Session Law 88-388

Florida Senate & House of Representatives

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House Health Care
Bill file, 1988. PCB HC 88-04
Meeting file (Sun Health Rep) 3-2-88
3-9-88
4-5-88
4-13-88
(full)

House F+T
Meeting 5-17-88
HA 15:16
20 666
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Undated 1, 5-3-11, and
Note: 4/13
# LEGISLATIVE SUPPLEMENT "B" - SESSION LAW ABSTRACT

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<th>Session Law Cite</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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Florida House of Representatives
Jon Mills, Speaker
Committee on Health Care

Mike Abrams
Chairman
Lois Frankel
Vice Chairman

HEALTH CARE COMMITTEE
Subcommittee on Health Regulation
March 2, 1988
10:00 - 12:00 Noon
317 The Capitol

AGENDA

I. CONSIDERATION OF PCB HC 88-03--CERTIFICATE OF NEED REGULATION OF CARDIAC CATHETERIZATION SERVICES

II. DISCUSSION AND TESTIMONY ON PCB HC 88-04--HEALTH MAINTENANCE ORGANIZATIONS: GUARANTY AND REGULATION OF HEALTH CARE SERVICES

The Honorable Bill Gunter
State Treasurer, Insurance Commissioner and State Fire Marshal

III. PRESENTATION BY THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES ON NURSING HOME QUALITY OF CARE AND LONG TERM CARE PROGRAM ORGANIZATIONAL CHANGES TAPED SIDE A
Florida House of Representatives
Jon Mills, Speaker
Committee on Health Care

Mike Abrams
Chairman

Lois Frankel
Vice Chairman

HEALTH CARE COMMITTEE
Subcommittee on Health Regulation

March 9, 1988
8:00 - 10:00 a.m.
413 The Capitol

AGENDA

I. CONSIDERATION OF PCB HC 88-03--CERTIFICATE OF NEED REGULATION OF CARDIAC CATHETERIZATION SERVICES "Tr"d

II. DISCUSSION AND TESTIMONY ON PCB HC 88-04--HEALTH MAINTENANCE ORGANIZATIONS: GUARANTY AND REGULATION OF HEALTH CARE SERVICES Tape 1 Side A
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<tr>
<th>Name</th>
<th>TED NICHOLS</th>
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<tbody>
<tr>
<td>Address</td>
<td>9400 S. DAVELAND BLVD</td>
</tr>
<tr>
<td>City</td>
<td>MIAMI</td>
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<td>State</td>
<td>FL 33156</td>
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<tr>
<td>Representing</td>
<td>FLA Assoc of Health Maintenance</td>
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<tr>
<td>Lobbyist (registered)</td>
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<tr>
<td>State employee</td>
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<td>HMO Guaranty Fund and Amendment</td>
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<td>HCS 88-04</td>
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<td>Name</td>
<td>Terry Butler</td>
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<td>Address</td>
<td>Room 413 Harson</td>
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<td>City</td>
<td>Tallahassee</td>
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<tr>
<td>Representing</td>
<td>Dept of Insurance</td>
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<td>State employee</td>
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<td>Proponent</td>
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<td>Subject</td>
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H-16(1982)
NOTICE OF COMMITTEE MEETING
House of Representatives

Health Care

Health Regulation

April 5 3:30 P.M.-5:30 P.M. 16 HOB

Consideration of:

**TAPE I SIDE A** PCB HC 88-03--Certificate of Need regulation of cardiac catheterization services
FAV. w/1 amendment 3-1

**TAPE I SIDE A** PCB HC 88-04--Health maintenance organizations: regulation and guaranty of health care services
FAV. w/1 amendment 3-0

**TAPE I SIDE A** PCB HC 88-12--Hospital emergency care
Not considered

**TAPE I SIDE A** HB 0299 by Mackenzie & others--Smoking/Public Places
FAV. w/10 amendment 4-0

Received in the Office of the Sergeant at Arms on

\[\text{April 1, 1988}\]

at \[\text{1:25} \] (time).

\[\text{Sergeant at Arms}\]

Filed by me with the Sergeant at Arms and the Clerk on

\[\text{April 1, 1988}\]

in compliance with Rule 6.

\[\text{Sergeant at Arms}\]

\[\text{Mike Alromay}\]
Chairman

\[\text{Cindy Allison}\]
Committee Secretary

Distribution: Sergeant; Clerk (Calendar); Leg. Info.; others as required by Rule 6.
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<thead>
<tr>
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<tbody>
<tr>
<td>Name</td>
<td>Mark Neimeier</td>
</tr>
<tr>
<td>Address</td>
<td>345 S. Magnolia Dr., Ste F21</td>
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<tr>
<td>City</td>
<td>Tallahassee</td>
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<tr>
<td>State</td>
<td>FL 32301</td>
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<td>I wish to speak</td>
<td>Yes</td>
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<td>Subject</td>
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COMMITTEE APPEARANCE RECORD

APRIL 5, 1988

(Name)

JERRY BUTLER

(Address)

City

State

Representing

DEPT OF INSURANCE

Lobbyist (registered) Yes No

State employee Yes No

I wish to speak

Proponent

Opponent

Information

Request of Chairman

Subject

H-16(1982)
Consideration of:

1. PCB HC 88-08--Affordable Health Care Assurance Act (Indigent Care/HCCB) TAPE I SIDE A
   Discussion only

2. PCB HC 88-04--Health maintenance organizations: regulation and guaranty of health care services TAPE I SIDE A
   FAV. w/1 amendment 17/0

3. PCB HC 88-07--Human Immunodeficiency Virus infection and Acquired Immunodeficiency Syndrome TAPE I SIDE B
   FAV. w/1 amendment 17/0

4. PCB HC 88-13--Health care; Medical Education and Tertiary Care Trust Fund TAPE I SIDE B
   FAV. 17/0

5. PCB HC 88-09--Rural hospitals not taken up

6. PCB HC 88-06--Shortage in the supply of registered nurses not taken up

7. PCB HC 88-01--Maternal and infant health not taken up

8. PCB HC 88-03--Certificate of Need regulation of cardiac catheterization services not taken up
9. HB 299 by Mackenzie & others--Smoking/Public Places
   not taken up

10. HB 406 by Tobin & others--Life-prolonging Procedure/Redefined
    not taken up

11. HB 498 by Smith & others--Patient Records/Copying Fees
    not taken up

12. PCS/HB 598 by Gonzalez-Quevedo--Long-term Health Care/Master Report
    not taken up

13. PCB HC 88-10--State Group Insurance Program
    not taken up
PRELIMINARY COMMITTEE REPORT
House of Representatives

Insurance

Full Committee

May 3 8:00 A.M. 317 C

HB 0464 By Gustafson & others--Insurance Premium Tax (Not considered)

HB 1576 By Health Care & others--Health Maintenance Organizations (Not considered)

HB 1033 By Hodges & others--Bail Bondsmen/Fingerprint Report (C/S, 13/0)

HB 1510 By Wise & others--Comprehensive Health Assn. Act (C/S, 13/0)

HB 1122 By Young & others--Motor Vehicle Insurers/Limitation (C/S, 13/0)

HB 1160 By Sanderson & others--Medical Malpractice Insurance (Favorable, 13/0)

HB 1328 By Patchett & others--Motor Veh. Rental/Collision Damage (C/S, 14/0)

HB 0953 By Lawson & others--Motor Vehicle Insurance (C/S, 14/0)

HB 1012 By C.F. Jones & others--Motor Vehicle Ins./Cancellation (Favorable, 14/0)
PRELIMINARY COMMITTEE REPORT
House of Representatives

Insurance

Full Committee

May 5 1:15 P.M. 317 C

HB 0464 By Gustafson & others--Insurance Premium Tax (C/S, 13/0)

HB 1576 By Health Care & others--Health Maintenance Organizations
(Favorable, 12/0)

HB 0221 By Rudd & others--Blind Vending Facility Operators
(Favorable, 11/0)

HB 0718 By Meffert & others--Funerals/Preneed Contracts (C/S, 11/0)

PCS/HB 718 - Funerals/Preneed Contracts
(C/S, 11/0)

SB 0595 By Barron & others--Sheriffs/Liability Insurance (Favorable, 11/0)

HB 0461 By Abrams & others--Adoption/Insurance Coverage (C/S, 10/1)

HB 0421 By Bloom & others--Health Insurance/Mammogram Coverage (Not considered)

HB 0579 By Bloom & others--Health Ins./Infertility Coverage (Not considered)

HB 1042 By Gordon & others--Health Insurance/Maternity Care (Not considered)

HB 1124 By Metcalf & others--Health Insurance/Mental Illness (Not considered)

HB 0226 By Sansom & others--Health Insurance/Alcohol & Drugs (Not considered)

HB 0570 By Souto & others--Health Insurance/Drugs & Alcohol (Not considered)

HB 1004 By Press & others--Employee Health Care (Not considered)
STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

1. SUMMARY:

A. Present Situation:

Under current law, there is no provision for a guaranty fund for health maintenance organizations (HMOs). Florida law does require HMOs licensed through the Department of Insurance to meet certain surplus ($100,000 or 5% of total liabilities) and insolvency ($100,000 or twice its reasonably estimated average monthly uncovered expenditures) standards.

Medicaid prepaid plans are exempt from this requirement until they become certified by the Department of Insurance to accept commercial subscribers. According to federal regulations, Medicaid prepaid plans have 3 years to meet the 75/25 enrollment composition rule. This requires them to have sufficient commercial (non-Medicaid) subscribers to comprise 25 percent of total membership. Before Medicaid HMOs can enroll commercial members they must meet Department of Insurance HMO requirements.
More than one HMO in Florida has become insolvent this year. In the quarter ending 6/30/87, 69% of the Florida HMOs reported a pre-tax loss to the Department of Insurance. Twelve of the HMOs reported a negative net worth.

B. Effect of Proposed Changes:

The proposed bill would create a guaranty fund which is intended to protect subscribers from claim liabilities arising out of an HMO's insolvency or revocation of its certificate of authority.

The fund would be funded by assessments from each HMO, beginning with a $25,000 assessment due on or before October 1, 1988. Annual assessments equal to 1% of commercial premiums plus 1% of Medicare and Medicaid premiums will be made on an annual calendar year basis. Annual assessments will continue until the fund balance equals \( \frac{1}{3} \) of the analyzed premium volume. The current insolvency requirements will be eliminated. Surplus requirements will increase to at least $500,000 or 10% of total liabilities. In addition, certificates of authority will not be issued unless the HMO has a minimum surplus of the greater of:

a) $1,500,000; or
b) 10% of total projected liabilities; or
c) $500,000 plus all start-up losses.

The change in the law relies on guaranty fund as a first defense against insolvency. The guaranty fund and surplus requirements create a financial burden for smaller HMOs, including those holding Medicaid prepaid plan contracts, which threatens their own solvency. This may lead to the termination of existing Medicaid contracts and will discourage other health care providers from negotiating Medicaid contracts.

2. ECONOMIC IMPACT AND FISCAL NOTE

It is anticipated that passage of the bill may lead to the cancellation of Medicaid prepaid plan contracts. As contracts are negotiated at 5% of projected fee for service expenditures, increases in Medicaid expenditures can be expected (see attached).

3. COMMENTS

The proposed bill should be amended to eliminate assessments of the Medicaid premium for the guaranty fund. Public (Medicaid) funds should not be transferred from one state agency to another for the purpose of protecting private commercial subscribers. In the event of an HMO's insolvency, Medicaid recipients will return to the regular fee-for-service program.
The surplus requirements should not be increased to the levels specified in the bill. These requirements discriminate against smaller HMOs and imply only large HMOs are entitled to exist.

It is recommended that the state develop other adequate requirements for initial capital, on-going surplus, insolvency insurance or guarantees, and mandatory hold-harmless clauses to prevent insolvencies and protect subscribers.

4. DISTRICT CONTACTS: N/A
5. LEGAL REVIEW: N/A
6. AMENDMENTS: N/A
I. Total Cost (Sum #II & III)
   Positions (FTE's)
   General Revenue Funds
   Other Funds
   Total Funds

II. Service/Program Costs
   General Revenue Funds
   Other Funds
   Total Funds

Description of cost basis (Caseload data, cost per service unit, projected services units, etc.) : (Detailed tables may be attached)
Medicaid contracts are negotiated at 95% of anticipated fee for service expenditures. Cancellation of Medicaid contracts will result in an increase of program expenditures of five percent.

III. Administrative Costs.
   A. Salaries & Benefits:
      Position Type* No. FTE's
      Clerical (pg 1-11) $______ $______ $______
      Professional (12-15) $______ $______ $______
      Supervisory (16-21) $______ $______ $______
      Other $______ $______ $______
      Total $______ $______ $______
   B. Other Personal Services (OPS):
      Temporary Employment Costs* $______ $______ $______
      Contractual Services Costs* $______ $______ $______
      Total OPS $______ $______ $______

*Needed only if a significant difference from Year 2
631.819 Assessments. --

(b) Class B assessments which shall be for the purpose of carrying out the powers and duties of the Guaranty Fund as they relate to Medicare subscribers of the member HMOs.

This language replaces 631.819 (1)(b), as proposed.
641.225 Surplus requirements.

(1) Each health maintenance organization shall at all times have and maintain a minimum surplus in an amount which is the greater of $100,000 $500,000 or 10 5 per cent of total liabilities.

This language replaces 641.255(1) and (2)(a), (b) and (c), as proposed.
I. SUMMARY:

A. PRESENT SITUATION:

Health maintenance organizations (HMOs), regulated by Parts II and IV of Chapter 641, are health care plans in which members, their employers or the federal Medicare program, pay a pre-determined fee in advance for specified medical services. In Florida, 43 HMOs serve more than 1.1 million subscribers.

In 1987, five HMOs failed and were placed in receivership by the Department of Insurance. The Department of Insurance reports that on the average, HMO medical costs are running at approximately 90 percent of premium revenues and administrative expenses at approximately 20 percent.

Florida HMO losses for 1987 were $115 million. This total reflects a first quarter loss of $12 million; a second quarter loss of 17 million; a third quarter loss of $32 million; and a fourth quarter loss of $54 million.

In the aftermath of the five insolvent HMOs, the Department of Insurance received thousands of telephone calls from subscribers complaining of the unavailability of health care coverage and of collection action as well as legal suits taken against them by uncompensated providers. So far, from the five HMOs in receivership, 70,467 claims totalling $156,699,314.33 have been filed. This data refers to actual dollar amounts filed -- no claims have been evaluated to date.

Currently the Department of Insurance regulates the financial aspects of health maintenance organizations. Part II of Chapter 641 sets forth a variety of consumer protection requirements including several surplus and solvency provisions.
Section 641.225, F.S., requires all HMOs to maintain a minimum surplus equal to the greater of $100,000 or 5 percent of total liabilities. The department must lower the surplus requirements to not less than $100,000 for any HMO that meets certain conditions. Also, an exemption from the surplus requirements is provided to an HMO that has its subscriber claims guaranteed by a guaranteeing organization which has a surplus of the greater of $2 million or 2 times the minimum surplus of the HMO.

Under section 641.285, F.S., all HMOs are required to deposit the greater of (1) twice its reasonably estimated average monthly uncovered expenditures, or (2) $100,000. ("Uncovered expenditures" means the cost of health care services that are covered by an HMO, for which a subscriber would also be liable in the event of the insolvency of the organization.) Department waiver of the deposit is authorized for financially viable HMOs; for HMOs with guaranteeing organizations meeting certain conditions; and for HMOs with approved plans for continuation of benefits in the event of insolvency.

B. EFFECT OF PROPOSED CHANGES:

This proposed committee bill creates a guaranty fund association for health maintenance organizations and strengthens the authority of the Department of Insurance to regulate health maintenance organizations.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates Part IV of chapter 631 entitled "Health Maintenance Organizations Guaranty of Health Care Services."

