) The commissioner (director, superintendent) may waive any of the deposit requirements set forth in subsection (1) and (2) above whenever satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, (hospital or medical service corporations), governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

(5) When an organization has achieved a net worth not including land, buildings, and equipment of at least $1 million or has achieved a net worth including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement shall not apply.

The annual deposit requirement shall not apply to an organization if the total amount of the accumulated deposit is equal to 25% of its estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation for admittance of an accident and health insurer in this state, whichever is less.

If the organization has a guaranteeing organization which has been in operation for at least five (5) years and has a net worth not including land, buildings and equipment of at least $1 million or which has been in operation for at least ten (10) years and has a net worth including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement shall not apply, provided, however, that if the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a net worth at least equal to the capital and surplus requirements for an accident and health insurer.

(6) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner (director, superintendent) before being substituted.

(7) In any year in which an annual deposit is not required of an organization, at the organization’s request the commissionet shall reduce the required, previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section.

(8) Each health maintenance organization that obtains a certificate of authority after the effective date of this subsection shall have and maintain a capital account of at least $100,000 in addition to any deposit requirements under this Section. The capital account shall be net of any accrued liabilities and be in the form of cash, securities or any combination of these or other measures acceptable to the commissioner (director, superintendent).

Comment. Even though very serious problems can arise if a health maintenance organization defaults on its contracts, fiscal control of health maintenance organizations in a manner comparable to that applied to insurance companies appears inappropriate in view of the service nature of such organizations. The best protection for the enrollees is a financially sound organization that generates net
income. However, beginning health maintenance organizations are often small businesses with limited financial resources that will sustain operating losses in their early years. Unreasonably high starting capital or reserve requirements may prevent some organization from starting or may unreasonably tie up the capital of those that do. Therefore, this Section provides for a structured but flexible approach to protecting against insolvency. It requires the maintenance of a minimum capital account, a deposit of cash or securities in a minimum amount, and the organization's generation of additional amounts annually as a source of funds to meet its contractual obligations to the enrollees in the event of insolvency. The commissioner may waive all or part of these requirements when satisfied that the organization has sufficient net worth or an adequate history of generating net income to assure its viability. The requirements may also be waived if the health maintenance organization's performance is guaranteed by another financially strong organization.

The section relates the deposit requirements to the amount of the health maintenance organization's uncovered expenditures. This amount will vary depending upon the type of organization and the nature of its arrangements with providers. For example, the physicians of the staff of the organization or a contracting medical group or individual practice association may agree to look only to the organization for payment for services provided to the organization's enrollees and agree not to bill them in the event of insolvency. An organization could have insurance for all or part of its hospitalization expense or another organization could agree to guarantee that the liabilities of the health maintenance organization are met.

In all such cases, it is recommended that the contractual provision require the provider or guarantor to notify the commissioner if the provision or insurance is modified or no longer in effect or if payment on the contract or policy has not been made in a reasonable period of time (Section 3(5) requires prior notification of cancellation of any reinsurance.) This can provide an early warning of possible adverse changes in the health maintenance organization's financial position. In addition, the status of such provisions or policies should be covered in annual interrogatories to the organization.

The requirement in Subsection (8) for a capital account only applies to organizations licensed after the effective date of the subsection. Thus, the capital account requirement would have to be taken into consideration by persons starting a new HMO. If a state wishes to apply the requirement to existing HMOs, it should allow for an appropriate phase-in period.

It is believed that these provisions and the related provisions of Section 4(2)(d), including possible insurance backup arrangements, provide adequate assurances. The failure to provide assurances as required would subject the health maintenance organization to suspension or revocation of its certificate of authority under Section 18.


(1) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:

(a) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment with a health maintenance organization.

* A Provision to accomplish this might read

ABC Medical Group and its physicians will look solely to XYZ HMO for compensation for medical services and other services incident thereto rendered by ABC Medical Group to enrollees of XYZ HMO, and will not assert any claim for compensation (other than collection of supplemental charges on XYZ HMO's behalf) against enrollees of XYZ HMO for medical services in the event of non payment by XYZ HMO. Any modification or deletion of this provision shall be reported within 15 days to the state commissioner of insurance.
MODEL HEALTH MAINTENANCE ORGANIZATION ACT

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Section 29. Severability

Section 1. Short Title. This Act may be cited as the Health Maintenance Organization Act of (insert year).

Introductory Comment.

The rising cost of health services in recent years has led government agencies, private organizations, and legislative bodies to seek alternatives to the traditional medical delivery system which would provide improved health care and would provide that health care at a lower cost. The health maintenance organization is a concept which has received much attention as one means through which an improvement in delivery might be achieved.

Shortcomings of the Existing Health Care Delivery System

The health care delivery system as it is now constituted presents several problems. First, many people are unable to obtain health care when they need it and in the form they need it. This problem can be divided into three subareas: (a) In many areas of the country, the availability of health care in terms of the quantity of manpower and facilities is inadequate, (b) Even where physicians, nurses, clinics, and hospitals do exist, they may lack accessibility due to...
poor location, poor management, lack of transportation, language or racial barriers, inconvenient hours, etc., and (c) Even if health care is available and accessible, it may not be continuous:
that is, a single patient may not be treated as a person with a continuing or a variety of problems but rather as a single isolated health care problem incident. The problems of availability, accessibility, and continuity, at least in part, have been attributed to the lack of responsibility vested in one person, group, or organization to assure the delivery of health care.

A second problem is the escalating cost of health care services. This stems from the limited supply of health care service facilities which is confronted by an expanded and fragmented financing mechanism and the consequent tremendous increase of demand for such services. This is the classic model for inflation. Traditional reimbursement of providers by the federal government, insurance plans, and hospital and medical service corporations, because of the inherent difficulties involved, has been accompanied by uneven efforts toward effective cost review or control. Furthermore, services or facilities are often duplicated or used inefficiently. A basic cause of inflation and inefficiency rests with the improper structuring of incentives. Where no individual, group, or organization is responsible for the use of more economical services and facilities, including those relating to preventive care, greater income is generated for providers by the more frequent use of services and facilities and by the use of the more expensive facilities and services available.

A third problem is the quality of health care delivered. Throughout various parts of the country, the quality of health care can range from the very best to very poor. Generally speaking, there is no locus for quality assessments either as to health care processes or health care results. In the absence of a means to measure quality, it is virtually impossible to effectively design and implement programs to rectify defects.

This brief discussion in no way attempts to provide a comprehensive discussion of the problems of the health care delivery system in the United States nor does it give adequate recognition to the strenuous efforts of many to improve the existing system. However, it does highlight some of the major problems prevailing today. Development of the health maintenance organization (HMO) concept offers one alternative means to help alleviate some of these problems. What then is an HMO?

Nature of the Health Maintenance Organization.

A health maintenance organization may be described as an organization which brings together a comprehensive range of medical services in a single organization to assure a patient of convenient access to health care services. It furnishes needed services for a prepaid fixed fee paid by or on behalf of the enrollees. An HMO can be organized, operated, and financed in a variety of ways. For example, an HMO may be organized by physicians, hospitals, community groups, labor unions, government units, insurance companies, etc. General speaking, an HMO delivery system is predicated on three principles. (1) It is an organized system for the delivery of health care which brings together health care providers. (2) Such arrangement makes available basic health care which the enrolled group might reasonably require, including emphasis on the prevention of illness or disability. (3) The payments will be made on a prepayment basis, whether by the individual enrollees, medicare, medicaid, or through employer-employee arrangements.