631.811 and 631.812 Short title and purpose. These sections provide a title and purpose. The purpose of the part is to protect subscribers against the failure of the HMO to perform its obligations due to an HMO's impairment, insolvency or revocation of its certificate of authority.

631.813 Application of part. This section provides a cross reference to HMOs regulated under part II of chapter 641. It also states that this part does not apply to Medicaid HMOs.

631.814 Definitions. This section provides definitions.

631.815 Florida Health Maintenance Organization Guaranty Association. This section creates the Florida HMO Guaranty Association. It requires all HMOs to be members. It establishes a board of directors for the Association which will be under the immediate supervision of the Department of Insurance.

631.816 Board of directors. This section specifies a board of directors of five to nine persons, appointed by the Insurance Commissioner based on recommendations from the member HMOs.
631.817 Eligibility. This section specifies that anyone who loses their HMO coverage as a result of insolvency, impairment or revocation of the HMO is eligible for coverage by the Association. Coverage terminates upon the receipt of maximum benefits of $300,000, failure to pay the premium, or obtaining coverage from another HMO, insurer, or a self-insurer.

631.818 Powers and duties of the Association. This section provides powers and duties of the Association. If an HMO is impaired, the Association may guarantee, reinsure or pay the HMO's liabilities or obligations or it may loan money to the HMO. If an HMO is insolvent or its certificate of authority has been revoked the Association shall: guarantee, reinsure or assume the HMO policies; pay all HMO obligations to make providers and all indirect obligations necessary to make arrangements for the provision of health care to the HMO subscribers; or provide for the continuance of services to the HMO subscribers. If the Association does not act in a timely fashion regarding the preceding duties, the Department of Insurance is authorized to assume such powers and duties.

This section also confers standing on the Association. It requires the Association to pay all costs of rehabilitation and liquidation incurred by the department. The Association may exercise the powers of an insurer or an HMO for the purposes of meeting the obligations of the Association and the insolvent HMO.

Finally, the Association is authorized, in issuing replacement coverage, to provide different coverage than that contained in the contract of the insolvent HMO.

631.819 Assessments. This section provides for the funding of the Guaranty Association. The Guaranty Association will be funded by assessments collected prior to any insolvency: Two funds are created. One fund is based on assessments for non-Medicare premiums, the other on assessments for Medicare generated premiums. Assessments for the Medicare fund will be paid by the Health Care Financing Administration. If the Health Care Financing Administration decides not to pay the assessment, then Medicare subscribers will not be covered by the Guaranty Association.

The first assessment will be $25,000 per HMO payable by October 1, 1988. After October 1, 1988, all HMOs seeking a certificate of authority will pay $25,000 prior to issuance. The next assessment will be for the period July 1, 1988 to December 31, 1988. Although this section creates two classes of assessments for Medicare and non-Medicare premiums the actual assessment is the same for both -- 1% of premium for the first six month period. Subsequently, assessments will be on an annual calendar year basis. The maximum assessment for any one year will be 1% of premium. On January 1st of each year, the department will estimate the premium volume for the upcoming year and inform the Association of the volume. On January 31st of each year, the Association will determine the assessment rate for that year and notify the HMOs of the rate. On January 31st of the following
year the Association will bill each HMO for the prior year's assessment. The payment of the assessment will then be due on July 1st. Annual assessments will continue until the Association has a fund balance equal to 5% of the analyzed premium volume. At that time assessments will cease until such time as the fund balance declines to 4% of non-Medicare premium. HMOs may include in their premium rates a factor to take into account assessments.

631.820 Plan of operation. This section requires the board of directors to establish a plan of operation and submit it to the department for approval. The plan is binding on all member HMOs. The plan may delegate any of the Association's powers, with the exception of its assessment powers, to an administrator.

631.821 Powers and duties of the department. This section provides to the department the power to suspend or revoke the certificate of authority of an HMO for failure to pay an assessment. The department is also authorized to require the Association to notify subscribers of an HMO insolvency. Finally the department may revoke the appointment of the Guaranty Association's servicing company for improper handling of claims.

631.822 Records of the Association. Requires record keeping of the Association and release upon the termination of a liquidation, rehabilitation or revocation proceeding.

631.823 Examination of the Association; annual report. This section requires the board to file an annual financial statement with the department.

631.824 Tax exemption. Specifies that the Association is exempt from all state fees and taxes except for real property tax.

631.825 Immunity. This section provides immunity to any member HMO, the Association or the department for any action taken by them in the performance of their powers and duties under this part.

631.826 Extent of liability of Association. Specifies the Association as a priority creditor of any impaired, insolvent or revoked HMO. Assets of the HMO shall be used to continue coverage and pay other obligations of the HMO. If the HMO is rehabilitated, the expenses of rehabilitation must be paid back to the Association by the HMO with 12% interest.

631.827 Health care coverage. This section provides for the Association to issue HMO policies, insurance contracts, enter into contracts with insurers or HMOs to provide coverage and enter into contracts with providers to service its HMO policies. The Association may continue the contract of the HMO or issue a different policy which complies with the Florida Insurance Code. The section provides that any subscriber recovery health care services under this part shall be deemed to have assigned his rights under the covered policy to the Association.
This section also provides that no pre-existing condition clause, other than the same clause contained in the original HMO policy, may be contained in the Association's policy or another policy.

Finally the Association is empowered to offer Medicare supplement policies.

631.828 Prohibited advertisement. This section prohibits advertising the existence of the Guaranty Association for the purpose of subscriber solicitations.

631.829 Income tax credit for assessments paid. Provides that assessments against HMOs may be offset against their corporate income tax.

631.830 Rates. This section requires that all HMO contracts issued by the Association must comply with all HMO laws and all insurance policies issued by the Association must comply with health insurance forms and rates laws.

Section 2. Definitions

This section amends the definition section of part II of chapter 641. It merges the definition of minimum services into the definition of health maintenance organizations. It adds a subparagraph to the definition of health maintenance organization to specify an HMO as providing services in a managed care system in which a primary care physician coordinates health care.

The definitions of insolvency and surplus are amended to take into account the statutory assets of an HMO. Definitions are added for the terms "statutory accounting principles," "subscriber" and "capitation."

Section 3. Application for certificate

Any entity which seeks to operate an HMO must apply for a certificate of authority. This section amends several application requirements and adds several more. It requires the furnishing of names of all owners of in excess of 5 percent of the common stock of the HMO corporation. It also requires a description by an independent certified actuary of rating methodology and certification that rates are adequate. Finally, this section requires an independent comprehensive feasibility study performed by an independent certified actuary in conjunction with a certified public accountant.

Section 4. Issuance of certificate of authority

This provision strengthens the department's ability to refuse to grant or continue authority to transact the business of an HMO when the ownership, control and management includes persons of questionable business practices.
Section 5. Surplus requirement

This section increases the present surplus requirement of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. It also provides an entry level surplus of the greater of 1,500,000 or 10 percent of total liabilities or $500,000 plus all start-up losses. This section authorizes the department to set uniform standards and criteria for detecting and evaluating the impaired financial condition of any HMO.

Currently in lieu of having any minimum surplus, the HMO may provide a written guarantee made by a guaranty organization to assure payment of covered subscriber claims. This section amends the written guarantee to cover all other liabilities of the HMO and requires the guarantee to be irrevocable unless the department approves its cancellation.

Section 6. Repeal of the Rehabilitation Administrative Expense Fund

This section repeals the Rehabilitation Administrative Expense Fund which requires all HMOs to deposit with the department $10,000 in cash. Currently the fund is used by the department for payment of administrative expenses during any court-ordered rehabilitation of an HMO. Section 7 of the bill transfers all assets of the Fund to the new guaranty association.

Section 7. Florida Health Maintenance Organization Guaranty Association

This section specifies certain requirements for the Guaranty Association created by Section 1 of this bill. It transfers all assets of the Rehabilitation and Administration Fund to the Association. It also provides for departmental powers regarding assessments.

Section 8. Revocation or cancellation of certificates; suspension of enrolling new subscribers

This section strengthens the department's power to act against noncompliant, impaired or insolvent HMOs. It requires compliance within 30 days instead of 60. It also provides authority to the department to take various action when the HMO's financial condition is such that its continued operation would be hazardous to enrollees, creditors or the general public. The department is authorized to order the HMO to reduce its liabilities, its volume of new businesses, its expense or it may suspend the HMO's authority to write new business or require an increase in the HMO's net worth.
Section 9. **Administrative, provider and management contracts**

This section creates new authority for the department to review and disapprove any HMO contract with other entities for administrative, management and other sources if the contract is detrimental to the subscribers, stockholders or creditors of the HMO.

Section 10. **Contract providers**

This section creates a new requirement for HMOs to file financial statements for all contract providers, except individual physicians, who have assumed through capitation or other means, more than ten percent of the health care risk of the HMO.

Section 11. **Administrative penalty in lieu of suspension or revocation**

This section increases the maximum administrative fine from $10,000 to $100,000.

Section 12. **Annual report**

This section requires unaudited financial statements to be filed quarterly. It requires HMOs to hire a certified public accountant who agrees to prepare financial statements in accordance with statutory accounting principles and make his working papers available to the department.

Section 13. **Examination by the department**

This section allows the department, in lieu of making it own financial examination, to accept an independent certified public accountant's audit report prepared on a statutory accounting basis.

Section 14. **Repeal of insolvency protection**

This section repeals s. 641.285 relating to insolvency protection.

Section 15. **Repeal of limitation on levy upon deposit**

This section repeals s. 681.286 which limits the levy upon deposit.

Section 16. **Fees**

This section increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the Department of Insurance estimates current processing costs of
$2,843 which includes examiner, administrative, and ancillary reviews and clerical support.

Section 17. Health maintenance contracts

This section requires the department to disapprove rates which are inadequate, excessive, or unfairly discriminatory or if the rating methodology is inconsistent or ambiguous. This section also requires that pre-existing condition provisions be clearly disclosed and that HMO contracts provide coverage of adopted children from the moment of birth if a written agreement to adopt has been entered prior to birth.

Section 18. Statewide Subscriber Assistance Program

This section amends the current statewide subscriber assistance program to allow the review panel to consider individual grievances as well as types of grievance.

Section 19. Extension of benefits

This section requires the extension of benefits for totally disabled subscribers.

Section 20. Provider contracts

This section requires 60 days written notice by a provider to the department and HMO before cancelling a contract.

Section 21. Assets, liabilities, and investments

Currently in determining the financial condition of an HMO there are certain allowable assets. This section requires the HMO to revalue or replace unqualified assets within 30 days of notice from the department rather than 90. It also includes agreements not to compete and advances to entities as assets not allowed. It deletes the requirement that an HMO deposit with the department be made in coin or currency. It requires the department to approve investment in service companies and of exchange of facilities or assets with service companies. Finally, this section deletes provisions allowing ineligible assets to be counted as eligible while the HMO is attempting to dispose of the property.

Section 22. Dividends

This section restricts the payment of dividends to not more than 10% of surplus and strengthens the department's ability to regulate matters relating to dividends.
Section 23. Penalties

This section increases the penalty for violation of a cease and desist order from $50,000 to $200,000.

Section 24. Conversion on termination of eligibility

This section disallows the right of a subscriber to convert upon termination if the subscriber has left the geographic area with the intent to relocate elsewhere.

Section 25. Effective date

This act takes effect October 1, 1988.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

Although this proposed committee bill, by creating a guaranty association, increases the regulation of HMOs, the costs of the regulation are borne by the association and not the Department.

Section 16 of the proposed committee bill increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the Department estimates current processing costs of $2,843 which includes examiner, administrative, and ancillary reviews and clerical support.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

This proposed committee bill will increase costs for HMOs in several ways. First, every HMO will pay $25,000 into the Guaranty Association. Second, every HMO will pay a one percent assessment on its total non-Medicare annual premium. Third, section 5 increases the present surplus requirements of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. The Department has analyzed the actual dollar requirements for each HMO and the amounts range from no additional capital required to $5,190,754 additional capital required. Also, this section increases the existing level surplus to the greater of $1,500,000 or 10 percent of total liabilities. Fourth, for new HMOs, the application fee for a certificate of authority is increased from $240 to $1,000.
For HMOs found in violation of the law, maximum administrative fines are increased from $10,000 to $100,000 and the penalty for violation of a cease and desist order is increased from $50,000 to $200,000. Since HMOs will pass on the cost of the Guaranty Association to subscribers, health care costs would increase for those subscribers.

2. Direct Private Sector Benefits:

This proposed committee bill benefits the private sector by guaranteeing continuity of health care coverage for HMO subscribers and by protecting them from providers suing for unpaid claims. It also benefits providers. From the five HMOs in receivership, 70,467 claims totaling $156,699,314.33 have been filed. As noted, these are unevaluated claims.

D. FISCAL COMMENTS:

None.

III. LONG RANGE CONSEQUENCES:

None.

IV. COMMENTS:

None.

V. AMENDMENTS:

None.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Tom Cooper  Staff Director: Mike Hansen

FINANCE & TAXATION:
Prepared by:

APPROPRIATIONS:
Prepared by:

I. SUMMARY:

A. PRESENT SITUATION:

Health maintenance organizations (HMOs), regulated by Parts II and IV of Chapter 641, are health care plans in which members, their employers or the federal Medicare program, pay a pre-determined fee in advance for specified medical services. In Florida, 43 HMOs serve more than 1.1 million subscribers.

In 1987, five HMOs failed and were placed in receivership by the Department of Insurance. The Department of Insurance reports that on the average, HMO medical costs are running at approximately 90 percent of premium revenues and administrative expenses at approximately 20 percent.

Florida HMO losses for 1987 were $115 million. This total reflects a first quarter loss of $12 million; a second quarter loss of 17 million; a third quarter loss of $32 million; and a fourth quarter loss of $54 million.

In the aftermath of the five insolvent HMOs, the Department of Insurance received thousands of telephone calls from subscribers complaining of the unavailability of health care coverage and of collection action as well as legal suits taken against them by uncompensated providers. So far, from the five HMOs in receivership, 70,467 claims totalling $156,699,314.33 have been filed. This data refers to actual dollar amounts filed -- no claims have been evaluated to date.

Currently the Department of Insurance regulates the financial aspects of health maintenance organizations. Part II of Chapter 641 sets forth a variety of consumer protection requirements including several surplus and solvency provisions.
Section 641.225, F.S., requires all HMOs to maintain a minimum surplus equal to the greater of $100,000 or 5 percent of total liabilities. The department must lower the surplus requirements to not less than $100,000 for any HMO that meets certain conditions. Also, an exemption from the surplus requirements is provided to an HMO that has its subscriber claims guaranteed by a guaranteeing organization which has a surplus of the greater of $2 million or 2 times the minimum surplus of the HMO.

Under section 641.285, F.S., all HMOs are required to deposit the greater of (1) twice its reasonably estimated average monthly uncovered expenditures, or (2) $100,000. ("Uncovered expenditures" means the cost of health care services that are covered by an HMO, for which a subscriber would also be liable in the event of the insolvency of the organization.) Department waiver of the deposit is authorized for financially viable HMOs; for HMOs with guaranteeing organizations meeting certain conditions; and for HMOs with approved plans for continuation of benefits in the event of insolvency.

B. EFFECT OF PROPOSED CHANGES:

This proposed committee bill creates a guaranty fund association for health maintenance organizations and strengthens the authority of the Department of Insurance to regulate health maintenance organizations.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates Part IV of chapter 631 entitled "Health Maintenance Organizations Guaranty of Health Care Services."

631.811 and 631.812 Short title and purpose. These sections provide a title and purpose. The purpose of the part is to protect subscribers against the failure of the HMO to perform its obligations due to an HMO's impairment, insolvency or revocation of its certificate of authority.

631.813 Application of part. This section provides a cross reference to HMOs regulated under part II of chapter 641. It also states that this part does not apply to Medicaid HMOs.

631.814 Definitions. This section provides definitions.

631.815 Florida Health Maintenance Organization Guaranty Association. This section creates the Florida HMO Guaranty Association. It requires all HMOs to be members. It establishes a board of directors for the Association which will be under the immediate supervision of the Department of Insurance.

631.816 Board of directors. This section specifies a board of directors of five to nine persons, appointed by the Insurance Commissioner based on recommendations from the member HMOs.
631.817 Eligibility. This section specifies that anyone who loses their HMO coverage as a result of insolvency, impairment or revocation of the HMO is eligible for coverage by the Association. Coverage terminates upon the receipt of maximum benefits of $300,000, failure to pay the premium, or obtaining coverage from another HMO, insurer, or a self-insurer.

631.818 Powers and duties of the Association. This section provides powers and duties of the Association. If an HMO is impaired, the Association may guarantee, reinsure or pay the HMO's liabilities or obligations or it may loan money to the HMO. If an HMO is insolvent or its certificate of authority has been revoked the Association shall: guarantee, reinsure or assume the HMO policies; pay all HMO obligations to make providers and all indirect obligations necessary to make arrangements for the provision of health care to the HMO subscribers; or provide for the continuance of services to the HMO subscribers. If the Association does not act in a timely fashion regarding the preceding duties, the Department of Insurance is authorized to assume such powers and duties.

This section also confers standing on the Association. It requires the Association to pay all costs of rehabilitation and liquidation incurred by the department. The Association may exercise the powers of an insurer or an HMO for the purposes of meeting the obligations of the Association and the insolvent HMO.

Finally, the Association is authorized, in issuing replacement coverage, to provide different coverage than that contained in the contract of the insolvent HMO.

631.819 Assessments. This section provides for the funding of the Guaranty Association. The Guaranty Association will be funded by assessments collected prior to any insolvency: Two funds are created. One fund is based on assessments for non-Medicare premiums, the other on assessments for Medicare generated premiums. Assessments for the Medicare fund will be paid by the Health Care Financing Administration. If the Health Care Financing Administration decides not to pay the assessment, then Medicare subscribers will not be covered by the Guaranty Association.

The first assessment will be $25,000 per HMO payable by October 1, 1988. After October 1, 1988, all HMOs seeking a certificate of authority will pay $25,000 prior to issuance. The next assessment will be for the period July 1, 1988 to December 31, 1988. Although this section creates two classes of assessments for Medicare and non-Medicare premiums the actual assessment is the same for both -- 1% of premium for the first six month period. Subsequently, assessments will be on an annual calendar year basis. The maximum assessment for any one year will be 1% of premium. On January 1st of each year, the department will estimate the premium volume for the upcoming year and inform the Association of the volume. On January 31st of each year, the Association will determine the assessment rate for that year and notify the HMOs of the rate. On January 31st of the following
year the Association will bill each HMO for the prior year's assessment. The payment of the assessment will then be due on July 1st. Annual assessments will continue until the Association has a fund balance equal to 5% of the analyzed premium volume. At that time assessments will cease until such time as the fund balance declines to 4% of non-Medicare premium. HMOs may include in their premium rates a factor to take into account assessments.

631.820 Plan of operation. This section requires the board of directors to establish a plan of operation and submit it to the department for approval. The plan is binding on all member HMOs. The plan may delegate any of the Association's powers, with the exception of its assessment powers, to an administrator.

631.821 Powers and duties of the department. This section provides to the department the power to suspend or revoke the certificate of authority of an HMO for failure to pay an assessment. The department is also authorized to require the Association to notify subscribers of an HMO insolvency. Finally the department may revoke the appointment of the Guaranty Association's servicing company for improper handling of claims.

631.822 Records of the Association. Requires record keeping of the Association and release upon the termination of a liquidation, rehabilitation or revocation proceeding.

631.823 Examination of the Association; annual report. This section requires the board to file an annual financial statement with the department.

631.824 Tax exemption. Specifies that the Association is exempt from all state fees and taxes except for real property tax.

631.825 Immunity. This section provides immunity to any member HMO, the Association or the department for any action taken by them in the performance of their powers and duties under this part.

631.826 Extent of liability of Association. Specifies the Association as a priority creditor of any impaired, insolvent or revoked HMO. Assets of the HMO shall be used to continue coverage and pay other obligations of the HMO. If the HMO is rehabilitated, the expenses of rehabilitation must be paid back to the Association by the HMO with 12% interest.

631.827 Health care coverage. This section provides for the Association to issue HMO policies, insurance contracts, enter into contracts with insurers or HMOs to provide coverage and enter into contracts with providers to service its HMO policies. The Association may continue the contract of the HMO or issue a different policy which complies with the Florida Insurance Code. The section provides that any subscriber recovery health care services under this part shall be deemed to have assigned his rights under the covered policy to the Association.
This section also provides that no pre-existing condition clause, other than the same clause contained in the original HMO policy, may be contained in the Association's policy or another policy.

Finally the Association is empowered to offer Medicare supplement policies.

631.828  Prohibited advertisement. This section prohibits advertising the existence of the Guaranty Association for the purpose of subscriber solicitations.

631.829  Income tax credit for assessments paid. Provides that assessments against HMOs may be offset against their corporate income tax.

631.830  Rates. This section requires that all HMO contracts issued by the Association must comply with all HMO laws and all insurance policies issued by the Association must comply with health insurance forms and rates laws.

Section 2.  Definitions

This section amends the definition section of part II of chapter 641. It merges the definition of minimum services into the definition of health maintenance organizations. It adds a subparagraph to the definition of health maintenance organization to specify an HMO as a provider of services in a managed care system in which a primary care physician coordinates health care. The HMO must designate a primary care physician licensed as a medical doctor or osteopathic physician and a chiropractic physician and podiatrist who in turn will coordinate the health care for subscribers requesting services be provided licensed under chapters 458, 459, 460, and 461.

The definitions of insolvency and surplus are amended to take into account the statutory assets of an HMO. Definitions are added for the terms "statutory accounting principles," "subscriber" and "capitation."

Section 3.  Application for certificate

Any entity which seeks to operate an HMO must apply for a certificate of authority. This section amends several application requirements and adds several more. It requires the furnishing of names of all owners of in excess of 5 percent of the common stock of the HMO corporation. It also requires a description by an independent certified actuary of rating methodology and certification that rates are adequate. Finally, this section requires an independent comprehensive feasibility study performed by an independent certified actuary in conjunction with a certified public accountant.
Section 4. Issuance of certificate of authority

This provision strengthens the department's ability to refuse to grant or continue authority to transact the business of an HMO when the ownership, control and management includes persons of questionable business practices.

Section 5. Surplus requirement

This section increases the present surplus requirement of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. It also provides an entry level surplus of the greater of 1,500,000 or 10 percent of total liabilities or $500,000 plus all start-up losses. This section authorizes the department to set uniform standards and criteria for detecting and evaluating the impaired financial condition of any HMO.

Currently in lieu of having any minimum surplus, the HMO may provide a written guarantee made by a guaranty organization to assure payment of covered subscriber claims. This section amends the written guarantee to cover all other liabilities of the HMO and requires the guarantee to be irrevocable unless the department approves its cancellation.

Section 6. Repeal of the Rehabilitation Administrative Expense Fund

This section repeals the Rehabilitation Administrative Expense Fund which requires all HMOs to deposit with the department $10,000 in cash. Currently the fund is used by the department for payment of administrative expenses during any court-ordered rehabilitation of an HMO. Section 7 of the bill transfers all assets of the Fund to the new guaranty association.

Section 7. Florida Health Maintenance Organization Guaranty Association

This section specifies certain requirements for the Guaranty Association created by Section 1 of this bill. It transfers all assets of the Rehabilitation and Administration Fund to the Association. It also provides for departmental powers regarding assessments.

Section 8. Revocation or cancellation of certificates; suspension of enrolling new subscribers

This section strengthens the department's power to act against noncompliant, impaired or insolvent HMOs. It requires compliance within 30 days instead of 60. It also provides authority to the department to take various action when the HMO's financial
condition is such that its continued operation would be hazardous to enrollees, creditors or the general public. The department is authorized to order the HMO to reduce its liabilities, its volume of new businesses, its expense or it may suspend the HMO's authority to write new business or require an increase in the HMO's net worth.

Section 9. Administrative, provider and management contracts

This section creates new authority for the department to review and disapprove any HMO contract with other entities for administrative, management and other sources if the contract is detrimental to the subscribers, stockholders or creditors of the HMO.

Section 10. Contract providers

This section creates a new requirement for HMOs to file financial statements for all contract providers, except individual physicians, who have assumed through capitation or other means, more than ten percent of the health care risk of the HMO.

Section 11. Administrative penalty in lieu of suspension or revocation

This section increases the maximum administrative fine from $10,000 to $100,000.

Section 12. Annual report

This section requires unaudited financial statements to be filed quarterly. It requires HMOs to hire a certified public accountant who agrees to prepare financial statements in accordance with statutory accounting principles and make his working papers available to the department.

Section 13. Examination by the department

This section allows the department, in lieu of making it own financial examination, to accept an independent certified public accountant's audit report prepared on a statutory accounting basis.

Section 14. Repeal of insolvency protection

This section repeals s. 641.285 relating to insolvency protection.
Section 15. Repeal of limitation on levy upon deposit

This section repeals s. 681.286 which limits the levy upon deposit.

Section 16. Fees

This section increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the Department of Insurance estimates current processing costs of $2,843 which includes examiner, administrative, and ancillary reviews and clerical support.

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This section requires the department to disapprove rates which are inadequate, excessive, or unfairly discriminatory or if the rating methodology is inconsistent or ambiguous. This section also requires that pre-existing condition provisions be clearly disclosed and that HMO contracts provide coverage of adopted children from the moment of birth if a written agreement to adopt has been entered prior to birth.

Section 18. Statewide Subscriber Assistance Program

This section amends the current statewide subscriber assistance program to allow the review panel to consider individual grievances as well as types of grievance.

Section 19. Extension of benefits

This section requires the extension of benefits for totally disabled subscribers.

Section 20. Provider contracts

This section requires 60 days written notice by a provider to the department and HMO before cancelling a contract.

Section 21. Assets, liabilities, and investments

Currently in determining the financial condition of an HMO there are certain allowable assets. This section requires the HMO to revalue or replace unqualified assets within 30 days of notice from the department rather than 90. It also includes agreements not to compete and advances to entities as assets not allowed. It deletes the requirement that an HMO deposit with the department be made in coin or currency. It requires the department to approve investment in service companies and of exchange of facilities or assets with service companies.
Finally, this section deletes provisions allowing ineligible assets to be counted as eligible while the HMO is attempting to dispose of the property.

Section 22. Dividends

This section restricts the payment of dividends to not more than 10% of surplus and strengthens the department's ability to regulate matters relating to dividends.

Section 23. Penalties

This section increases the penalty for violation of a cease and desist order from $50,000 to $200,000.

Section 24. Conversion on termination of eligibility

This section disallows the right of a subscriber to convert upon termination if the subscriber has left the geographic area with the intent to relocate elsewhere.

Section 25. Effective date

This act takes effect October 1, 1988.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

Although this proposed committee bill, by creating a guaranty association, increases the regulation of HMOs, the costs of the regulation are borne by the association and not the Department.

Section 16 of the proposed committee bill increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the Department estimates current processing costs of $2,843 which includes examiner, administrative, and ancillary reviews and clerical support.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

This proposed committee bill will increase costs for HMOs in several ways. First, every HMO will pay $25,000 into the Guaranty Association. Second, every HMO will pay a one percent assessment on its total non-Medicare annual premium.
Third, section 5 increases the present surplus requirements of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. The Department has analyzed the actual dollar requirements for each HMO and the amounts range from no additional capital required to $5,190,754 additional capital required. Also, this section increases the existing level surplus to the greater of $1,500,000 or 10 percent of total liabilities. Fourth, for new HMOs, the application fee for a certificate of authority is increased from $240 to $1,000.

For HMOs found in violation of the law, maximum administrative fines are increased from $10,000 to $100,000 and the penalty for violation of a cease and desist order is increased from $50,000 to $200,000. Since HMOs will pass on the cost of the Guaranty Association to subscribers, health care costs would increase for those subscribers.

2. **Direct Private Sector Benefits:**

This proposed committee bill benefits the private sector by guaranteeing continuity of health care coverage for HMO subscribers and by protecting them from providers suing for unpaid claims. It also benefits providers. From the five HMOs in receivership, 70,467 claims totaling $156,699,314.33 have been filed. As noted, these are unevaluated claims.

D. **FISCAL COMMENTS:**

None.

III. **LONG RANGE CONSEQUENCES:**

None.

IV. **COMMENTS:**

None.

V. **AMENDMENTS:**

None.

VI. **SIGNATURES:**

**SUBSTANTIVE COMMITTEE:**
Prepared by: Tom Cooper  
Staff Director: Mike Hansen

[Signature]

[Signature]
I. SUMMARY:

Creates a guaranty fund for health maintenance organizations (HMOs) and strengthens the authority of the Department of Insurance to regulate HMOs.

A. PRESENT SITUATION:

Health maintenance organizations (HMOs), regulated by Parts II and IV of Chapter 641, are health care plans in which members, their employers or the federal Medicare program, pay a pre-determined fee in advance for specified medical services. In Florida, 43 HMOs serve more than 1.1 million subscribers.

In 1987, five HMOs failed and were placed in receivership by the Department of Insurance. The department reports that on the average, HMO medical costs are running at approximately 90 percent of premium revenues and administrative expenses at approximately 20 percent.

Florida HMO losses for 1987 were $115 million. This total reflects a first quarter loss of $12 million; a second quarter loss of 17 million; a third quarter loss of $32 million; and a fourth quarter loss of $54 million.

In the aftermath of the five insolvent HMOs, the department received thousands of telephone calls from subscribers complaining of the unavailability of health care coverage and of collection action as well as legal suits taken against them by uncompensated providers. So far, from the five HMOs in receivership, 70,467 claims totalling $156,699,314.33 have been filed. This data refers to actual dollar amounts filed -- no claims have been evaluated to date.
Currently the department regulates the financial aspects of health maintenance organizations. Part II of Chapter 641 sets forth a variety of consumer protection requirements including several surplus and solvency provisions.

Section 641.225, F.S., requires all HMOs to maintain a minimum surplus equal to the greater of $100,000 or 5 percent of total liabilities. The department must lower the surplus requirements to not less than $100,000 for any HMO that meets certain conditions. Also, an exemption from the surplus requirements is provided to an HMO that has its subscriber claims guaranteed by a guaranteeing organization which has a surplus of the greater of $2 million or 2 times the minimum surplus of the HMO.

Under section 641.285, F.S., all HMOs are required to deposit the greater of (1) twice its reasonably estimated average monthly uncovered expenditures, or (2) $100,000. ("Uncovered expenditures" means the cost of health care services that are covered by an HMO, for which a subscriber would also be liable in the event of the insolvency of the organization.) Department waiver of the deposit is authorized for financially viable HMOs; for HMOs with guaranteeing organizations meeting certain conditions; and for HMOs with approved plans for continuation of benefits in the event of insolvency.

B. EFFECT OF PROPOSED CHANGES:

This bill creates a guaranty fund association for HMOs, increases mandatory surplus requirements, and strengthens the authority of the department to regulate HMOs.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates Part IV of chapter 631 entitled "Health Maintenance Organizations Guaranty of Health Care Services."

631.811 and 631.812 Short title and purpose. These sections provide a title and purpose. The purpose of the part is to protect subscribers against the failure of the HMO to perform its obligations due to an HMO's impairment, insolvency or revocation of its certificate of authority.

631.813 Application of part. This section provides a cross reference to HMOs regulated under part II of chapter 641. It also states that this part does not apply to Medicaid HMOs.

631.814 Definitions. This section provides definitions.

631.815 Florida Health Maintenance Organization Guaranty Association. This section creates the Florida HMO Guaranty Association. It requires all HMOs to be members. It establishes a board of directors for the Association which will be under the immediate supervision of the Department of Insurance.
631.816 Board of directors. This section specifies a board of directors of five to nine persons, appointed by the Insurance Commissioner based on recommendations from the member HMOs.