How might the HMO concept contribute to alleviating the difficulties posed by the current health care delivery system?

An HMO can directly address itself to the problems of availability, accessibility, and continuity, since it is a health care delivery system. It assumes responsibility for actually furnishing to its enrollees those health care services necessary to meet the obligations it undertakes. Thus the HMO occupies a position through which both the accessibility and continuity of care may be affected.

An HMO, by its very nature, may provide incentive toward lessening costs in delivering health
care. It has a limited membership prepaying fixed sums of money. The providers are obligated to deliver a specified set of health care services. The fixed amount of income provides incentive to control expenses and costs. The HMO provides a mechanism to analyze costs, expenses and utilization of services, and affords a means to implement measures to enhance efficiency.

The problem of the quality of health care is not susceptible to an easy solution. An HMO is in a position to assess the quality of care provided since it is a closed system. It can study the health of its members, review the records of treatment, and in general, provide a monitoring mechanism.

Medical Care Foundations.

A variation of the HMO concept is seen in some medical care foundations. Although individual foundations differ greatly in detail, a foundation for medical care is usually sponsored and organized by a county or state medical society. The membership consists of physicians who apply to and are accepted by the foundation.

Those medical care foundations which can be considered as a variant of the HMO concept, often contract with an insurer or other prepayment plan (e.g., hospital or medical service corporations) to provide coverage meeting certain minimum criteria consistent with the delivery of quality medical care. The insurer collects the premiums, promotes, markets, and underwrites the program. The enrollee may seek physician services from any member of the foundation who then bills either the insurer or the foundation, not the enrollee. Although such billings are on a fee-for-service basis, the amount charged the enrollee is fixed and prepaid without regard to the number or type of services used. The foundation establishes some form of peer review to monitor not only the level of charges but also the type and quality of care rendered. Since the amount of income does not vary with the number or type of services provided, incentives exist to maintain costs at as low a level as possible. However, unlike the HMO concept described above, even though physician services are prepaid from the patients’ viewpoint, from the physicians’ viewpoint, the fee-for-service practice is maintained.

The Need for State Authorizing and Regulatory Legislation.

The Administration and Committees in both houses of Congress have given great amounts of time to analysis of the health maintenance organization alternative in connection with national health insurance and federal assistance bills for HMO’s. Although legislation was not enacted in 1972, consideration of the topic will probably be resumed in the 93rd Congress. With the increasing public interest, both in the private and government sectors, it may be assumed that the health maintenance organization concept will soon enter a period of growth.

At the present time, few states have a statutory framework tailored to the supervision of health maintenance organizations. Chartering, licensing, contract and rate regulation, and other supervision is being carried out under general insurance laws, hospital and medical service corporation statutes, other special statutes, or not at all. However, the HMO is a unique type of organization. Many provisions of existing laws are inapplicable. Others are highly restrictive or prohibitive to the formation and operation of an HMO. Thus, in view of the growing interest in organizing health maintenance organizations and recognizing the current limitations on their organization in many states due to statutory restrictions, it is appropriate to consider a model bill dovetailed to the unique features of HMO’s.

Purpose of a State Model Bill.

On the one hand, such a model bill should clearly authorize the establishment and operation of HMO’s. Restrictive provisions in other laws which are inappropriate to HMO’s need to be rendered inapplicable. Appropriate grants of authority should be given to enable the HMO’s to fulfill the function envisioned for them. At the same time, however, the public has a vital interest in the fiscally sound, efficient, and ethical operation of HMO’s. As is the case with
insurance and hospital and medical service corporations, HMO's are "affected with the public interest." Regulatory safeguards dovetailed to the unique nature of HMO's are essential. Thus, the purpose of this model bill is twofold.

First, it attempts to provide a legal framework enabling the organization and functioning of HMO's of a wide variety including those based upon the medical care foundation concept. The legal environment is designed to permit a high degree of flexibility. No one form of organization or one type of modus operandi is required. But, rather, the HMO concept can be refined and subjected to further experimentation. Second, the model bill attempts to provide a regulatory monitoring system not only to prevent or remedy abuses, but also to assist in the future improvement and development of this alternative form of a health care delivery system.

Of course, it is also possible that the statutes of a given State are presently broad enough to allow operation of at least certain types of HMO's and provide the Commissioners with appropriate authority to regulate them. In those States, a bill such as this may be desirable in order to consolidate and more clearly define the authority for and manner of regulation of an HMO. However, it may be possible to form HMO's under existing laws in some states before passage of this model legislation and it is anticipated that such programs can develop concurrently with any legislative activity.

Because of existing law in a given state, it may be necessary to modify or replace certain language in the model bill prior to legislative consideration to make terminology consistent with existing law. To simplify this adjustment, three frequently used terms known to be subject to variation from state to state are enclosed in parentheses wherever used to facilitate necessary modification. These terms are: (1) Commissioner, whose counterparts in some states are known as Director or Superintendent; (2) Commissioner of Public Health, whose counterparts in other states are known as Director of Public Health or by some other title; and (3) hospital or medical service corporations, whose counterparts in other states may be known as health service corporations, hospital indemnity corporations, etc. Where specific reference to existing state laws is required, the nature of the citation is indicated parenthetically.

Section 2. Definitions.

(1) "Commissioner" (Director, Superintendent) means the Commissioner (Director, Superintendent) of Insurance.

(2) "Basic health care services" means health care services which an enrolled population might reasonably require in order to be maintained in good health, including as a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services.

(3) "Enrollee" means an individual who has been enrolled in a health care plan.

(4) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled.

(5) "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of such arrangement consists of arranging for or the provision of health care services, as distinguished from mere indemnification against the cost of such services, on a prepaid basis through insurance or otherwise.

(6) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.*

* [Editor's Note: Amended in 1974 by adding "physical disability" See 1974 NAIC Proceedings I 413 ]
(7) "Health maintenance organization" means any person which undertakes to provide or arrange for one or more health care plans.

(8) "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, or corporations.

(9) "Provider" means any physician, hospital, or other person which is licensed or otherwise authorized in this State to furnish health care services.

Comment Section 2(5) broadly defines a health care plan, in essence, to be any arrangement which furnishes health care services so long as some part of the arrangement consists of arranging for or the actual provision of such services vis-à-vis merely paying or reimbursing for such services. However, to be a health care plan, some of the services must be paid for by or on behalf of the enrollee (e.g., by an employer) on a fixed sum prepaid basis. That is, the amount of payment for an enrollee for such services is unaffected by the actual amount or type of services which the individual actually receives. In other words, whenever there is an arrangement of which part provides health care services on a prepaid basis, there is a health care plan. This would embrace, for example, the type of HMO’s and medical care foundations described in the introductory comments above. It would exclude the provision of health care services paid for by or on behalf of the enrollee exclusively on a fee-for-service basis (even where a group practice is involved).

In Section 2(5), with respect to the language “the provision of health care services,” the term “arrangement” does not contemplate those traditional arrangements which hospital or medical service corporations make in conjunction with their prepayment service plans pursuant to hospital or medical service corporation laws. If it were otherwise, the traditional hospital and medical service corporation prepayment service plan, by itself, might create a health care plan.

Section 2(7) defines a HMO to be any person which undertakes to provide or arrange for one or more health care plans. The providing or arranging for basic health care services on a prepaid basis can be achieved either (a) by providing the services directly through physicians or other providers actually employed by the HMO and through hospitals or facilities owned or directly operated by the HMO, or (b) by contracting or arranging with physicians, hospitals or other facilities to provide such services.

Subsection (2) defines basic health care services. This definition, combined with the requirement that an HMO provide for basic health care services in Sections 4(2)(c) and 19(1)(c), establishes a minimum package of health care services which an HMO must provide or arrange for. This is intended to assure that the enrollees obtain at least a sufficiently broad range of services to meet a reasonable amount of their health care needs. At the same time, however, the definition should not be so broad as to be financially prohibitive to a substantial number of enrollees.

Since no HMO may function without a certificate of authority (see Section 3(1)) and since an HMO must furnish basic health care services (see Section 4(2)(c)), no health care services may be provided or arranged for on a prepaid basis without the minimum package of basic health care benefits. This serves two purposes (a) it requires the provision of adequate protection and (b) it prevents the avoidance of the applicability of the Act by the mere expediency of failing to meet the minimum package requirements.

In addition, the HMO may furnish additional services, certain limited indemnity benefits and more comprehensive indemnity benefits if provided through an insurer or medical or hospital service corporation. (See Section 5(1)(f)) These additional services and benefits can be put together in any one of a variety of ways. The indemnity or service benefits might cover such situations as out-of-area emergency services, out-of-area benefits for dependents away at college, or services which the affiliated providers lack the capacity to make available. This flexibility in piecing together the package of coverage through direct and indirect services and indemnity benefits enables an HMO type operation to meet health care needs in a wide variety of circumstances.

The definition of an HMO affords wide latitude for different arrangements. This highly flexible approach seems best suited to our diverse and pluralistic society with problems varying from locality to locality. Flexibility will allow continued innovation and experimentation with different organizational structures. It may be easier to recruit health personnel if a number of alternative approaches are available. Consistent with this philosophy is the absence of any requirement of a minimum number of enrollees or of a mandate as to whether or not the HMO should be a profit or non-profit organization. Permitting both profit and non-profit organizations will broaden the financial and managerial resources which can be drawn upon in developing the HMO concept.

Section 3. Establishment of Health Maintenance Organizations.

(1) Notwithstanding any law of this State to the contrary, any person may apply to the Commissioner (Director, Superintendent) for and obtain a certificate of authority to
establish and operate a health maintenance organization in compliance with this Act. No person shall establish or operate a health maintenance organization in this State, without obtaining a certificate of authority under this Act. A foreign corporation may qualify under this Act, subject to its registration to do business in this State as a foreign corporation under (insert citation).

* [Editor Note Amended in 1974 by deleting after the word "state" the phrase "nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization" See 1974 NAIC Proceedings I 413]

(2) Every health maintenance organization as of the effective date of this Act shall submit an application for a certificate of authority under Subsection (3) within (insert number) days of the effective date of this Act. Each such applicant may continue to operate until the Commissioner (Director, Superintendent) acts upon the application. In the event that an application is denied under Section 4, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

(3) Each application for a certificate of authority shall be verified by an officer or authorized representative of the application, shall be in a form prescribed by the Commissioner (Director, Superintendent), and shall set forth or be accompanied by the following:

(a) A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(b) A copy of the by-laws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(c) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(d) A copy of an contract made or to be made between any providers or persons listed in Paragraph (c) and the applicant;

(f) A copy of the form of evidence of coverage to be issued to the enrollees;

(g) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(h) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the Commissioner (Director, Superintendent) directs that additional or more recent financial information is required for the proper administration of this Act;

(i) A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding;

(j) A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the Commissioner (Director, Superintendent) and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;
(k) A statement reasonably describing the geographic area or areas to be served;

(l) A description of the complaint procedures to be utilized as required under Section 12;

(m) A description of the procedures and programs to be implemented to meet the quality of health care requirements in Section 4(1)(b);

(n) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under Section 6(2);

(o) Such other information as the Commissioner (Director, Superintendent) may require to make the determinations required in Section 4.

(4) (a) A health maintenance organization shall, unless otherwise provided for in this Act, file a notice describing any modification of the operation set out in the information required by Subsection (3). Such notice shall be filed with the Commissioner (Director, Superintendent) prior to the modification. If the Commissioner (Director, Superintendent) does not disapprove within (insert number) days of filing, such modification shall be deemed approved.

(b) The Commissioner (Director, Superintendent) may promulgate rules and regulations exempting from the filing requirements of Paragraph (a) those items he deems unnecessary.

Comment. Section 3 requires the licensing of an HMO in order to provide health care services on a prepaid basis. The legal entity, in which the responsibilities imposed by this Act are vested, serves as the focus of regulatory attention to assure that the consuming public is well served.

Subsection (1) is intended to provide a general override to existing state laws which restrict or prevent the formation or operation of health maintenance organizations. Among other restrictions, existing state laws may:

(1) require approval of a health maintenance organization by a medical society;

(2) require that physicians constitute all or a majority of the governing body of a health maintenance organization;

(3) require that all physicians or a percentage of physicians in the local medical society be permitted to participate in rendering the services of the organization;

(4) require that such organization submit to regulation as an insurer of health care services;

(5) require that only unincorporated individuals or associations or partnerships may provide health care services;

(6) prohibit advertising by a professional group for recruitment of enrollees.

In addition to the general override provided in Subsection (1), Section 25 specifically provides that the insurance law, the hospital and medical service corporation law and certain other provisions do not apply to HMO's. Furthermore, Section 6 specifically provides that any persons, whether or not providers of health care services, may serve on the governing body. There is no statutory requirement as to the appropriate composition of the membership of the governing body.

It is assumed that, restrictive provisions of state laws having been overcome, the "person" making application for a certificate of authority, if not an individual, will be created through existing state mechanisms such as the applicable non-profit corporation act, business corporation act, etc., as appropriate. Since state laws generally establish detailed procedures related to business organizations, inclusion of organizational procedures in a model Act of this nature would appear unnecessary. A business having incorporated under the law of a foreign state could qualify under this Act after following appropriate state procedures required of foreign corporations seeking to do business in the state.

No provision for the organization of a health maintenance has been included in the model Act. As is indicated in the health maintenance organization definition, any person—i.e., any natural or any artificial person created under the laws of the particular state—may function as a health maintenance organization, subject to the licensing and regulatory provisions of the model Act.
Section 4. Issuance of Certificate of Authority.

(1) (a) Upon receipt of all application for issuance of a certificate of authority, the Commissioner (Director, Superintendent) shall forthwith transmit copies of such application and accompanying documents to the (Commissioner of Public Health).

(b) The (Commissioner of the Public Health) shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished

(i) Has demonstrated the willingness and potential ability to assure that such health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility and continuity of service;

(ii) Has arrangements, established in accordance with regulations promulgated by the (Commissioner of Public Health) for an on-going quality of health assurance program concerning health care processes and outcomes; and

(iii) Has a procedure, established in accordance with regulations of the (Commissioner of Public Health), to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required, by the (Commissioner of Public Health).

(c) Within (insert number) days of receipt of the application for issuance of a certificate of authority, the (Commissioner of Public Health) shall certify to the Commissioner (Director, Superintendent) whether the proposed health maintenance organization meets the requirements of Paragraph (b). If the (Commissioner of Public Health) certifies that the health maintenance organization does not meet such requirements, he shall specify in what respects it is deficient.