631.817 Eligibility. This section specifies that anyone who loses HMO coverage as a result of insolvency, impairment or revocation of the HMO is eligible for coverage by the Association. Coverage terminates upon the receipt of maximum benefits of $300,000, failure to pay the premium, or obtaining coverage from another HMO, insurer, or a self-insurer.

631.818 Powers and duties of the Association. This section provides powers and duties of the Association. If an HMO is impaired, the Association may guarantee, reinsure or pay the HMO's liabilities or obligations or it may loan money to the HMO. If an HMO is insolvent or its certificate of authority has been revoked the Association shall: guarantee, reinsure or assume the HMO policies; pay all HMO obligations to make providers and all indirect obligations necessary to make arrangements for the provision of health care to the HMO subscribers; or provide for the continuance of services to the HMO subscribers. If the Association does not act in a timely fashion regarding the preceding duties, the Department of Insurance is authorized to assume such powers and duties.

This section also confers standing on the Association. It requires the Association to pay all costs of rehabilitation and liquidation incurred by the department. The Association may exercise the powers of an insurer or an HMO for the purposes of meeting the obligations of the Association and the insolvent HMO.

Finally, the Association is authorized, in issuing replacement coverage, to provide different coverage than that contained in the contract of the insolvent HMO.

631.819 Assessments. This section provides for the funding of the Guaranty Association. The Guaranty Association will be funded by assessments collected prior to any insolvency: Two funds are created. One fund is based on assessments for non-Medicare premiums, the other on assessments for Medicare generated premiums. The Health Care Financing Administration must decide by January 1, 1989, if it wishes to participate in the association. If so, assessments for the Medicare fund will be paid by the Health Care Financing Administration. If the Health Care Financing Administration decides not to pay the assessment, then Medicare subscribers will not be covered by the Guaranty Association.

The first assessment will be $25,000 per HMO payable by October 1, 1988. After October 1, 1988, all HMOs seeking a certificate of authority will pay $25,000 prior to issuance. The next assessment will be for the period July 1, 1988 to December 31, 1988. Although this section creates two classes of assessments for Medicare and non-Medicare premiums the actual assessment is the same for both -- 1% of premium for the first six month period. Subsequently, assessments will be on an annual calendar.
year basis. The maximum assessment for any one year will be 1% of premium. On January 1st of each year, the department will estimate the premium volume for the upcoming year and inform the Association of the volume. On January 31st of each year, the Association will determine the assessment rate for that year and notify the HMOs of the rate. On January 31st of the following year the Association will bill each HMO for the prior year's assessment. The payment of the assessment will then be due on July 1st. Annual assessments will continue until the Association has a fund balance equal to 5% of the analyzed premium volume. At that time assessments will cease until such time as the fund balance declines to 5% of non-Medicare premium. HMOs may include in their premium rates a factor to take into account assessments.

631.820 Plan of operation. This section requires the board of directors to establish a plan of operation and submit it to the department for approval. The plan is binding on all member HMOs. The plan may delegate any of the Association's powers, with the exception of its assessment powers and powers to sue, be sued, and lend money, to an administrator.

631.821 Powers and duties of the department. This section provides to the department the power to suspend or revoke the certificate of authority of an HMO for failure to pay an assessment. The department is also authorized to require the Association to notify subscribers of an HMO insolvency. Finally the department may revoke the appointment of the Guaranty Association's servicing company for improper handling of claims.

631.822 Records of the Association. Requires record keeping of the Association and release upon the termination of a liquidation, rehabilitation or revocation proceeding.

631.823 Examination of the Association; annual report. This section requires the board to file an annual financial statement with the department.

631.824 Tax exemption. Specifies that the Association is exempt from all state fees and taxes except for real property tax.

631.825 Immunity. This section provides immunity to any member HMO, the Association, or the department for any action taken by them in the performance of their powers and duties under this part.

631.826 Extent of liability of Association. Specifies the Association as a priority creditor of any impaired, insolvent or revoked HMO. Assets of the HMO shall be used to continue coverage and pay other obligations of the HMO. Unlike insurers under FIGA or FLAHEGA, if the HMO is rehabilitated, the expenses of rehabilitation must be paid back to the Association by the HMO with 12% interest.

631.827 Health care coverage. This section provides for the Association to issue HMO policies, insurance contracts, enter into contracts with insurers or HMOs to provide coverage and
enter into contracts with providers to service its HMO policies. The Association may continue the contract of the HMO or issue a different policy which complies with the Florida Insurance Code. The section provides that any subscriber recovery health care services under this part shall be deemed to have assigned his rights under the covered policy to the Association.

This section also provides that no pre-existing condition clause, other than the same clause contained in the original HMO policy, may be contained in the Association's policy or another policy.

Finally the Association is empowered to offer Medicare supplement policies if assessments are made against medicare HMO premiums.

631.828 Prohibited advertisement. This section prohibits advertising the existence of the Guaranty Association for the purpose of subscriber solicitations.

631.829 Income tax credit for assessments paid. Provides that assessments against HMOs may be offset against their corporate income tax.

631.830 Rates. This section requires that all HMO contracts issued by the Association must comply with all HMO laws and all insurance policies issued by the Association must comply with individual and group health insurance forms and rating laws.

Section 2. Definitions

This section amends the definition section of part II of chapter 641. It merges the definition of minimum services into the definition of health maintenance organizations. It adds a subparagraph to the definition of health maintenance organization to specify an HMO as a provider of services in a managed care system in which a primary care physician coordinates health care. The HMO must designate a primary care physician licensed as a medical doctor or osteopathic physician and a chiropractic physician and podiatrist who in turn will coordinate the health care for subscribers requesting services be provided licensed under chapters 458, 459, 460, and 461.

The definitions of insolvency and surplus are amended to take into account the statutory assets of an HMO. Definitions are added for the terms "statutory accounting principles," "subscriber" and "capitation."

Section 3. Application for certificate

Any entity which seeks to operate an HMO must apply for a certificate of authority. This section amends several application requirements and adds several more. It requires the furnishing of names of all owners of in excess of 5 percent of the common stock of the HMO corporation. It also requires a description by an independent certified actuary of rating
methodology and certification that rates are adequate. Finally, this section requires an independent comprehensive feasibility study performed by an independent certified actuary in conjunction with a certified public accountant.

Section 4. Issuance of certificate of authority

This provision strengthens the department's ability to refuse to grant or continue authority to transact the business of an HMO when the ownership, control and management includes persons of questionable business practices.

Section 5. Surplus requirement

This section increases the present surplus requirement of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. It also provides an entry level surplus of the greater of $1,500,000 or 10 percent of total liabilities or $500,000 plus all start-up losses. This section authorizes the department to set uniform financial standards and criteria for detecting and evaluating the impaired financial condition of any HMO.

Currently in lieu of having any minimum surplus, the HMO may provide a written guarantee made by a guaranty organization to assure payment of covered subscriber claims. This section amends the written guarantee to cover all other liabilities of the HMO and requires the guarantee to be irrevocable unless the department approves its cancellation.

Section 6. Repeal of the Rehabilitation Administrative Expense Fund

This section repeals the Rehabilitation Administrative Expense Fund which requires all HMOs to deposit with the department $10,000 in cash. Currently the fund is used by the department for payment of administrative expenses during any court-ordered rehabilitation of an HMO. Section 7 of the bill transfers all assets of the Fund to the new guaranty association.

Section 7. Florida Health Maintenance Organization Guaranty Association

This section specifies certain requirements for the Guaranty Association created by Section 1 of this bill. It transfers all assets of the Rehabilitation and Administration Fund to the Association. No more refunds of these deposits may be allowed to HMOs which cease to operate and to have a certificate of authority. It also provides for departmental powers regarding assessments.
Section 8. **Revocation or cancellation of certificates; suspension of enrolling new subscribers**

This section strengthens the department's power to act against noncompliant, impaired or insolvent HMOs. It requires compliance within 30 days instead of 60. It also provides authority to the department to take various action when the HMO's financial condition is such that its continued operation would be hazardous to enrollees, creditors or the general public. The department is authorized to order the HMO to reduce its liabilities, its volume of new businesses, its expense or it may suspend the HMO's authority to write new business or require an increase in the HMO's net worth.

Section 9. **Administrative, provider and management contracts**

This section creates new authority for the department to review and disapprove any HMO contract with other entities for administrative, management and other sources if the contract is detrimental to the subscribers, stockholders or creditors of the HMO.

Section 10. **Contract providers**

This section creates a new requirement for HMOs to file financial statements for all contract providers, except individual physicians, who have assumed through capitation or other means, more than ten percent of the health care risk of the HMO.

Section 11. **Administrative penalty in lieu of suspension or revocation**

This section increases the maximum administrative fine from $10,000 to $100,000.

Section 12. **Annual report**

This section requires unaudited financial statements to be filed quarterly. It requires HMOs to hire a certified public accountant who agrees to prepare financial statements in accordance with statutory accounting principles and make his working papers available to the department.

Section 13. **Examination by the department**

This section allows the department, in lieu of making it own financial examination, to accept an independent certified public accountant's audit report prepared on a statutory accounting basis.
Section 14. Repeal of insolvency protection

This section repeals s. 641.285 relating to insolvency protection. Currently, HMOs must deposit cash or securities with the department as insolvency protection. The department may waive the requirement under certain circumstances.

Section 15. Repeal of limitation on levy upon deposit

This section repeals s. 681.286 which limits the levy upon the insolvency deposit.

Section 16. Fees

This section increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the Department of Insurance estimates current processing costs of $2,843 which includes examiner, administrative, and ancillary reviews and clerical support.

Section 17. Health maintenance contracts

This section requires the department to disapprove rates which are inadequate, excessive, or unfairly discriminatory or if the rating methodology is inconsistent or ambiguous. This section also requires that pre-existing condition provisions be clearly disclosed and that HMO contracts provide coverage of adopted children from the moment of birth if a written agreement to adopt has been entered prior to birth.

Section 18. Statewide Subscriber Assistance Program

This section amends the current statewide subscriber assistance program to allow the review panel to consider individual grievances as well as types of grievance.

Section 19. Extension of benefits

This section requires that HMO contracts provide for extension of benefits beyond the contract period for losses commenced while the contract was in force, when the HMO terminates the contract. However, certain limitations are specified, including authorization that the extension of benefits be predicated upon the continuous total disability of the subscriber.

Section 20. Provider contracts

This section requires 60 days written notice by a provider to the department and HMO before cancelling a contract. This applies to existing contracts within 180 days after the effective date of the act and to new contracts after the effective date of the act.


Section 21. Assets, liabilities, and investments

Currently in determining the financial condition of an HMO there are certain allowable assets. This section requires the HMO to revalue or replace unqualified assets within 30 days of notice from the department rather than 90. It also includes agreements not to compete and advances to entities as assets not allowed. It deletes the requirement that an HMO deposit with the department be made in coin or currency. It requires the department to approve investment in service companies and of exchange of facilities or assets with service companies. Finally, this section deletes provisions allowing ineligible assets to be counted as eligible while the HMO is attempting to dispose of the property.

Section 22. Dividends

This section restricts the payment of dividends to not more than 10% of surplus and strengthens the department's ability to regulate matters relating to dividends.

Section 23. Penalties

This section increases the penalty for violation of a cease and desist order from $50,000 to $200,000.

Section 24. Conversion on termination of eligibility

This section disallows the right of a subscriber to convert upon termination if the subscriber has left the geographic area with the intent to relocate elsewhere.

Sections 25 & 26. Sunset Review

These sections schedule new statutes in the act to sunset review and repeal on October 1, 1991.

Section 27. Effective date

This act takes effect October 1, 1988.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

Although this bill, by creating a guaranty association, increases the regulation of HMOs, the costs of the regulation are borne by the association and not the Department.

Section 16 of the bill increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the Department estimates current processing costs of $2,843 which includes examiner, administrative, and ancillary reviews and clerical support.
B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

This bill will increase costs for HMOs in several ways. First, every HMO will pay $25,000 into the Guaranty Association. Second, every HMO will pay a one percent assessment on its total non-Medicare annual premium. Third, section 5 increases the present surplus requirements of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. The Department has analyzed the actual dollar requirements for each HMO and the amounts range from no additional capital required to $5,190,754 additional capital required. Also, this section increases the existing level surplus to the greater of $1,500,000 or 10 percent of total liabilities. Fourth, for new HMOs, the application fee for a certificate of authority is increased from $240 to $1,000. For HMOs found in violation of the law, maximum administrative fines are increased from $10,000 to $100,000 and the penalty for violation of a cease and desist order is increased from $50,000 to $200,000. Since HMOs will pass on the cost of the Guaranty Association to subscribers, health care costs would increase for those subscribers.

2. Direct Private Sector Benefits:

This bill benefits the private sector by guaranteeing continuity of health care coverage for HMO subscribers and by protecting them from providers suing for unpaid claims. It also benefits providers. From the five HMOs in receivership, 70,467 claims totaling $156,699,314.33 have been filed. As noted, these are unevaluated claims.

D. FISCAL COMMENTS:

None.

III. LONG RANGE CONSEQUENCES:

IV. COMMENTS:

This bill originated in the Health Care Committee as PCB HC 88-04 and embodies legislation proposed by the Department of Insurance. Similar legislation has been filed in the Senate by Senator Margolis (SB 1009).
V. AMENDMENTS:

None.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Tom Cooper

Staff Director: Mike Hansen

INSURANCE:
Prepared by: William Leary

FINANCE & TAXATION:
Prepared by: William Leary

APPROPRIATIONS:
Prepared by:

Staff Director:
I. SUMMARY:

Creates a consumer assistance plan for health maintenance organizations (HMOs), increases mandatory surplus requirements, and strengthens the authority of the Department of Insurance to regulate HMOs.

A. PRESENT SITUATION:

Health maintenance organizations (HMOs), regulated by Parts II and IV of Chapter 641, are health care plans in which members, their employers or the federal Medicare program, pay a pre-determined fee in advance for specified medical services. In Florida, 43 HMOs serve more than 1.1 million subscribers.

In the past year and a half, six HMOs failed and were placed in receivership by the Department of Insurance. The department reports that on the average, HMO medical costs are running at approximately 90 percent of premium revenues and administrative expenses at approximately 20 percent.

Florida HMO losses for 1987 were $115 million. This total reflects a first quarter loss of $12 million; a second quarter loss of 17 million; a third quarter loss of $32 million; and a fourth quarter loss of $54 million.

In the aftermath of the insolvent HMOs, the department received thousands of telephone calls from subscribers complaining of the unavailability of health care coverage and of collection action as well as legal suits taken against them by uncompensated providers. So far, from five HMOs which went into receivership, in 1987, 70,467 claims totalling $156,699,314.33 have been filed. This data refers to actual dollar amounts filed -- no claims have been evaluated to date.
Currently the department regulates the financial aspects of health maintenance organizations. Part II of Chapter 641 sets forth a variety of consumer protection requirements including several surplus and solvency provisions.

Section 641.225, F.S., requires all HMOs to maintain a minimum surplus equal to the greater of $100,000 or 5 percent of total liabilities. The department must lower the surplus requirements to not less than $100,000 for any HMO that meets certain conditions. Also, an exemption from the surplus requirements is provided to an HMO that has its subscriber claims guaranteed by a guaranteeing organization which has a surplus of the greater of $2 million or 2 times the minimum surplus of the HMO.

Under section 641.285, F.S., all HMOs are required to deposit the greater of (1) twice its reasonably estimated average monthly uncovered expenditures, or (2) $100,000. ("Uncovered expenditures" means the cost of health care services that are covered by an HMO, for which a subscriber would also be liable in the event of the insolvency of the organization.) Department waiver of the deposit is authorized for financially viable HMOs; for HMOs with guaranteeing organizations meeting certain conditions; and for HMOs with approved plans for continuation of benefits in the event of insolvency.