(2) The Commissioner (Director, Superintendent) shall issue or deny a certificate of authority to any person filing an application pursuant to Section 3 within (insert number) days of receipt of the certification from the (Commissioner of Public Health). Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in Section 23 if the Commissioner (Director, Superintendent) is satisfied that the following conditions are met:

(a) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(b) The (Commissioner of Public Health) certifies, in accordance with Subsection (1), that the health maintenance organization's proposed plan of operation meets the requirements of Subsection (1)(b);

(c) The health care plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for co-payments;

(d) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commissioner (Director, Superintendent) may consider:

(i) The financial soundness of the health care plan's arrangements for health care services and the schedule of charges used in connection therewith;
(ii) The adequacy of working capital;

(iii) Any agreement with an insurer, a (hospital or medical service corporation), a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

(iv) Any agreement with providers for the provision of health care services; and

(v) Any surety bond or deposit of cash or securities submitted in accordance with Section 14 as a guarantee that the obligations will be duly performed;

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to Section 6;

(f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to Section 3 or by independent investigation, is contrary to the public interest; and

(g) Any deficiencies certified by the (Commissioner of Public Health) have been corrected.

(3) A certificate of authority shall be denied only after compliance with the requirements of Section 22.

Comment. A health maintenance organization combines several characteristics of an insurance operation (including the need for financial responsibility, the assumption of risk and similarity in marketing activities) with the characteristics of a health care delivery system. Section 4 provides for the authorization and regulation of health maintenance organizations to be carried out through existing state agencies. The creation of a new agency specifically for health maintenance organizations would unnecessarily duplicate existing functions in the state insurance and health departments. It is felt that the expertise of the state insurance department on fiscal and other regulatory matters and the familiarity of the state health department with regard to health matters should both be utilized in the regulation of health maintenance organizations. To minimize administrative problems, the prime responsibility for administration is vested in one agency—the insurance department. However, to the extent possible, the responsibilities of the two agencies are clearly defined with the insurance commissioner obligated to rely on the health department with respect to the latter's sphere of expertise.

Subsection (1)(b) empowers the Commissioner of Public Health to establish and apply standards of quality concerning health care. Among the arguments raised against quality control are: (1) they may limit the number of HMO's which will get started, (2) quality assurance procedures will prove to be expensive and (3) such controls will engender opposition from certain providers. On the other hand, existing methods for quality control are said to be fragmented and inadequate. If the states are to authorize and encourage HMO's by this legislation, they have an obligation to assure that the health care services provided are of reasonable quality. This is particularly true because of the built-in incentive for an HMO to restrict the utilization of services due to the incentives to stay within a fixed budget.

Subsection (1)(b)(i) is intended to require the HMO to define and set standards for the availability and accessibility of health care services which are adequate for the population which it intends to serve under its health care plan. Among other things, consideration might be given to whether there are enough physicians to provide the promised services and whether the services are available at convenient locations and hours. Subsection (1)(b)(ii) focuses responsibility upon the HMO to implement quality control as to processes and results to the extent that such concepts are developed into workable form. Such a program would require an assessment or monitoring of the processes used and the results achieved. For example, peer group and utilization review might be required. It is recognized that monitoring techniques concerning quality of health care are in their early stage of development. Nevertheless, this Subsection is drafted to authorize the use of more sophisticated monitoring techniques as they are developed and perfected. An HMO being a system with a defined population and providers is in the best position to identify problems and implement remedies. It is anticipated that in meeting these requirements, the HMO will have a person or a committee to serve as the focus of responsibility to assure quality care. Subsection (1)(b)(iii) requires the disclosure of information which, among other things, will provide comparative data among HMO's. This provides an incentive against negatively deviating from the norm. It also affords enrollees information to assist them in participating in the operation of the HMO as required in Section 6.
Subsection (2)(c) makes explicit the requirement that an HMO must provide a minimum package of services on a prepaid basis. Reasonable co-payments, however, are permitted and do not violate the requirement for prepayment. Such co-payments may be used to (a) reduce the amount of prepayments and (b) minimize frivolous utilization of services.

Under Subsection (2)(d), to grant a certificate of authority, the Commissioner should be satisfied that the health maintenance organization will have the financial resources to provide the health care services for which it is obligated to its enrollees. However, it is recognized that requiring an HMO to have a specified minimum capitalization might prevent the organization or implementation of an otherwise viable HMO. Furthermore, with various possible insurance and surety arrangements available to back up the HMO’s promise of performance, reserve requirements such as those found in the insurance laws are not deemed necessary.

Section 5. Powers of Health Maintenance Organizations.

(1) The powers of a health maintenance organization include, but are not limited to the following:

(a) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

(b) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees.

(c) The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;

(d) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(e) The contracting with an insurance company licensed in this State, or with a (hospital or medical service corporation) authorized to do business in this State, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.

(f) The offering, in addition to basic health care services, of:

(i) additional health care services;

(ii) indemnity benefits covering out-of-area or emergency services; and

(iii) indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or (hospital or medical service corporations).

(2) (a) A health maintenance organization shall file notice, with adequate supporting information, with the Commissioner (Director, Superintendent) prior to the exercise of any power granted in Subsections (1)(a) or (b). The Commissioner (Director, Superintendent) shall disapprove such exercise of power if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the Commissioner (Director, Superintendent) does not disapprove within (insert number) days of the filing, it shall be deemed approved.

(b) The Commissioner (Director, Superintendent) may promulgate rules and regulations exempting from the filing requirement of Paragraph (a) those activities having a de minimis effect.
Comment The exercise of authority granted in Subsections (1)(a) and (1)(b) shall be subject to disapproval by the Commissioner within (insert number) days of a filing by a health maintenance organization. The Commissioner may promulgate rules and regulations exempting certain contracts from the filing requirement where exercise of the authority granted in the Section would have little or no effect on the financial condition and ability to meet obligations of the organization.

Where the State has established certification requirements upon the expansion or acquisition of health facilities, such requirements should be made applicable to the operations of health maintenance organizations.


(1) The governing body of any health maintenance organization may include providers, other individuals, or both.

(2) Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

Comment While Section 3(1) should adequately override restrictive laws related to membership of a governing body, Section 6(1) makes explicit the permissible membership of such a group. The model bill does not, however, require that a health maintenance organization be consumer controlled. It is expected that HMO's controlled in a variety of ways will be organized. Where organizations are not consumer controlled, it is believed that some means for enrollee participation should be provided. For example, such matters as availability, accessibility and continuity of health care services are factors which directly confront the consumers and in which they have a particular interest. The disclosure of information under other sections is also designed to assist the consumers.

Arguments against a role for the consumer include: (1) such participation is unnecessary and perhaps even harmful to the efficient and professional delivery of health care services, (2) a consumer role will impede the initiation of an HMO since more people must be involved and (3) consumers can always seek alternative health care. The arguments for a consumer role seem more persuasive. These include: (1) consumer participation results in a more responsive organization, and (2) consumer participation is not the same as lay control over the rendering of professional service.

Section 7. Fiduciary Responsibilities.

Any director, officer or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees.

Section 8. Evidence of Coverage and Charges for Health Care Services.