B. EFFECT OF PROPOSED CHANGES:

This bill creates a consumer assistance plan for HMOs, increases mandatory surplus requirements, and strengthens the authority of the department to regulate HMOs.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates Part IV of chapter 631 entitled "Health Maintenance Organizations Consumer Assistance Plan."

631.811 and 631.812 Short title and purpose. These sections provide a title and purpose. The purpose of the part is to protect subscribers against the failure of the HMO to perform its obligations due to an HMO's insolvency.

631.813 Application of part. This section provides a cross reference to HMOs regulated under part II of chapter 641. It also states that this part does not apply to Medicaid HMOs.

631.814 Definitions. This section provides definitions.

631.815 Florida Health Maintenance Organization Consumer Assistance Plan. This section creates the Florida HMO Consumer Assistance Plan. It requires all HMOs to be members. It establishes a board of directors for the Plan which will be under the immediate supervision of the Department of Insurance.

631.816 Board of directors. This section specifies a board of directors of five to nine persons, appointed by the Insurance Commissioner based on recommendations from the member HMOs.
631.817 Eligibility. This section specifies that anyone who loses HMO coverage as a result of insolvency of the HMO is eligible for coverage by the Plan. Coverage terminates upon the receipt of maximum benefits of $300,000, failure to pay the premium, or after a reasonable time as set by the board.

631.818 Powers and duties of the Plan. This section provides powers and duties of the Plan. If an HMO is insolvent the Plan shall guarantee, reinsure or assume the HMO policies. The plan will also consult with all HMOs in the same geographical area to obtain coverage for all subscribers of the insolvent HMO. If the plan is unable to obtain coverage voluntarily an open enrollment period will occur and subscribers can elect coverage from one of the available HMOs. Enrollment of subscribers will be based on proportionate market share.

The section also sets forth the use of the Plan's funds. The Plan will pay for all services, excluding the premium, provided by an HMO appointed to provide services. It will also pay for all services which would have been covered by the subscriber's contract with the insolvent HMO until the plan obtains coverage for the subscriber with another HMO. Moreover, the Plan will defend any claim filed contrary to the hold harmless provision of the bill. Finally, the Plan is responsible for payment of services for the same length of time as the original HMO's contract and for illness diagnosed during the initial contract. If the Plan does not act in a timely fashion regarding the preceding duties, the Department of Insurance is authorized to assume such powers and duties.

631.819 Assessments. This section provides for the funding of the Consumer Assistance Plan. The Consumer Assistance Plan will be funded by assessments collected prior to any insolvency: Two funds are created. One fund is based on assessments for non-Medicare premiums, the other on assessments for Medicare generated premiums. The Health Care Financing Administration must decide by January 1, 1989, if it wishes to participate in the association. If so, assessments for the Medicare fund will be paid by the Health Care Financing Administration. If the Health Care Financing Administration decides not to pay the assessment, then Medicare subscribers will not be covered by the Consumer Assistance Plan.

The first assessment will be $25,000 per HMO payable by October 1, 1988. After October 1, 1988, all HMOs seeking a certificate of authority will pay $25,000 prior to issuance. In addition, the Plan is authorized to assess, if needed, up to one-half of one percent of each HMO's annual earned premium revenue for non-Medicare and non-Medicaid contracts.

631.820 Plan of operation. This section requires the board of directors to establish a plan of operation and submit it to the department for approval. The plan is binding on all member HMOs. The plan may delegate any of the Plan's powers, with the exception of its assessment powers and powers to sue, be sued, and lend money, to an administrator.
631.821 Powers and duties of the department. This section provides to the department the power to suspend or revoke the certificate of authority of an HMO for failure to pay an assessment. The department is also authorized to require the Plan to notify subscribers of an HMO insolvency. Finally the department may revoke the appointment of the Plan's servicing company for improper handling of claims.

631.822 Records of the Plan. Requires record keeping of the Plan and release upon the termination of a liquidation, rehabilitation or revocation proceeding.

631.823 Examination of the Plan; annual report. This section requires the board to file an annual financial statement with the department.

631.824 Tax exemption. Specifies that the Plan is exempt from all state fees and taxes except for real property tax.

631.825 Immunity. This section provides immunity to any member HMO, the Plan, or the department for any action taken by them in the performance of their powers and duties under this part.

631.826 Extent of liability of Association. Specifies the Plan as a priority creditor of any insolvent HMO. Assets of the HMO shall be used to continue coverage and pay other obligations of the HMO. Unlike insurers under FIGA or FLAHEGA, if the HMO is rehabilitated, the expenses of rehabilitation must be paid back to the Association by the HMO with 12% interest.

631.827 Prohibited advertisement. This section prohibits advertising the existence of the Consumer Assistance Plan for the purpose of subscriber solicitations.

631.828 Income tax credit for assessments paid. Provides that assessments against HMOs may be offset against their corporate income tax.

Section 2. Definitions

This section amends the definition section of part II of chapter 641. It merges the definition of minimum services into the definition of health maintenance organizations. It adds a subparagraph to the definition of health maintenance organization to specify that if an HMO offers services through a managed care system the HMO must designate a primary care physician licensed as a medical doctor or osteopathic physician and a chiropractic physician and podiatrist who in turn will coordinate the health care for subscribers requesting services be provided licensed under chapters 458, 459, 460, and 461.

The definitions of insolvency and surplus are amended to take into account the statutory assets of an HMO. Definitions are added for the terms "statutory accounting principles," "subscriber" and "capitation."
Section 3. Application for certificate of authority

Any entity which seeks to operate an HMO must apply for a certificate of authority. This section amends several application requirements and adds several more. It requires the furnishing of names of all owners of in excess of 5 percent of the common stock of the HMO corporation. It also requires a description by an independent certified actuary of rating methodology and certification that rates are adequate. Finally, this section requires an independent comprehensive feasibility study performed by an independent certified actuary in conjunction with a certified public accountant.

Section 4. Issuance of certificate of authority

This provision strengthens the department's ability to refuse to grant or continue authority to transact the business of an HMO when the ownership, control and management includes persons of questionable business practices.

Section 5. Surplus requirement

This section increases the present surplus requirement of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, and for HMOs which have serving Medicaid clients, this section provides a graduated step-up. It also provides an entry level surplus of the greater of 1,500,000 or 10 percent of total liabilities or $500,000 plus all start-up losses. This section authorizes the department to set uniform standards and criteria for detecting and evaluating the impaired financial condition of any HMO.

Currently in lieu of having any minimum surplus, the HMO may provide a written guarantee made by a guaranty organization to assure payment of covered subscriber claims. This section amends the written guarantee to cover all other liabilities of the HMO and requires the guarantee to be irrevocable unless the department approves its cancellation.

Section 6. Florida Health Maintenance Organization Consumer Assistance Plan

This section specifies that any HMO seeking a certificate of authority must pay assessments to fund the Plan and that the department may take action against an HMO which fails to pay.

Section 7. Revocation or cancellation of certificates; suspension of enrolling new subscribers

This section strengthens the department's power to act against noncompliant, impaired or insolvent HMOs. It requires compliance within 30 days instead of 60. It also provides authority to the department to take various action when the HMO's financial condition is such that its continued operation would be hazardous to enrollees, creditors or the general public. The department is
authorized to order the HMO to reduce its liabilities, its volume of new businesses, its expense or it may suspend the HMO's authority to write new business or require an increase in the HMO's net worth.

Section 8. Administrative, provider and management contracts

This section creates new authority for the department to review and disapprove any HMO contract with other entities for administrative, management and other sources if the contract is detrimental to the subscribers, stockholders or creditors of the HMO.

Section 9. Contract providers

This section creates a new requirement for HMOs to file financial statements for all contract providers, except individual physicians, who have assumed through capitation or other means, more than ten percent of the health care risk of the HMO.

Section 10. Administrative penalty in lieu of suspension or revocation

This section increases the maximum administrative fine from $10,000 to $100,000.

Section 11. Annual report

This section requires unaudited financial statements to be filed quarterly. It requires HMOs to hire a certified public accountant who agrees to prepare financial statements in accordance with statutory accounting principles and make his working papers available to the department.

Section 12. Examination by the department

This section allows the department, in lieu of making its own financial examination, to accept an independent certified public accountant's audit report prepared on a statutory accounting basis.

Section 13. Fees

This section increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the Department of Insurance estimates current processing costs of each application to be $2,843, which includes examiner, administrative, and ancillary reviews and clerical support.

Section 14. Health maintenance contracts

This section requires the department to disapprove rates which are inadequate, excessive, or unfairly discriminatory or if the rating methodology is inconsistent or ambiguous. This section also requires that pre-existing condition provisions be clearly disclosed and that HMO contracts provide coverage of adopted
children from the moment of birth if a written agreement to adopt has been entered prior to birth.

Section 15. Statewide Subscriber Assistance Program

This section amends the current statewide subscriber assistance program to allow the review panel to consider individual grievances as well as types of grievance.

Section 16. Extension of benefits

This section requires that HMO contracts provide for extension of benefits beyond the contract period for losses commenced while the contract was in force, when the HMO terminates the contract. However, certain limitations are specified, including authorization that the extension of benefits be predicated upon the continuous total disability of the subscriber.

Section 17. Provider contracts

This section strengthens current law regarding hold harmless provisions. This section requires 30 days written notice by a provider to the department and HMO before cancelling a contract. This applies to existing contracts within 180 days after the effective date of the act and to new contracts after the effective date of the act. Presently, provider contracts are required to specify that the HMO, not the subscriber, is responsible for paying for services rendered. This section states that no subscriber is liable for services provided by an HMO and that no provider may sue or collect from a subscriber any money for services covered by an HMO.

Section 18. Assets, liabilities, and investments

Currently in determining the financial condition of an HMO there are certain allowable assets. This section requires the HMO to revalue or replace unqualified assets within 30 days of notice from the department rather than 90. It also includes agreements not to compete and advances to entities as assets not allowed. It deletes the requirement that an HMO deposit with the department be made in coin or currency. It requires the department to approve investment in service companies and of exchange of facilities or assets with service companies. Finally, this section deletes provisions allowing ineligible assets to be counted as eligible while the HMO is attempting to dispose of the property.

Section 19. Dividends

This section restricts the payment of dividends to not more than 10% of surplus and strengthens the department's ability to regulate matters relating to dividends.
Section 20. Penalties
This section increases the penalty for violation of a cease and desist order from $50,000 to $200,000.

Section 21. Conversion on termination of eligibility
This section disallows the right of a subscriber to convert upon termination if the subscriber has left the geographic area with the intent to relocate elsewhere.

Section 22. Credit stacking
This section provides a conforming amendment to allow credit stacking for HMO assessments.

Sections 23 & 24. Sunset Review
These sections schedule new statutes in the act to sunset review and repeal on October 1, 1991.

Section 25. Effective date
This act takes effect October 1, 1988.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring or First Year Start-Up Effects:
In FY 88-89, the bill will result in approximately $7 million in assessments for the Guaranty Association. State general revenue will be reduced by approximately $1.4 million because of the new credit provided by s.631.829 against corporate income taxes.

Although this bill, by creating a guaranty association, increases the regulation of HMOs, the costs of the regulation are borne by the association and not the Department.

2. Recurring or Annualized Continuation Effects:
If the new credit were fully implemented in FY 88-89, the bill would reduce state general revenues by $7 million on a recurring basis. In effect, the state will bear the cost of assessments against HMO's.

3. Long Run Effects Other Than Normal Growth:

4. Appropriations Consequences:
B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

This bill will increase costs for HMOs in several ways. First, every HMO will pay $25,000 into the Guaranty Association. Approximately $1,000,000 will be raised by the lump-sum $25,000 assessment. Second, every HMO will pay a one percent assessment on its total non-Medicare annual premium. The 1% assessment will raise approximately $6 million annually. Third, section 5 increases the present surplus requirements of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. The Department has analyzed the actual dollar requirements for each HMO and the amounts range from no additional capital required to $5,190,754 additional capital required. Also, this section increases the existing level surplus to the greater of $1,500,000 or 10 percent of total liabilities. Fourth, for new HMOs, the application fee for a certificate of authority is increased from $240 to $1,000.

For HMOs found in violation of the law, maximum administrative fines are increased from $10,000 to $100,000 and the penalty for violation of a cease and desist order is increased from $50,000 to $200,000. Since HMOs will pass on the cost of the Guaranty Association to subscribers, health care costs would increase for those subscribers.

2. Direct Private Sector Benefits:

HMOs' will benefit from the new credit against corporate income taxes and other liabilities to the state by the same amount that assessments are paid into the guaranty association. In effect, the state will bear the cost for HMO insolvencies, even though the assessment appears to impose these costs on other HMO's.

This bill benefits the private sector by guaranteeing continuity of health care coverage for HMO subscribers and by protecting them from providers suing for unpaid claims. It also benefits providers. From the five HMOs in receivership, 70,467 claims totaling $156,699,314.33 have been filed. As noted, these are unevaluated claims.
D. FISCAL COMMENTS:

The credit against corporate income taxes provided by s. 631.829 should be incorporated into s.220.02(9), where the order of credit application against the corporate tax is established.

III. LONG RANGE CONSEQUENCES:

IV. COMMENTS:

This bill originated in the Health Care Committee as PCB HC 88-04 and embodies legislation proposed by the Department of Insurance. Similar legislation has been filed in the Senate by Senator Margolis (SB 1009).

V. AMENDMENTS:

None.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: 
Tom Cooper
Staff Director: 
Mike Hansen

INSURANCE:
Prepared by: 
William Leary

FINANCE & TAXATION:
Prepared by: 
Alan W. Johansen
Staff Director: 
Dr. Henry C. Cain

APPROPRIATIONS:
Prepared by: 


BILL #: CS/HB 1576

RELATING TO: Health Care Services

SPONSOR(S): Committees on Finance and Tax, Health Care, Rep. Press,
Abrams & Others

EFFECTIVE DATE: October 1, 1988

COMPANION BILL(S): SB 1009 by Senator Margolis

OTHER COMMITTEES OF REFERENCE: (1) Appropriations
(2) 
(3) 

I. SUMMARY:

Creates a consumer assistance plan for health maintenance organizations (HMOs), increases mandatory surplus requirements, and strengthens the authority of the Department of Insurance to regulate HMOs.

A. PRESENT SITUATION:

Health maintenance organizations (HMOs), regulated by Parts II and IV of Chapter 641, are health care plans in which members, their employers or the federal Medicare program, pay a pre-determined fee in advance for specified medical services. In Florida, 43 HMOs serve more than 1.1 million subscribers.

In the past year and a half, six HMOs failed and were placed in receivership by the Department of Insurance. The department reports that on the average, HMO medical costs are running at approximately 90 percent of premium revenues and administrative expenses at approximately 20 percent.

Florida HMO losses for 1987 were $115 million. This total reflects a first quarter loss of $12 million; a second quarter loss of 17 million; a third quarter loss of $32 million; and a fourth quarter loss of $54 million.

In the aftermath of the insolvent HMOs, the department received thousands of telephone calls from subscribers complaining of the unavailability of health care coverage and of collection action as well as legal suits taken against them by uncompensated providers. So far, from five HMOs which went into receivership, in 1987, 70,467 claims totalling $156,699,314.33 have been filed. This data refers to actual dollar amounts filed -- no claims have been evaluated to date.

Currently the department regulates the financial aspects of health maintenance organizations. Part II of Chapter 641 sets forth a variety of consumer protection requirements including several surplus and solvency provisions.
Section 641.225, F.S., requires all HMOs to maintain a minimum surplus equal to the greater of $100,000 or 5 percent of total liabilities. The department must lower the surplus requirements to not less than $100,000 for any HMO that meets certain conditions. Also, an exemption from the surplus requirements is provided to an HMO that has its subscriber claims guaranteed by a guaranteeing organization which has a surplus of the greater of $2 million or 2 times the minimum surplus of the HMO.

Under section 641.285, F.S., all HMOs are required to deposit the greater of (1) twice its reasonably estimated average monthly uncovered expenditures, or (2) $100,000. ("Uncovered expenditures" means the cost of health care services that are covered by an HMO, for which a subscriber would also be liable in the event of the insolvency of the organization.) Department waiver of the deposit is authorized for financially viable HMOs; for HMOs with guaranteeing organizations meeting certain conditions; and for HMOs with approved plans for continuation of benefits in the event of insolvency.

B. EFFECT OF PROPOSED CHANGES:

This bill creates a consumer assistance plan for HMOs, increases mandatory surplus requirements, and strengthens the authority of the department to regulate HMOs.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates Part IV of chapter 631 entitled "Health Maintenance Organizations Consumer Assistance Plan."

631.811 and 631.812 Short title and purpose. These sections provide a title and purpose. The purpose of the part is to protect subscribers against the failure of the HMO to perform its obligations due to an HMO's insolvency.

631.813 Application of part. This section provides a cross reference to HMOs regulated under part II of chapter 641. It also states that this part does not apply to Medicaid HMOs.

631.814 Definitions. This section provides definitions.

631.815 Florida Health Maintenance Organization Consumer Assistance Plan. This section creates the Florida HMO Consumer Assistance Plan. It requires all HMOs to be members. It establishes a board of directors for the Plan which will be under the immediate supervision of the Department of Insurance.

631.816 Board of directors. This section specifies a board of directors of five to nine persons, appointed by the Insurance Commissioner based on recommendations from the member HMOs.

631.817 Eligibility. This section specifies that anyone who loses HMO coverage as a result of insolvency of the HMO is eligible for coverage by the Plan. Coverage terminates upon the receipt of maximum benefits of $300,000, failure to pay the premium, or after a reasonable time as set by the board.

631.818 Powers and duties of the Plan. This section provides powers and duties of the Plan. If an HMO is insolvent the Plan shall guarantee, reinsure or assume the HMO policies. The plan will also consult with all HMOs in the same geographical area to obtain coverage for all subscribers of the insolvent HMO.
If the plan is unable to obtain coverage voluntarily an open enrollment period will occur and subscribers can elect coverage from one of the available HMOs. Enrollment of subscribers will be based on proportionate market share.

The section also sets forth the use of the Plan's funds. The Plan will pay for all services, excluding the premium, provided by an HMO appointed to provide services. It will also pay for all services which would have been covered by the subscriber's contract with the insolvent HMO until the plan obtains coverage for the subscriber with another HMO. Moreover, the Plan will defend any claim filed contrary to the hold harmless provision of the bill. Finally, the Plan is responsible for payment of services for the same length of time as the original HMO's contract and for illness diagnosed during the initial contract. If the Plan does not act in a timely fashion regarding the preceding duties, the Department of Insurance is authorized to assume such powers and duties.

631.819 Assessments. This section provides for the funding of the Consumer Assistance Plan. The Consumer Assistance Plan will be funded by assessments collected prior to any insolvency: Two funds are created. One fund is based on assessments for non-Medicare premiums, the other on assessments for Medicare generated premiums. The Health Care Financing Administration must decide by January 1, 1989, if it wishes to participate in the association. If so, assessments for the Medicare fund will be paid by the Health Care Financing Administration. If the Health Care Financing Administration decides not to pay the assessment, then Medicare subscribers will not be covered by the Consumer Assistance Plan.

The first assessment will be $25,000 per HMO payable by January 1, 1989. After January 1, 1989, all HMOs seeking a certificate of authority will pay $25,000 prior to issuance. In addition, the Plan is authorized to assess, if needed, up to one-half of one percent of each HMO's annual earned premium revenue for non-Medicare and non-Medicaid contracts.

631.820 Plan of operation. This section requires the board of directors to establish a plan of operation and submit it to the department for approval. The plan is binding on all member HMOs. The plan may delegate any of the Plan's powers, with the exception of its assessment powers and powers to sue, be sued, and lend money, to an administrator.

631.821 Powers and duties of the department. This section provides to the department the power to suspend or revoke the certificate of authority of an HMO for failure to pay an assessment. The department is also authorized to require the Plan to notify subscribers of an HMO insolvency. Finally the department may revoke the appointment of the Plan's servicing company for improper handling of claims.

631.822 Records of the Plan. Requires record keeping of the Plan and release upon the termination of a liquidation, rehabilitation or revocation proceeding.

631.823 Examination of the Plan; annual report. This section requires the board to file an annual financial statement with the department.

631.824 Tax exemption. Specifies that the Plan is exempt from all state fees and taxes except for real property tax.
631.825 **Immunity.** This section provides immunity to any member HMO, the Plan, or the department for any action taken by them in the performance of their powers and duties under this part.

631.826 **Extent of liability of Association.** Specifies the Plan as a priority creditor of any insolvent HMO. Assets of the HMO shall be used to continue coverage and pay other obligations of the HMO. Unlike insurers under FIGA or FLAHEGA, if the HMO is rehabilitated, the expenses of rehabilitation must be paid back to the Association by the HMO with 12% interest.

631.827 **Prohibited advertisement.** This section prohibits advertising the existence of the Consumer Assistance Plan for the purpose of subscriber solicitations.

631.828 **Income tax credit for assessments paid.** Provides that assessments against HMOs may be offset against their corporate income tax.

**Section 2. Definitions**

This section amends the definition section of part II of chapter 641. It merges the definition of minimum services into the definition of health maintenance organizations. It adds a subparagraph to the definition of health maintenance organization to specify that if an HMO offers services through a managed care system the HMO must designate a primary care physician licensed as a medical doctor or osteopathic physician and a chiropractic physician and podiatrist who in turn will coordinate the health care for subscribers requesting services be provided licensed under chapters 458, 459, 460, and 461.

The definitions of insolvency and surplus are amended to take into account the statutory assets of an HMO. Definitions are added for the terms "statutory accounting principles," "subscriber" and "capitation."

**Section 3. Application for certificate**

Any entity which seeks to operate an HMO must apply for a certificate of authority. This section amends several application requirements and adds several more. It requires the furnishing of names of all owners of in excess of 5 percent of the common stock of the HMO corporation. It also requires a description by an independent certified actuary of rating methodology and certification that rates are adequate. Finally, this section requires an independent comprehensive feasibility study performed by an independent certified actuary in conjunction with a certified public accountant.

**Section 4. Issuance of certificate of authority**

This provision strengthens the department's ability to refuse to grant or continue authority to transact the business of an HMO when the ownership, control and management includes persons of questionable business practices.

**Section 5. Surplus requirement**

This section increases the present surplus requirement of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, and for HMOs which have serving Medicaid clients, this section provides a graduated step-up. It also provides an entry level surplus of the greater of 1,500,000 or 10 percent of total.
liabilities or $500,000 plus all start-up losses. This section authorizes the department to set uniform standards and criteria for detecting and evaluating the impaired financial condition of any HMO.

Currently in lieu of having any minimum surplus, the HMO may provide a written guarantee made by a guaranty organization to assure payment of covered subscriber claims. This section amends the written guarantee to cover all other liabilities of the HMO and requires the guarantee to be irrevocable unless the department approves its cancellation.

Section 6. Florida Health Maintenance Organization Consumer Assistance Plan

This section specifies that any HMO seeking a certificate of authority must pay assessments to fund the Plan and that the department may take action against an HMO which fails to pay.

Section 7. Revocation or cancellation of certificates; suspension of enrolling new subscribers

This section strengthens the department's power to act against noncompliant, impaired or insolvent HMOs. It requires compliance within 30 days instead of 60. It also provides authority to the department to take various action when the HMO's financial condition is such that its continued operation would be hazardous to enrollees, creditors or the general public. The department is authorized to order the HMO to reduce its liabilities, its volume of new businesses, its expense or it may suspend the HMO's authority to write new business or require an increase in the HMO's net worth.

Section 8. Administrative, provider and management contracts

This section creates new authority for the department to review and disapprove any HMO contract with other entities for administrative, management and other sources if the contract is detrimental to the subscribers, stockholders or creditors of the HMO.

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This section creates a new requirement for HMOs to file financial statements for all contract providers, except individual physicians, who have assumed through capitation or other means, more than ten percent of the health care risk of the HMO.

Section 10. Administrative penalty in lieu of suspension or revocation

This section increases the maximum administrative fine from $10,000 to $100,000.

Section 11. Annual report

This section requires unaudited financial statements to be filed quarterly. It requires HMOs to hire a certified public accountant who agrees to prepare financial statements in accordance with statutory accounting principles and make his working papers available to the department.

Section 12. Examination by the department
This section allows the department, in lieu of making its own financial examination, to accept an independent certified public accountant's audit report prepared on a statutory accounting basis.

Section 13. Fees

This section increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the Department of Insurance estimates current processing costs of each application to be $2,843, which includes examiner, administrative, and ancillary reviews and clerical support.

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Section 15. Statewide Subscriber Assistance Program

This section amends the current statewide subscriber assistance program to allow the review panel to consider individual grievances as well as types of grievance.

Section 16. Extension of benefits

This section requires that HMO contracts provide for extension of benefits beyond the contract period for losses commenced while the contract was in force, when the HMO terminates the contract. However, certain limitations are specified, including authorization that the extension of benefits be predicated upon the continuous total disability of the subscriber.

Section 17. Provider contracts

This section strengthens current law regarding hold harmless provisions. This section requires 30 days written notice by a provider to the department and HMO before canceling a contract. This applies to existing contracts within 180 days after the effective date of the act and to new contracts after the effective date of the act. Presently, provider contracts are required to specify that the HMO, not the subscriber, is responsible for paying for services rendered. This section states that no subscriber is liable for services provided by an HMO and that no provider may sue or collect from a subscriber any money for services covered by an HMO.

Section 18. Assets, liabilities, and investments

Currently in determining the financial condition of an HMO there are certain allowable assets. This section requires the HMO to revalue or replace unqualified assets within 30 days of notice from the department rather than 90. It also includes agreements not to compete and advances to entities as assets not allowed. It deletes the requirement that an HMO deposit with the department be made in coin or currency. It requires the department to approve investment in service companies and of exchange of facilities or assets with service companies. Finally, this section deletes provisions allowing ineligible assets.
to be counted as eligible while the HMO is attempting to dispose of the
property.

Section 19. Dividends

This section restricts the payment of dividends to not more than 10\% of surplus
and strengthens the department's ability to regulate matters relating to
dividends.

Section 20. Penalties

This section increases the penalty for violation of a cease and desist order
from $50,000 to $200,000.

Section 21. Conversion on termination of eligibility

This section disallows the right of a subscriber to convert upon termination if
the subscriber has left the geographic area with the intent to relocate
elsewhere.

Section 22. Credit stacking

This section provides a conforming amendment to allow credit stacking for HMO
assessments.

Sections 23 & 24. Sunset Review

These sections schedule new statutes in the act to sunset review and repeal on
October 1, 1991.

Section 25. Effective date

This act takes effect October 1, 1988.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring or First Year Start-Up Effects:

   In FY 88-89, the bill will result in approximately $1 million in assessments
   for the Consumer Assistance Plan. State general revenue will be reduced by
   approximately $ .2 million because of the new credit provided by s.631.828
   against corporate income taxes. Raising the application fee from $240 to
   $1,000 will result in an annual increase of $12,000 to the Insurance
   Commissioner's Regulatory Trust Fund.

2. Recurring or Annualized Continuation Effects:

   The $25,000 assessment per HMO will reduce state general revenues by $ .2
   million per year for the next five years.

3. Long Run Effects Other Than Normal Growth:

   HMO insolvencies which lead to assessments of one-half percent could
   increase the general revenue loss by $ .7 million for each year such
assessments are needed. The actual anticipated loss from credits for such
assessments is indeterminate.

4. Appropriations Consequences:

Although this bill, by creating a Consumer Assistance Plan,
increases the regulation of HMOs, the costs of the regulation are borne by
the association and not the Department.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

This bill will increase costs for HMOs in several ways. First, every HMO
will pay $25,000 into the Consumer Assistance Plan. Approximately
$1,000,000 will be raised by the lump-sum $25,000 assessment. Second, every
HMO could pay a one-half percent assessment on its total non-Medicare annual
premium. The one-half percent assessment would raise approximately $3
million annually. Third, section 5 increases the present surplus
requirements of an HMO from the greater of $100,000 or 5 percent of total
liabilities to the greater of $500,000 or 10 percent. For HMOs already
operating, this section provides a graduated step-up. The Department has
analyzed the actual dollar requirements for each HMO and the amounts range
from no additional capital required to $5,190,754 additional capital
required. Also, this section increases the existing level surplus to the
greater of $1,500,000 or 10 percent of total liabilities. Fourth, for new
HMOs, the application fee for a certificate of authority is increased from
$240 to $1,000. The Department estimates this will raise an additional
$12,000 annually to be deposited in the Insurance Commissioner's Regulatory
Trust Fund.

For HMOs found in violation of the law, maximum administrative fines are
increased from $10,000 to $100,000 and the penalty for violation of a cease
and desist order is increased from $50,000 to $200,000. Since HMOs will
pass on the cost of the Consumer Assistance Plan to subscribers, health care
costs would increase for those subscribers.

2. Direct Private Sector Benefits:

HMOs' will benefit from the new credit against corporate income taxes and
other liabilities to the state by the same amount that assessments are paid
into the Consumer Assistance Plan. In effect, the state will bear the cost
for HMO insolvencies, even though the assessment appears to impose these
costs on other HMO's, and their subscribers.

This bill benefits the private sector by guaranteeing continuity of health
care coverage for HMO subscribers and by protecting them from providers
suing for unpaid claims.
III. LONG RANGE CONSEQUENCES:

IV. COMMENTS:

This bill originated in the Health Care Committee as PCB HC 88-04 and embodies legislation proposed by the Department of Insurance. Similar legislation has been filed in the Senate by Senator Margolis (SB 1009).

V. AMENDMENTS:

None.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by:
Tom Cooper

INSURANCE:
Prepared by:
William Leary

FINANCE & TAXATION:
Prepared by:
Alan W. Johansen

APPROPRIATIONS:
Prepared by:
Lori Kilpatrick

Staff Director:
Mike Hansen

Staff Director:
William Leary

Staff Director:
Dr. Henry C. Cain

Staff Director:
Dr. James A. Zingale
I. SUMMARY:

Creates a consumer assistance plan for health maintenance organizations (HMOs), increases mandatory surplus requirements, and strengthens the authority of the Department of Insurance to regulate HMOs.

A. PRESENT SITUATION:

Health maintenance organizations (HMOs), regulated by Parts II and IV of Chapter 641, are health care plans in which members, their employers or the federal Medicare program, pay a pre-determined fee in advance for specified medical services. In Florida, 43 HMOs serve more than 1.1 million subscribers.

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This section increases the penalty for violation of a cease and desist order from $50,000 to $200,000.

Section 21. Conversion on termination of eligibility

This section disallows the right of a subscriber to convert upon termination if the subscriber has left the geographic area with the intent to relocate elsewhere.

Section 22. Credit stacking

This section provides a conforming amendment to allow credit stacking for HMO assessments.

Sections 23 & 24. Sunset Review

These sections schedule new statutes in the act to sunset review and repeal on October 1, 1991.

Section 25. Effective date

This act takes effect October 1, 1988, except for Sections 1 and 6, implementing the Consumer Assistance Plan, which take effect July 1, 1989.
II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring or First Year Start-Up Effects:

In FY 89-90, the bill will result in approximately $1 million in assessments for the Consumer Assistance Plan. State general revenue will be reduced by approximately $0.2 million because of the new credit provided by s.631.828 against corporate income taxes. Raising the application fee from $240 to $1,000 will result in an annual increase of $12,000 to the Insurance Commissioner's Regulatory Trust Fund.

2. Recurring or Annualized Continuation Effects:

The $25,000 assessment per HMO will reduce state general revenues by $0.2 million per year for five years beginning July 1, 1989.