(1) (a) Every enrollee residing in this State is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a (hospital or medical service corporation), whether by option or otherwise, the insurer or the (hospital or medical service corporation) shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(b) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the Commissioner (Director, Superintendent).

(c) An evidence of coverage shall contain:

No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in Section 15(1); and

(ii) A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:
(A) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(B) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or co-payment feature;

(C) Where and in what manner information is available as to how services may be obtained; and

(D) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or non-contributory with respect to group certificates.

(E) A clear and understandable description of the health maintenance organizations’s method for resolving enrollee complaints.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

(d) A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto, shall be subject to the filing and approval requirements of Paragraph (b) unless it is subject to the jurisdiction of the Commissioner (Director, Superintendent) under the laws governing health insurance or (hospital or medical service corporations) in which event the filing and approval provisions of such laws shall apply. To the extent, however, that such provisions do not apply the requirements in Paragraph (c), the requirements in Paragraph (c) shall be applicable.

(2) (a) No schedule of charges for enrollee coverage for health care services, or amendment thereto, may be used in conjunction with any health care plan until a copy of such schedule, or amendment thereto, has been filed with and approved by the Commissioner (Director, Superintendent).

(b) Such charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. However, the charges shall not be excessive, inadequate, or unfairly discriminatory. A certification, by a qualified actuary, to the appropriateness of the charges, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(3) The Commissioner (Director, Superintendent) shall within a reasonable period, approve any form if the requirements of Subsection (1) are met and any schedule of charges if the requirements of Subsection (2) are met. It shall be unlawful to issue such form or to use such schedule of charges until approved. If the Commissioner (Director, Superintendent) disapproves such filing, he shall notify the filer. In the notice, the Commissioner (Director, Superintendent) shall specify the reasons for his disapproval. A hearing will be granted within (insert number) days after a request in writing by the person filing. If the Commissioner (Director, Superintendent) does not approve any form or schedule of charges within (insert number) days of the filing of such forms or charges, they shall be deemed approved.

(4) The Commissioner (Director, Superintendent) may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this Section.

Comment. Subsection (1)(a) requires that every enrollee be provided with evidence of coverage and
allocates the responsibility for providing that evidence. Paragraph (c) establishes requirements which such evidence of coverage must meet. The group contracts required to be filed pursuant to Section 3(3) (g) are not subject to the standards and filing requirements of Section 8, since such group contracts are not issued to enrollees. Such contracts are subject to the insurance or hospital or medical service corporation laws.) Paragraph (d) clarifies the relationship between filing requirements under this Section and under the state insurance or hospital or medical service corporation law. Filing is required under Paragraph (b) unless the form is already subject to filing requirements under existing state law. However, where existing state law does not apply standards as strict as those contained in Paragraph (c), such standards are, in effect, read into the existing law. Where the filing under state insurance or medical or hospital service corporation law is required to meet standards as strict as those in Paragraph (c), the former would be applicable. A State may want Paragraph (d) to be revised to make specific reference to existing state laws.

Subsection (2)(a) provides for the filing of charges for health care services, i.e., that part of the health care plan which is provided in the form of service vis-a-vis indemnity or service benefits. Those parts of the package providing benefits under agreement with an insurance company or hospital or medical service corporation will be subject to regulation in accordance with existing laws.

Paragraph (b) neither requires nor prohibits community rating. Reasonable underwriting classifications are permitted for the purpose of establishing the charges. Different charges may be imposed on different groups of enrollees. Ability to adjust rates for certain groups with serious adverse experience is a necessary parallel to the mandatory availability requirement under the open enrollment provisions of Section 11. Such a rigid requirement as community rating would appear to be inappropriate during the era of experimentation. Furthermore, the competing financing mechanisms are not subject to such a constraint. The competitive disadvantage which such a requirement might impose could impede the development of HMO's.

Because of its somewhat different nature, an HMO is not required by this Act to meet reserve requirements similar to those imposed on insurance companies. Thus it is important that the charges be set at an adequate level. The requirement for certification by an actuary along with supporting information is intended to assist the Commissioner in determining adequacy. In applying the standard of excessive, inadequate, or unfairly discriminatory, it is contemplated that the Commissioner may consider the amount necessary to assure a reasonable return upon the initial and subsequent capital invested and an amount needed to accumulate adequate reserves to stabilize the level of charges against fluctuation due to inflation, changes in medical technology and related causes.


(1) Every health maintenance organization shall annually, on or before the first day of March, file a report verified by at least two principal officers with the Commissioner (Director, Superintendent), with a copy to the (Commissioner of Public Health) covering the preceding calendar year.

(2) Such report shall be on forms prescribed by the Commissioner (Director, Superintendent) and shall include:

(a) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant;

(b) Any material changes in the information submitted pursuant to Section 3(3);

(c) The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year;

(d) A summary of information compiled pursuant to Section 4(1)(b)(iii) in such form as required by the (Commissioner of Public Health); and

(e) Such other information relating to the performance of the health maintenance organization as is necessary to enable the Commissioner (Director, Superintendent) to carry out his duties under this Act.

Section 10. Information to Enrollees.

Every health maintenance organization shall annually provide to its enrollee:
Section 11. Open Enrollment.

(1) After a health maintenance organization has been in operation 24 months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. A health maintenance organization may apply to the Commissioner (Director, Superintendent) for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The Commissioner (Director, Superintendent) shall approve or deny such application within (insert number) days of the receipt thereof from the health maintenance organization.

(2) Health maintenance organizations providing or arranging for services exclusively on a group contract basis may limit the open enrollment provided for in Subsection (1) to all members of the group or groups covered by such contracts.

Comment. Subsection (1)'s requirement for an open enrollment period is intended to provide the benefits of health maintenance organizations to the general public or to all members of those groups of persons which the organization is designed to serve. Mandatory availability is in accord with the national health insurance regulatory program developed by NAIC. The capacity of the organization is to be determined by the health maintenance organization itself based upon an analysis of its resources and capabilities. A health maintenance organization is not required to have an open enrollment period during the initial 24 months of its operation. This delay provision is intended to facilitate initial operations which might otherwise be hampered by the possibility of adverse selection.

Subsection (2) modifies the principal of "first come, first served" with respect to members of groups. The nucleus if not predominant proportion of an HMO's business consists of groups, often pursuant to an HMO option under group insurance policies or group contracts of medical or hospital service corporations. If HMO's are to achieve widespread viability, all members of the group must be permitted to enroll. Furthermore, if insurers are to be expected to invest their money in the development of HMO's, provision needs to be made that their various groups have priority in enrolling in the HMO. For example, such groups might include employees, members of a labor union, members of an association, or persons whose group coverage has for some reason been terminated. To assist in attracting physicians to participate in an HMO, priority treatment could be afforded to the patients of a physician who desire to come along with their physician into the HMO.

Section 12. Complaint System.

(1) (a) Every health maintenance organization shall establish and maintain a complaint system which has been approved by the Commissioner (Director, Superintendent), after consultation with the (Commissioner of Public Health), to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

(b) Each health maintenance organization shall submit to the Commissioner (Director, Superintendent) and the (Commissioner of Public Health) an annual report in a form prescribed by the Commissioner (Director, Superintendent), after consultation with the (Commissioner of Public Health), which shall include:

(i) A description of the procedures of such complaint system;
(ii) The total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed, and

(iii) The number, amount, and disposition of malpractice claims settled during the year by the health maintenance organization and any of the providers used by it.

(2) The health maintenance organization shall maintain records of written complaints filed with it concerning other than health care services and shall submit to the Commissioner (Director, Superintendent) a summary report at such times and in such format as the Commissioner (Director, Superintendent) may require. Such complaints involving other persons shall be referred to such persons with a copy to the Commissioner (Director, Superintendent).

(3) The Commissioner or the (Commissioner of Public Health) may examine such complaint system.

Comment. Every health maintenance organization is required to establish a complaint system to provide reasonable procedures for the disposition of complaints. The organizations may be expected to receive two types of complaints. One type is related to the basic health care services or additional services furnished by it. The other type is related to that portion of the coverage in addition to the basic health care services which is provided by insurance, hospital or medical service corporations, or some means other than being furnished by the organization. Subsection (1) deals with complaints arising from health care services and requires reporting and the establishment of administrative procedures to properly dispose of complaints. The administrative procedure to handle complaints should provide the mechanism through which enrollees receive a fair and proper opportunity to have their cases heard. Subsection (2) deals with complaints regarding benefits over which the health maintenance organization has no direct control such as those portions of the health care plan which are covered by insurance. With respect to these complaints, the health maintenance organization is responsible only for maintaining statistical information and transmitting the complaints to the persons responsible.

In establishing the format for records and reports pursuant to this Section, the Commissioner may want to require disclosure similar to that provided for under the NAIC Model Unfair Trade Practices Act Section 4(10) of that Act requires, among other data, a record of total number of complaints since the last examination, the nature of each complaint, the disposition of the complaint, and the time it took to process each complaint (See 1972 NAIC Proceedings 1 443).

Section 13. Investments.

With the exception of investments made in accordance with Section 5(1)(a) and (b) and Section 5(2), the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the Commissioner (Director, Superintendent) may permit.

Comment. Life and health insurers are subject to statutory investment requirements designed to assure conservatism and liquidity in the handling of the insurer's funds. Sound financial management is an important element in the variable operation of an HMO. Furthermore, it is contrary to the intent of this bill to foster conditions which would enable an HMO to be used as a "front" for a speculative investment operation. At the same time, however, it is recognized that for an HMO to fulfill its expected functions, it may be both desirable and necessary for the HMO to invest a portion of its capital funds in facilities and services to better enable it to meet its obligations. Such investments may not conform to the traditional insurance law investment limitations. Consequently, this Section excepts this type of investment when approved by the Commissioner in accordance with the standards set out in Section 5(2).

Section 14. Protection Against Insolvency.

Each health maintenance organization shall furnish a surety bond in an amount satisfactory to the Commissioner (Director, Superintendent) or deposit with the Commissioner (Director, Superintendent) cash or securities acceptable to him in at least the same amount as a guarantee that the obligations to the enrollees will be performed. The Commissioner (Director, Superintendent) may waive this requirement whenever satisfied that the assets of the organization or its contracts with insurers, (hospital or medical service corporations), governments, or other organizations are sufficient to reasonably assure the performance of its obligations.
Comment Fiscal control of health maintenance organizations in a manner comparable to that applied
to insurance companies appears inappropriate in view of the service nature of such organizations. How­
ever, very serious problems can arise if a health maintenance organization defaults on its contracts,
whether the reasons are fiscal or not. Some enrollees may be unable to obtain care thereafter if an
HMO defaults, either because of their insurability or for other reasons. This Section provides for the
posting of a surety bond or cash or securities in an amount satisfactory to the Commissioner as a guar­
antee that the obligations to the enrollees will be performed or at least that money will be available to
purchase such services. Alternatively, the Commissioner may waive this requirement when satisfied by
other arrangements. It is believed that these provisions and the related provisions of Section 4(2)(d),
including possible insurance backup arrangements, provide adequate assurances. The failure to provide
assurances as required would subject the health maintenance organization to suspension or revocation
of certificate of authority under Section 19.

Section 15. Prohibited Practices.

(1) No health maintenance organization, or representative thereof, may cause or knowingly
permit the use of advertising which is untrue or misleading, solicitation which is untrue
or misleading, or any form of evidence of coverage which is deceptive. For purposes of
this Act

(a) A statement or item of information shall be deemed to be untrue if it does not
conform to fact in any respect which is or may be significant to an enrollee of, or
person considering enrollment in, a health care plan;

(b) A statement or item of information shall be deemed to be misleading, whether or
not it may be literally untrue, if, in the total context in which such statement is
made or such item of information is communicated, such statement or item of
information may be reasonably understood by a reasonable person, not possessing
special knowledge regarding health care coverage, as indicating any benefit or
advantage or the absence of any exclusion, limitation, or disadvantage of possible
significance to an enrollee of, or person considering enrollment in, a health care
plan. If such benefit or advantage or absence of limitation, exclusion or disadvan­
tage does not in fact exist;

(c) An evidence of coverage shall be deemed to be deceptive if the evidence of cover­
age taken as a whole, and with consideration given to typography and format, as
well as language, shall be such as to cause a reasonable person, not possessing
special knowledge regarding health care plans and evidences of coverage therefor,
to expect benefits, services, charges, or other advantages which the evidence of
coverage does not provide or which the health care plan issuing such evidence of
coverage does not regularly make available for enrollees covered under such evi­
dence of coverage.

(2) Sections (cite State code Sections affecting unfair trade practices) shall be construed to
apply to health maintenance organizations, health care plans and evidences of coverage
except to the extent that the Commissioner (Director, Superintendent) determines that
the nature of health maintenance organizations, health care plans and evidences of cover­
age render such Sections clearly inappropriate.

(3) An enrollee may not be cancelled or non renewed except for the failure to pay the charge
for such coverage, or for such other reasons as may be promulgated by the Commissioner
(Director, Superintendent)

(4) No health maintenance organization, unless licensed as an insurer, may use in its name,
contracts, or literature any of the words “insurance,” “casualty,” “surety,” “mutual,”
or any other words descriptive of the insurance, casualty, or surety business or decepti­
tively similar to the name or description of any insurance or surety corporation doing
business in this State.

Comment Subsection (3) is designed to foster continuance of coverage to the extent possible. However,
depending on the circumstances in a given state, some exceptions may be necessary. Such exceptions
might include termination of a health care plan, termination of employment, termination of the group
plan, enrollee moving out of the area served, enrollee moving out of an eligible class, failure to make
reasonable co-payment, or refusal to accept services.

Section 16. Regulation of Agents.

The Commissioner (Director, Superintendent) may, after notice and hearing, promulgate such
reasonable rules and regulations as are necessary to provide for the licensing of agents. An
agent means a person directly or indirectly associated with a health care plan who engages in
solicitation or enrollment.

Section 17. Powers of Insurers and (Hospital and Medical Service Corporations).

(1) An insurance company licensed in this State, or a (hospital or medical service corpora-
tion) authorized to do business in this State, may either directly or through a subsidiary
or affiliate organize and operate a health maintenance organization under the provisions
of this Act. Notwithstanding any other law which may be inconsistent herewith, any two
or more such insurance companies, (hospital or medical service corporations), or subsidi-
daries or affiliates thereof, may jointly organize and operate a health maintenance organi-
zation. The business of insurance is deemed to include the providing of health care by a
health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any provision of insurance and (hospital or medical service corporation)
laws (citations), an insurer or a (hospital or medical service corporation) may contract
with a health maintenance organization to provide insurance or similar protection against
the cost of care provided through health maintenance organizations and to provide
coverage in the event of the failure of the health maintenance organization to meet its
obligations.