3. Long Run Effects Other Than Normal Growth:

HMO insolvencies which lead to assessments of one-half percent could increase the general revenue loss by $0.7 million for each year such assessments are needed. The actual anticipated loss from credits for such assessments is indeterminate.

4. Appropriations Consequences:

Although this bill, by creating a Consumer Assistance Plan, increases the regulation of HMOs, the costs of the regulation are borne by the plan and not the Department.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

This bill will increase costs for HMOs in several ways. First, every HMO will pay $25,000 into the Consumer Assistance Plan. Approximately $1,000,000 will be raised by the lump-sum $25,000 assessment. Second, every HMO could pay a one-half percent assessment on its total non-Medicare annual premium. The one-half percent assessment would raise approximately $3 million annually. Third, section 5 increases the present surplus requirements of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. The Department has analyzed the actual dollar requirements for each HMO and the amounts range from no additional capital required to $5,190,754 additional capital required. Also, this section increases the existing level surplus to the greater of $1,500,000 or 10 percent of total liabilities. Fourth, for new HMOs, the application fee for a certificate of authority is increased from $240 to $1,000. The Department estimates
this will raise an additional $12,000 annually to be deposited in the Insurance Commissioner's Regulatory Trust Fund.

For HMOs found in violation of the law, maximum administrative fines are increased from $10,000 to $100,000 and the penalty for violation of a cease and desist order is increased from $50,000 to $200,000. Since HMOs will pass on the cost of the Consumer Assistance Plan to subscribers, health care costs would increase for those subscribers.

2. Direct Private Sector Benefits:

HMOs' will benefit from the new credit against corporate income taxes and other liabilities to the state by the same amount that assessments are paid into the Consumer Assistance Plan. In effect, the state will bear the cost for HMO insolvencies, even though the assessment appears to impose these costs on other HMO's, and their subscribers.

This bill benefits the private sector by guaranteeing continuity of health care coverage for HMO subscribers and by protecting them from providers suing for unpaid claims.

D. FISCAL COMMENTS:

III. LONG RANGE CONSEQUENCES:

IV. COMMENTS:

This bill originated as Proposed Committee Bill HC 88-04 by the Committee on Health Care. The Department of Insurance presented testimony to the Subcommittee on Health Regulation on January 5, 1988 and drafted legislation which was distributed to the public in February. The draft was discussed at a subcommittee meeting on March 9, 1988, and the subcommittee passed the PCB on April 5, 1988. The full committee passed the PCB on April 13, 1988; subsequently, the bill was introduced and referred to the Committee on Insurance.

Prior to the bill being heard in the Committee on Insurance a compromise was reached with members of the industry; the elements of which were encompassed in the bill in its current form. The concepts of this compromise were presented to the Committee on Insurance and the bill passed the Insurance Committee on May 5, 1988.

On May 17, 1988, the Committee on Finance and Taxation passed the bill as a committee substitute with a strike everything after the enacting clause amendment which embodied the compromise version. The essential difference between the original version and this bill is that the original provided for a guaranty fund with an automatic
annual assessment of one percent on non-Medicare and non-Medicaid premium. The bill, on the other hand, creates a consumer assistance plan which is funded by a one-half of one percent assessment if needed. (Both versions provide(d) for an initial $25,000 individual assessment to pay for start-up and operating costs.)

The bill passed the Appropriations Committee on May 26, 1988, and the House on June 1, 1988. The Senate took up the bill on June 7, 1988, substituted it for SB 1009, amended the bill and passed it 30-0. The two substantive amendments adopted by the Senate struck language which called for all HMOs which utilize a managed care delivery system to appoint medical doctors or osteopathic and chiropractors and podiatrists as primary care physicians and moved the effective date of the Consumer Assistance Plan from October 1, 1988 to July 1, 1989. The House concurred in the amendments and passed the bill 117-0.

V. SIGNATURES:

SUBSTANTIVE COMMITTEE: Prepared by: ____________________________

Tom Cooper ____________________________________________________

INSURANCE: Prepared by: ____________________________

William Leary __________________________________________________

FINANCE & TAXATION: Prepared by: ____________________________

Alan W. Johnson __________________________________________

APPROPRIATIONS: Prepared by: ____________________________

Lori Kilpatrick ____________________________________________

Staff Director: ____________________________

Mike Hansen ____________________________________________

William Leary ____________________________________________

Dr. Henry C. Cain __________________________________________

Dr. James A. Zingale __________________________________________

STANDARD FORM 5/88
I. SUMMARY:

A. Present Situation:

Health maintenance organizations (HMOs), regulated by parts II and IV of ch. 641, F.S., are health care plans in which members, their employers or the federal Medicare program, pay a pre-determined fee in advance for specified medical services. In Florida, 43 HMOs serve more than 1.1 million subscribers.

In 1987, five Florida HMOs failed and were placed in receivership by the Department of Insurance. The Department of Insurance reports that on the average, HMO medical costs are running at approximately 90 percent of premium revenues and administrative expenses at approximately 20 percent.

Florida HMO losses for 1987 were $115 million. This total reflects a first quarter loss of $12 million; a second quarter loss of $17 million; a third quarter loss of $32 million; and a fourth quarter loss of $54 million.

In the aftermath of the five insolvent HMOs, the Department of Insurance received thousands of telephone calls from subscribers complaining of the unavailability of health care coverage and of collection action as well as legal suits taken against them by uncompensated providers. So far, from the five HMOs in receivership, 70,467 claims totaling $156,699,314.33 have been filed. These data refer to actual dollar amounts filed; no claims have been evaluated to date.

Currently, the Department of Insurance regulates the financial aspects of health maintenance organizations. Part II of ch. 641, F.S., sets forth a variety of consumer protection requirements including several surplus and solvency provisions.

Section 641.225, F.S., requires all HMOs to maintain a minimum surplus equal to the greater of $100,000, or 5 percent of total liabilities. The department must lower the surplus requirements to not less than $100,000 for any HMO that meets certain conditions. Also, an exemption from the surplus requirements is provided to an HMO that has its subscriber claims guaranteed by a guaranteeing organization which has a surplus of the greater of $2 million or 2 times the minimum surplus of the HMO.

Under s. 641.285, F.S., all HMOs are required to deposit with the Department of Insurance the greater of (1) twice its reasonably estimated average monthly uncovered expenditures, or (2) $100,000. ("Uncovered expenditures" means the cost of health care services that are covered by an HMO, for which a subscriber would also be liable in the event of the insolvency of the organization.) A Department of Insurance waiver of the deposit is authorized for: financially viable HMOs; HMOs with guaranteeing organizations meeting certain conditions; and HMOs
with approved plans for continuation of benefits in the event of insolvency.

Section 409.266(2), F.S., exempts from the provisions of Part II of chapter 641, F.S., those HMOs which provide no prepaid health service other than Medicaid services under contract with the Department of Health and Rehabilitative Services. According to federal regulations, Medicaid prepaid plans have three years from their initial startup to meet the 75/25 enrollment composition rule. This requires Medicaid HMOs to have sufficient commercial (non-Medicaid) subscribers to comprise 25 percent of total membership. Before Medicaid HMOs can enroll commercial members, the HMOs must meet the requirements of the Department of Insurance.

B. Effect of Proposed Changes:

This bill creates a guaranty fund association for health maintenance organizations and strengthens the authority of the Department of Insurance to regulate health maintenance organizations. For ease of understanding, a section-by-section analysis follows.

Section 1. Creates Part IV of chapter 631 entitled "Health Maintenance Organizations Guaranty of Health Care Services."

631.811 and 631.812 Short title and purpose. These sections provide a title and purpose. The purpose of the part is to protect subscribers against the failure of the HMO to perform its obligations due to an HMO's impairment, insolvency or revocation of its certificate of authority.

631.813 Application of part. This section provides a cross reference to HMOs regulated under part II of ch. 641, F.S. It also states that this part does not apply to Medicaid HMOs.

631.814 Definitions. This section provides definitions.

631.815 Florida Health Maintenance Organization Guaranty Association. This section creates the Florida HMO Guaranty Association. It requires all HMOs to be members. It establishes a board of directors for the Association which will be under the immediate supervision of the Department of Insurance.

631.816 Board of directors. This section specifies a board of directors of five to nine persons, appointed by the Department of Insurance based on recommendations from the member HMOs.

631.817 Eligibility. This section specifies that anyone who loses their HMO coverage as a result of insolvency, impairment or revocation of the HMO is eligible for coverage by the Association. Coverage terminates upon the receipt of maximum benefits of $300,000, failure to pay the premium, or obtaining coverage from another HMO, insurer, or a self-insurer.

631.818 Powers and duties of the association. This section provides powers and duties of the Association. If an HMO is impaired, the Association may guarantee, reinsure or pay the HMO's liabilities or obligations or it may loan money to the HMO. If an HMO is insolvent or its certificate of authority has been revoked, the Association shall: guarantee, reinsure or assume the HMO policies, pay all HMO obligations to providers and all indirect obligations necessary to make arrangements for the provision of health care to the HMO subscribers; or provide for the continuation of services to the HMO subscribers. If the Association does not act in a timely fashion regarding the preceding duties, the Department of Insurance is authorized to assume such powers and duties.
This section also confers standing on the Association. It requires the Association to pay all costs of rehabilitation and liquidation incurred by the Department of Insurance. The Association may exercise the powers of an insurer or an HMO for the purposes of meeting the obligations of the Association and the insolvent HMO.

Finally, the Association is authorized, in issuing replacement coverage, to provide different coverage than that contained in the contract of the insolvent HMO.

631.819 Assessments. This section provides for the funding of the Guaranty Association. The Guaranty Association will be funded by assessments collected prior to any insolvency. Two funds are created. One fund is based on assessments for non-Medicare premiums, the other on assessments for Medicare generated premiums. Assessments for the Medicare fund will be paid by the Health Care Financing Administration. If the Health Care Financing Administration decides not to pay the assessment, then Medicare subscribers will not be covered by the Guaranty Association.

The first assessment will be $25,000 per HMO payable by October 1, 1988. After October 1, 1988, all HMOs seeking a certificate of authority will pay $25,000 prior to issuance. The next assessment will be for the period July 1, 1988 to December 31, 1988. Although this section creates two classes of assessments for Medicare and non-Medicare premiums, the actual assessment is the same for both: 1 percent of premium for the first 6-month period. Subsequently, assessments will be on an annual calendar year basis. The maximum assessment for any 1 year will be 1 percent of premium. On January 1 of each year, the department will estimate the premium volume for the upcoming year and inform the Association of the volume. On January 31 of each year, the Association will determine the assessment rate for that year and notify the HMOs of the rate. On January 31 of the following year the Association will bill each HMO for the prior year's assessment. The payment of the assessment will then be due on July 1. Annual assessments will continue until the Association has a fund balance equal to 5 percent of the analyzed premium volume. At that time assessments will cease until such time as the fund balance declines to 4 percent of non-Medicare premium. HMOs may include in their premium rates a factor to take into account assessments.

631.820 Plan of operation. This section requires the board of directors to establish a plan of operation and submit it to the department for approval. The plan is binding on all member HMOs. The plan may delegate any of the Association's powers, with the exception of its assessment powers, to an administrator.

631.821 Powers and duties of the department. This section provides to the Department of Insurance the power to suspend or revoke the certificate of authority of an HMO for failure to pay an assessment. The department is also authorized to require the Association to notify subscribers of an HMO insolvency. Finally, the department may revoke the appointment of the Guaranty Association's servicing company for improper handling of claims.

631.822 Records of association. Requires record keeping of the Association and release upon the termination of a liquidation, rehabilitation or revocation proceeding.

631.823 Examination of the association; annual report. This section requires the board to file an annual financial statement with the department.
631.824 Tax exemption. Specifies that the Association is exempt from all state fees and taxes except for real property tax.

631.825 Immunity. This section provides immunity to any member HMO, the Association or the department for any action taken by them in the performance of their powers and duties under this part.

631.826 Extent of liability of association. Specifies the Association as a priority creditor of any impaired, insolvent or revoked HMO. Assets of the HMO shall be used to continue coverage and pay other obligations of the HMO. If the HMO is rehabilitated, the expenses of rehabilitation must be paid back to the Association by the HMO with 12 percent interest.

631.827 Health care coverage. This section provides for the Association to issue HMO policies, insurance contracts, enter into contracts with insurers or HMOs to provide coverage and enter into contracts with providers to service its HMO policies. The Association may continue the contract of the HMO or issue a different policy which complies with the Florida Insurance Code. The section provides that any subscriber receiving health care services under this part shall be deemed to have assigned his rights under the covered policy to the Association.

This section also provides that no preexisting condition clause, other than the same clause contained in the original HMO policy, may be contained in the Association's policy or another policy.

Finally, the Association is empowered to offer Medicare supplement policies.

631.828 Prohibited advertisement. This section prohibits advertising the existence of the Guaranty Association for the purpose of subscriber solicitations.

631.829 Assessments against member HMOs' income tax credit for assessments paid. Provides that assessments against HMOs may be offset against their corporate income tax.

631.830 Rates. This section requires that all HMO contracts issued by the Association must comply with all HMO laws and all insurance policies issued by the Association must comply with health insurance forms and rates laws.

Section 2. Definitions

This section amends the definition section of part II of ch. 641, F.S. It merges the definition of minimum services into the definition of health maintenance organizations. It adds a subparagraph to the definition of health maintenance organization to specify an HMO as a provider of services in a managed care system in which a primary care physician coordinates health care.

The definitions of insolvency and surplus are amended to take into account the statutory assets of an HMO. Definitions are added for the terms "statutory accounting principles," "subscriber" and "capitation."

Section 3. Application for certificate

Any entity which seeks to operate an HMO must apply for a certificate of authority. This section amends several application requirements and adds several more. It requires the furnishing of names of all owners of in excess of 5 percent of the common stock of the HMO corporation. It also requires a description by an independent certified actuary of rating
methodology and certification that rates are adequate. Finally, this section requires an independent comprehensive feasibility study performed by an independent certified actuary in conjunction with a certified public accountant.

Section 4. Issuance of certificate of authority

This provision strengthens the ability of the Department of Insurance to refuse to grant or continue authority to transact the business of an HMO when the ownership, control and management includes persons of questionable business practices.

Section 5. Surplus requirement

This section increases the present surplus requirement of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. It also provides an entry level surplus of the greater of $1,500,000 or 10 percent of total liability or $500,000 plus all start-up losses. This section authorizes the department to set uniform standards and criteria for detecting and evaluating the impaired financial condition of any HMO.

Currently in lieu of having any minimum surplus, the HMO may provide a written guarantee made by a guaranty organization to assure payment of covered subscriber claims. This section amends the written guarantee to cover all other liabilities of the HMO and requires the guarantee to be irrevocable unless the department approves its cancellation.

Section 6. Repeal of the Rehabilitation Administrative Expense Fund

This section repeals the Rehabilitation Administrative Expense Fund which requires all HMOs to deposit with the Department of Insurance $10,000 in cash. Currently, the fund is used by the department for payment of administrative expenses during any court-ordered rehabilitation of an HMO. Section 7 of the bill transfers all assets of the fund to the new guaranty association.

Section 7. Florida Health Maintenance Organization Guaranty Association

This section specifies certain requirements for the Guaranty Association created by Section 1 of this bill. It transfers all assets of the Rehabilitation and Administration Fund to the Association. It also provides for departmental powers regarding assessments.

Section 8. Revocation or cancellation of certificates; suspension of enrolling new subscribers; terms of suspension

This section strengthens the power of the Department of Insurance to act against any noncompliant, impaired or insolvent HMO. It requires compliance within 30 days instead of 60. It also provides authority to the department to take various action when an HMO's financial condition is such that its continued operation would be hazardous to enrollees, creditors or the general public. The department is authorized to order the HMO to reduce its liabilities, its volume of new businesses, its expense or it may suspend the HMO's authority to write new business or require an increase in the HMO's net worth.

Section 9. Administrative, provider and management contracts

This section creates new authority for the Department of Insurance to review and disapprove any HMO contract with other entities for administrative, management and other sources if
the contract is detrimental to the subscribers, stockholders or creditors of the HMO.