The enrollees of a health maintenance organization constitute a permissible group under
such laws. Among other things, under such contracts, the insurer or (hospital or medical
service corporation) may make benefit payments to health maintenance organizations for
health care services rendered by providers pursuant to the health care plan.

Comment Subsection (2) overrides the group laws to permit an insurer or a hospital or medical service
corporation to provide coverage protecting enrollees of an HMO. This authority is intended to permit
insurers and the service corporations to write coverage (1) to fill the gaps which the providers of health
care services do not provide, (2) to provide coverage in excess of the services provided, (3) to cover
catastrophe situations, (4) to provide protection to the enrollees in the event the HMO becomes insol-
vent, and (5) to provide coverage against the cost of health care services as the health maintenance
organization deems necessary. This Section might also be redrafted to make specific reference to the
relevant Section of existing law.

Section 18. Examination.

(1) The Commissioner (Director, Superintendent) may make an examination of the affairs of
any health maintenance organization and providers with whom such organization has con-
tracts, agreements, or other arrangements pursuant to its health care plan as often as he
deems it necessary for the protection of the interests of the people of this State but not
less frequently than once every three years.

(2) The (Commissioner of Public Health) may make an examination concerning the quality
of health care services of any health maintenance organization and providers with whom
such organization has contracts, agreements, or other arrangements pursuant to its health
care plan as often as he deems it necessary for the protection of the interests of the people of this State but not
less frequently than once every three years.

(3) Every health maintenance organization and provider shall submit its books and records
relating to the health care plan to such examinations and in every way facilitate them.
For the purpose of examinations, the Commissioner (Director, Superintendent) and the
(Commissioner of Public Health) may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

(4) The expenses of examinations under this Section shall be assessed against the organization being examined and remitted to the Commissioner (Director, Superintendent) or the (Commissioner of Public Health) for whom the examination is being conducted.

(5) In lieu of such examination, the Commissioner (Director, Superintendent) or (Commissioner of Public Health) may accept the report of an examination made by the Commissioner (Director, Superintendent) or (Commissioner of Public Health) of another State.

Comment. The Commissioner is provided authority to examine health maintenance organizations as he deems necessary. However, any determination related to the quality of health care services is the exclusive responsibility of the Commissioner of Public Health.

Section 19. Suspension or Revocation of Certificate of Authority.

(1) The Commissioner (Director, Superintendent) may suspend or revoke any certificate of authority issued to a health maintenance organization under this Act if he finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under Section 3, unless amendments to such submissions have been filed with and approved by the Commissioner (Director, Superintendent),

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of Section 8;

(c) The health care plan does not provide or arrange for basic health care services;

(d) The (Commissioner of Public Health) certifies to the Commissioner (Director, Superintendent) that:
   (i) The health maintenance organization does not meet the requirements of Section 4(1)(b), or
   (ii) The health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its health care plan.

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under Section 6,

(g) The health maintenance organization has failed to implement the complaint system required by Section 12 in a manner to reasonably resolve valid complaints.

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.
(1) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(2) The health maintenance organization has otherwise failed to substantially comply with this Act.

(2) A certificate of authority shall be suspended or revoked only after compliance with the requirements of Section 22.

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(4) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The Commissioner (Director, Superintendent) may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Section 20. Rehabilitation, Liquidation, or Conservation of Health Maintenance Organization.

Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Commissioner (Director, Superintendent) pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The Commissioner (Director, Superintendent) may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in (cite Sections of State rehabilitation law), or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this State.

Comment. Section 20 provides for the rehabilitation, liquidation, or conservation of health maintenance organizations to be carried out by the Commissioner under state laws applicable to insurance companies. Inasmuch as all states have existing authority, it is felt that the use of such statutes would be appropriate and would avoid the necessity of developing new administrative procedures applicable only to health maintenance organizations. Incidentally, the NAJC has recommended the adoption of a model liquidation and rehabilitation act (See 1968 NAIC Proceedings I 214)

Section 21. Regulations.

The Commissioner (Director, Superintendent) may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out the provisions of this Act. Such rules and regulations shall be subject to review in accordance with (insert section number providing for review of administrative orders).

Section 22. Administrative Procedures.

(1) When the Commissioner (Director, Superintendent) has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization and the (Commissioner of Public Health) in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least (insert number) days thereafter for a hearing on the matter.

(2) The (Commissioner of Public Health), or his designated representative, shall be in atten-
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(2) The (Commissioner of Public Health), or his designated representative, shall be in atten-
dance at the hearing and shall participate in the proceedings. The recommendation and findings of the (Commissioner of Public Health) with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority, shall be conclusive and binding upon the Commissioner (Director, Superintendent). After such hearing, or upon the failure of the health maintenance organization to appear at such hearing, the Commissioner (Director, Superintendent) shall take action as is deemed advisable on written findings which shall be mailed to the health maintenance organization with a copy thereof to the (Commissioner of Public Health). The action of the Commissioner (Director, Superintendent) and the recommendation and findings of the (Commissioner of Public Health) shall be subject to review by the (name of court of primary jurisdiction for claims of the nature and magnitude described) having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Commissioner (Director, Superintendent) in whole or in part.

(3) The provisions of the (Administrative Procedure Act) of this State shall apply to proceedings under this Section to the extent they are not in conflict with Subsections (1) and (2).

Comment. This Section provides an administrative framework within which action related to the denial, suspension, or revocation of any certificate of authority may be taken. Where a State has a comprehensive Administrative Procedure Act or other legislation providing appropriate procedural requirements, this Section may be omitted.

Section 23. Fees.

(1) Every health maintenance organization subject to this Act shall pay to the Commissioner (Director, Superintendent) the following fees:

(a) For filing an application for a certificate of authority or amendment thereto, (insert amount) dollars;

(b) For filing each annual report, (insert amount) dollars.

(2) Fees charged under this Section shall be distributed as follows: (insert dollar amount) to the Commissioner (Director, Superintendent) and (insert dollar amount) to the (Commissioner of Public Health).

Comment. Proper administration of the HMO program by the Departments of Insurance and Public Health will impose additional financial burdens on the respective Departments. For this reason, it is appropriate to establish a fee system through which HMO's are required to bear the expenses associated with their regulation by the State. While provisions of some State laws require that income generated by fees be placed with general State revenues, the fees should not be looked upon as a general revenue producing device since such action might adversely affect the establishment of HMO's.

As an alternative to requiring fees with the filing of the annual report, a State might provide for a certificate renewal fee. In addition, or in lieu thereof, a State might consider a per capita enrollee tax or a tax on the charges made for health care services. Those parts of the health care plan provided by insurance will already be subject to a state's premium tax.

Inasmuch as the responsibility for the administration of the Act is shared by the Department of Insurance and Public Health, it would appear proper to provide for an equitable division of the fee income in those states where such receipts accrue to the collecting agencies and are not placed in the general revenue.

Section 24. Penalties and Enforcement.

(1) The Commissioner (Director, Superintendent) may, in lieu of suspension or revocation of a certificate of authority under Section 19, levy an administrative penalty in an amount not less than (insert amount) dollars nor more than (insert amount) dollars, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance
organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The Commissioner (Director, Superintendent) may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

(2) Any person who violates this Act shall be guilty of a misdemeanor and may be punished by a fine not to exceed (insert amount) dollars or by imprisonment for a period not exceeding (insert time period) or both.

(3) (a) If the Commissioner (Director, Superintendent) or the (Commissioner of Public Health) shall for any reason have cause to believe that any violation of this Act has occurred or is threatened, the Commissioner (Director, Superintendent) or (Commissioner of Public Health) may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(b) Proceedings under this Subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the Commissioner (Director, Superintendent) or the (Commissioner of Public Health) may deem appropriate under the circumstances.

(4) (a) The Commissioner (Director, Superintendent) may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this Act.

(b) Within (insert number) days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Act have occurred. Such hearings shall be conducted pursuant to (cite Sections of State Administrative Procedure Act), and judicial review shall be available as provided by (cite Sections of State Administrative Procedure Act).

(5) In the case of any violation of the provisions of this Act, if the Commissioner (Director, Superintendent) elects not to issue a cease and desist order, or in the event of non-compliance with a cease and desist order issued pursuant to Subsection (4), the Commissioner (Director, Superintendent) may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the (name of court of primary jurisdiction for actions of this nature).

Comment Sections 24(4) and 24(5) authorize the Commissioner to issue a cease and desist order and to apply for injunctive relief. Where the Commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the Attorney General or other appropriate State official.

Section 25. Statutory Construction and Relationship to Other Laws.

(1) Except as otherwise provided in this Act, Provisions of the insurance law and provisions of (hospital or medical service corporation) laws shall not be applicable to any health maintenance organization granted a certificate of authority under this Act. This provision shall not apply to an insurer or (hospital or medical service corporation) licensed and regulated pursuant to the insurance laws or the (hospital or medical service corporation) laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this Act.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of
authority, or its representatives, shall not be construed to violate of any provision of law relating to solicitation or advertising by health professionals.

(3) Any health maintenance organization authorized under this Act shall not be deemed to be practicing medicine and shall be exempt from the provision of (citation) relating to the practice of medicine.

Section 26. Filings and Reports as Public Documents.

All applications, filings and reports required under this Act shall be treated as public documents.

Section 27. Confidentiality of Medical Information.

Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

Section 28. (Commissioner of Public Health's) Authority to Contract.

The (Commissioner of Public Health), in carrying out his obligations under Sections 4(1)(b), 18(2), and 19(1), may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the (Commissioner of Public Health).

Comment. This Section authorizes the Department of Public Health to draw upon outside expertise where appropriate. One alternative would be to contract with Professional Standards Review Organizations established pursuant to Public Law 92-604.

Section 29. Severability.

If any Section, term, or provision of this Act shall be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other Section, term, or provision of this Act, but the remaining Section, terms, and provisions shall be and remain in full force and effect.

Legislative History (all references are to the Proceedings of the NAIC).

1973 Proc II 202-222
1974 Proc I 413

PCB 83-35 temporarily passed.

PCB 83-34 presented by Hala Ayoub.

Amendment #1 offered by Rep. Deratany -- adopted.

Amendment #2 offered by Rep. Deratany -- adopted.

Vince Rio speaks to Amendment #1, PCB 83-34.

Vote taken on PCB 83-34 -- bill passes w/2 amendments.

PCB 83-37 presented by Hala Ayoub.

Amendment #1 offered by Rep. Abrams -- adopted.

The following persons spoke to PCB 83-37:

Jerry Conger, HCCB;
Steve Wilkerson, Pres., Florida League of Hospitals.
Mr. Wilkerson spoke regarding case-mix data handling.

Rep. Abrams questions Mr. Wilkerson.

Rep. Deratany left meeting.

John M. McBryde, Florida Hospital Association, spoke re. PCB 83-37.

Rep. Martinez questions Mr. McBryde.

Rep. Deratany returns to meeting.

Vote taken on PCB 83-37 -- bill passes with 1 amendment.

Rep. Ogden speaks to bill.


Rep. Ogden speaks regarding evidence of proof of handicapped child.

Vote taken on PCB 83-35 -- bill passes.

PCB 83-39 presented by Bill Quattlebaum.


Rep. Ogden speaks to bill.

Earl G. Treadway, Florida Hospital Association, speaks to PCB 83-39.

Rep. Deratany questions Mr. Treadway.

Rep. Abrams questions Mr. Treadway.

Rep. Martinez offers Amendment #2. Bill Quattlebaum explains Amendment -- bed certification.

Rep. Ogden offers Amendment #3 as a substitute for Amendment #2. Amendment #2 was not considered; Amendment #3 was adopted.

Rep. Martinez offers Amendment #4 -- failed.

SUBCOMMITTEE REPORT

File with Parent Committee

To Chairman, Committee on Commerce

Subcommittee on Health Care and Life & Health Insurance

Date of meeting April 12, 1983

Time 1:00 - 4:00 PM

Place 21 HOB

Final Action: ___ FAVORABLE

___ FAVORABLE WITH 2 AMENDMENTS

___ UNFAVORABLE

VOTE:

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Total Yea 6

Total Nays 0

A = ABSENT

REO. Abrams
REO. Deratany
REO. Martinez
REO. Ogden
REO. Upchurch
REO. Wallace

SUBCOMMITTEE APPEARANCE RECORD

The following persons (other than legislators) appeared before the subcommittee during consideration of this bill:

Name

Representing

Address

(If additional persons, enter on reverse side and check here)

NOTE: Please indicate by an "X" any State employee appearing at the request of Subcommittee Chairman

Received by Parent Committee:

Date

Received by
2:01 PM Meeting began.

2:05 PM PCB 83-22 taken up. Vote taken -- bill passed 17-0.

PCB 83-34 taken up. Vote taken -- bill passed 19-0.

2:08 PM PCB 83-35 taken up. Vote taken -- bill passed 19-0.

PCB 83-37 taken up. Vote taken -- bill passed 19-2.

PCB 83-39 taken up. Vote taken -- bill passed 19-0 w/1 amendment.


2:30 PM Rep. James Harold Thompson leaves the meeting.


Vote taken -- bill passed 16-1 w/3 amendments.

2:47 PM TAPE 1 - SIDE B BEGAN

3:28 PM TAPE 2 - SIDE A BEGAN

Vote taken on HB 531 -- bill fails -- tie vote -- 10-10.

Motion was made for previous question; passed by voice vote.

Rep. Kutun moved that bill be taken up for immediate disposition.

Vote taken -- motion passed 12-4.

Motion was made by Rep. M. E. Hawkins to reconsider and leave pending.


Vote taken on HB 332 -- bill passed w/2 amendments -- 12-2.


4:00 PM Rep. Lehtinen moves to RISE.

3:52 PM HB 56 taken up. Vote taken -- passed favorably (20-0) as a committee substitute.

3:58 PM HB 531 taken up. Amend. #1 offered -- adopted without objection. Amend. #2 offered -- adopted without objection. Amend. #3 offered -- adopted. Amend. #4 offered -- adopted without objection. Amend. #5 offered -- adopted without objection.
Committee Information Record

Date of meeting April 19, 1983
Time 2:00 p.m.
Place 21 HOB

Final Action: x FAVORABLE

Vote:

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Total Yea 19
Total Nays 0

Committee Appearance Record

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<thead>
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(If additional persons, enter on reverse side and check here)