Section 10. Contract providers

This section creates a new requirement for HMOs to file financial statements for all contract providers, except individual physicians, who have assumed, through capitation or other means, more than 10 percent of the health care risk of the HMO.

Section 11. Administrative penalty in lieu of suspension or revocation

This section increases the maximum administrative fine from $10,000 to $100,000.

Section 12. Annual report

This section requires unaudited financial statements to be filed quarterly. It requires HMOs to hire a certified public accountant who agrees to prepare financial statements in accordance with statutory accounting principles and make his working papers available to the department.

Section 13. Examination by the department

This section allows the department, in lieu of making its own financial examination, to accept an independent certified public accountant's audit report prepared on a statutory accounting basis.

Section 14. Repeal of insolvency protection and limitation on levy upon deposit

This section repeals s. 641.285, F.S., relating to insolvency protection.

This section repeals s. 681.286, F.S., which limits the levy upon deposit.

Section 15. Fees

This section increases the application fee for a certificate of authority from $240 to $1,000.

Section 16. Health maintenance contracts

This section requires the department to disapprove rates which are inadequate, excessive, or unfairly discriminatory or if the rating methodology is inconsistent or ambiguous. This section also requires that preexisting condition provisions be clearly disclosed and that HMO contracts provide coverage of adopted children from the moment of birth if a written agreement to adopt has been entered into prior to birth.

Section 17. Statewide Subscriber Assistance Program

This section amends the current statewide subscriber assistance program to allow the review panel to consider individual grievances as well as types of grievances.

Section 18. Extension of benefits

This section requires the extension of benefits for totally disabled subscribers.

Section 19. Provider contracts
This section requires 60 days written notice by a provider to the Department of Insurance and HMO before cancelling a contract.

Section 20. Assets, liabilities, and investments

Currently, in determining the financial condition of an HMO there are certain allowable assets. This section requires the HMO to revalue or replace unqualified assets within 30 days of notice from the department rather than 90. It also includes agreements not to compete, and advances to entities, as assets not allowed. It deletes the requirement that an HMO deposit with the department be made in coin or currency. It requires the department to approve investment in service companies and of exchange of facilities or assets with service companies.

Finally, this section deletes provisions allowing ineligible assets to be counted as eligible while the HMO is attempting to dispose of the property.

Section 21. Dividends

This section restricts the payment of dividends to not more than 10 percent of surplus unless approved by the Department of Insurance and strengthens the department's ability to regulate matters relating to dividends.

Section 22. Penalty for violation of cease and desist orders

This section increases the penalty for violation of a cease and desist order from $50,000 to $200,000.

Section 23. Conversion on termination of eligibility

This section disallows the right of a subscriber to convert upon termination if the subscriber has left the geographic area with the intent to relocate elsewhere.

Section 24. Effective date

This act takes effect October 1, 1988.

II. ECONOMIC IMPACT AND FISCAL NOTE:

A. Public:

This bill will increase costs for HMOs in several ways. First, every HMO will pay $25,000 into the Guaranty Association. Second, every HMO will pay a 1 percent assessment on its total non-Medicare annual premium.

Third, section 5 increases the present surplus requirements of an HMO from the greater of $100,000 or 5 percent of total liabilities to the greater of $500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. The Department of Insurance has analyzed the actual dollar requirements for each HMO and the amounts range from no additional capital required to $5,190,754 additional capital required. Also, this section increases the existing level surplus to the greater of $1,500,000 or 10 percent of total liabilities. Fourth, for new HMOs, the application fee for a certificate of authority is increased from $240 to $1,000.

For HMOs found in violation of the law, maximum administrative fines are increased from $10,000 to $100,000 and the penalty for violation of a cease and desist order is increased from $50,000 to $200,000. Since HMOs will pass on the cost of the Guaranty Association to subscribers, health care costs would increase for those subscribers.
This bill benefits the private sector by guaranteeing continuity of health care coverage for HMO subscribers and by protecting them from providers suing for unpaid claims. It also benefits providers. From the five HMOs in receivership, 70,467 claims totaling $156,699,314.33 have been filed. As noted, these are unevaluated claims.

B. Government:

Although this bill, by creating a guaranty association, increases the regulation of HMOs, the costs of the regulation are borne by the Guaranty Association and not the Department of Insurance.

Section 15 of the bill increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the department estimates current processing costs of $2,843 which includes examiner, administrative, and ancillary reviews and clerical support.

It is anticipated that passage of the bill may lead to the cancellation of Medicaid prepaid plan contracts. Because contracts are negotiated at 95 percent of Medicaid fee for service expenditures, increases in Medicaid expenditures can be anticipated should any of the current Medicaid prepaid plans discontinue their service to Medicaid clients.

III. COMMENTS:

The provision in the bill requiring providers to provide 60 days written notice to the department and the HMO before cancelling the contract, affects contracts existing before the effective date of the act, and, thus, may be constitutionally impermissible pursuant to Art. I, sec. 10, Fla. Const., as impairing rights of existing contracts.

Chapter 87-188, L.O.F., requires that every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a part of either an individual or a group policy must submit to the appropriate legislative committee a report which assesses the social and financial impacts of the proposed coverage. The act provides guidelines for assessing the impact of a proposed mandated benefit or mandated option. The Department of Insurance has submitted the required report which indicates no significant increase in the cost of the treatment or service and no impact on the total cost of health care.

The surplus requirements anticipated by this bill could discriminate against smaller HMOs and imply that only large HMOs are entitled to exist.

IV. AMENDMENTS:

#1 by Commerce:
Adds a subparagraph to the definition of health maintenance organization to specify an HMO as a provider of services in a managed care system in which a primary care physician coordinates health care. The HMO must designate a primary care physician licensed as a medical doctor, an osteopathic physician, a chiropractic physician, and a podiatrist who in turn will coordinate the health care for subscribers requesting services be provided licensed under chs. 458, 459, 460, and 461, F.S., respectively.
SUMMARY

This proposed committee bill creates a guaranty fund association for health maintenance organizations and strengthens the authority of the Department of Insurance to regulate health maintenance organizations.

Section 1. Creates Part IV of chapter 631 entitled "Health Maintenance Organizations Guaranty of Health Care Services."

631.811 and 631.812 Short title and purpose. These sections provide a title and purpose. The purpose of the part is to protect subscribers against the failure of the HMO to perform its obligations due to an HMO's impairment, insolvency or revocation of its certificate of authority.

631.813 Application of part. This section provides a cross reference to HMOs regulated under part II of chapter 641.

631.814 Definitions. This section provides definitions.

631.815 Florida Health Maintenance Organization Guaranty Association. This section creates the Florida HMO Guaranty Association. It requires all HMOs to be members. It establishes a board of directors for the Association which will be under the immediate supervision of the Department of Insurance.

631.816 Board of directors. This section specifies a board of directors of five to nine persons, appointed by the Insurance Commissioner based on recommendations from the member HMOs.

631.817 Eligibility. This section specifies that anyone who loses their HMO coverage as a result of insolvency, impairment or revocation of the HMO is eligible for coverage by the Association. Coverage terminates upon the receipt of maximum benefits of $300,000 or failure to pay the premium or obtaining coverage from another HMO, an insurer, or a self-insurer.

631.818 Powers and duties of the Association. This section provides powers and duties of the Association. If an HMO is impaired, the Association may guarantee, reinsure or pay the HMO's liabilities or obligations or it may loan money to the HMO. If an HMO is insolvent or its certificate of authority has been revoked the Association shall: guarantee, reinsure or assume the HMO policies; pay all HMO obligations to make providers and all indirect obligations necessary to make
arrangements for the provision of health care to the HMO subscribers; or provide for the continuance of services to the HMO subscribers. If the Association does not act in a timely fashion regarding the preceding duties, the Department of Insurance is authorized to assume such powers and duties.

This section also confers standing on the Association. It requires the Association to pay all costs of rehabilitation and liquidation incurred by the department. The Association may exercise the powers of an insurer or an HMO for the purposes of meeting the obligations of the Association and the insolvent HMO.

Finally, the Association is authorized, in issuing replacement coverage, to provide different coverage than that contained in the contract of the insolvent HMO.

631.819 Assessments. This section provides for the funding of the Guaranty Association. The Guaranty Association will be funded by assessments collected prior to any insolvency. The first assessment will be $25,000 per HMO payable by October 1, 1988. After October 1, 1988, all HMOs seeking a certificate of authority will pay $25,000 prior to issuance. The next assessment will be for the period July 1, 1988 to December 31, 1988. Although this section creates two classes of assessments for Medicare and non-Medicare premiums the actual assessment is the same for both -- 1% of premium for the first six month period. Subsequently, assessments will be on an annual calendar year basis. The maximum assessment for any one year will be 1% of premium. On January 1st of each year, the department will estimate the premium volume for the upcoming year and inform the Association of the volume. On January 31st of each year, the Association will determine the assessment rate for that year and notify the HMOs of the rate. On January 31st of the following year the Association will bill each HMO for the prior year's assessment. The payment of the assessment will then be due on July 1st. Annual assessments will continue until the Association has a fund balance equal to 5% of the analyzed premium volume. At that time assessments will cease until such time as the fund balance declines to 4% of non-Medicare premium. HMOs may include in their premium rates a factor to take into account assessments.

631.820 Plan of operation. This section requires the board of directors to establish a plan of operation and submit it to the department for approval. The plan is binding on all member HMOs. The plan may delegate any of the Association's powers, with the exception of its assessment powers, to an administrator.
631.821 Powers and duties of the department. This section provides to the department the power to suspend or revoke the certificate of authority of an HMO for failure to pay an assessment. The department is also authorized to require the Association to notify subscribers of an HMO insolvency. Finally the department may revoke the appointment of the Guaranty Association's servicing company for improper handling of claims.

631.822 Records of the Association. Requires recordkeeping of the Association and release upon the termination of a liquidation, rehabilitation or revocation proceeding.

631.823 Examination of the Association; annual report. This section requires the board to file an annual financial statement with the department.

631.824 Tax exemption. Specifies that the Association is exempt from all state fees and taxes except for real property tax.

631.825 Immunity. This section provides immunity to any member HMO, the Association or the department for any action taken by them in the performance of their powers and duties under this part.

631.826 Extent of liability of Association. Specifies the Association as a priority creditor of any impaired, insolvent or revoked HMO. Assets of the HMO shall be used to continue coverage and pay other obligations of the HMO. If the HMO is rehabilitated, the expenses of rehabilitation must be paid back to the Association by the HMO with 12% interest.

631.827 Health care coverage. This section provides for the Association to issue HMO policies, insurance contracts, enter into contracts with insurers or HMOs to provide coverage and enter into contracts with providers to service its HMO policies. The Association may continue the contract of the HMO or issue a different policy which complies with the Florida Insurance Code. The section provides that any subscriber recovery health care services under this part shall be deemed to have assigned his rights under the covered policy to the Association.

This section also provides that no pre-existing condition clause, other than the same clause contained in the original HMO policy may be contained in the Association's or another policy.

Finally the Association is empowered to offer Medicare supplement policies.
Section 2. Definitions

This section amends the definition section of part II of chapter 641. It merges the definition of minimum services into the definition of health maintenance organizations. It adds a subparagraph to the definition of health maintenance organization to specify an HMO as providing services in a managed care system in which a primary care physician coordinates health care.

The definitions of insolvency and surplus are amended to take into account the statutory assets of an HMO. And definitions are added for the terms "statutory accounting principles," "subscriber" and "capitation."

Section 3. Application for certificate

Any entity which seeks to operate an HMO must apply for a certificate of authority. This section amends several application requirements and adds several more. It requires the furnishing of names of all owners of in excess of 5 percent of the common stock of the HMO corporation. It also requires a description by an independent certified actuary of rating methodology and certification that rates are adequate. Finally this section requires an independent comprehensive feasibility study performed by an independent certified actuary in conjunction with a certified public accountant.

Section 4. Issuance of certificate of authority

This provision strengthens the department's ability to refuse to grant or continue authority to transact the business of an HMO when the ownership, control and management includes persons of questionable business practices.
Section 5. Surplus requirement

This section increases the present surplus requirement of an HMO from the greater of 100,000 or 5 percent of total liabilities to the greater 500,000 or 10 percent. For HMOs already operating, this section provides a graduated step-up. It also provides an entry level surplus of the greater of 1,500,000 or 10 percent of total liabilities or $500,000 plus all start-up losses. This section authorizes the department to set uniform standards and criteria for detecting and evaluating the impaired financial condition of any HMO.

Currently in lieu of having any minimum surplus, the HMO may provide a written guarantee made by a guaranty organization to assure payment of covered subscriber claims. This section amends the written guarantee to cover all other liabilities of the HMO and requires the guarantee to be irrevocable unless the department approves its cancellation.

Section 6. Repeal of the Rehabilitation Administrative Expense Fund

This section repeals the Rehabilitation Administrative Expense Fund which requires all HMOs to deposit with the department $10,000 in cash. Currently the fund is used by the department for payment of administrative expenses during any court-ordered rehabilitation of an HMO. Section 7 of the bill transfers all assets of the Fund to the new guaranty association.

Section 7. Florida Health Maintenance Organization Guaranty Association

This section specifies certain requirements for the Guaranty Association created by Section 1 of this bill. It transfers all assets of the Rehabilitation and Administration Fund to the Association. It also provides for departmental powers regarding assessments.

Section 8. Revocation or cancellation of certificates; suspension of enrolling new subscribers

This section strengthens the department's power to act against noncompliant, impaired or insolvent HMOs. It requires compliance within 30 days instead of 60. It also provides authority to the department to take various action when the HMO's financial condition is such that its continued operation would be hazardous to enrollees, creditors or the general public. The department is authorized to order the HMO to reduce its liabilities, its
volume of new businesses, its expense or it may suspend the
HMO's authority to write new business or require an increase
in the HMO's net worth.

Section 9. Administrative, provider and management contracts

This section creates new authority for the department to
review and disapprove any HMO contract with other entities
for administrative, management and other sources if the
contract is detrimental to the subscribers, stockholders or
creditors of the HMO.

Section 10. Contract providers

This section creates a new requirement for HMOs to file
financial statements for all contract providers, except
individual physicians, who have assumed through capitation
or other means, more than ten percent of the health care
risk of the HMO.

Section 11. Administrative penalty in lieu of suspension or
revocation

This section increases the maximum administrative fine from
$10,000 to $100,000.

Section 12. Annual report

This section requires unaudited financial statements to be
filed quarterly. It requires HMOs to hire a certified
public accountant who agrees to prepare financial statements
in accordance with statutory accounting principles and make
his working papers available to the department.

Section 13. Examination by the department

This section allows the department, in lieu of making it own
financial examination, to accept an independent certified
public accountant's audit report prepared on a statutory
accounting basis.

Section 14. Repeal of insolvency protection

This section repeals s. 641.285 relating to insolvency
protection.

Section 15. Repeal of limitation on levy upon deposit
This section repeals s. 681.286 which limits the levy upon deposit.

Section 16. Fees

This section increases the application fee for a certificate of authority from $240 to $1,000. The Bureau of Allied Lines of the Department of Insurance estimates current processing costs of $2,843 which includes examiner, administrative, and ancillary reviews and clerical support.

Section 17. Health maintenance contracts

This section requires the department to disapprove rates which are inadequate, excessive, or unfairly discriminatory or if the rating methodology is inconsistent or ambiguous. This section also requires that pre-existing condition provisions be clearly disclosed and that HMO contracts provide coverage of adopted children from the moment of birth if a written agreement to adopt has been entered prior to birth.

Section 18. Statewide Subscriber Assistance Program

This section amends the current statewide subscriber assistance program to allow the review panel to consider individual grievances as well as types of grievance.

Section 19. Extension of benefits

This section requires the extension of benefits for totally disabled subscribers.

Section 20. Provider contracts

This section requires 60 days written notice by a provider to the department and HMO before cancelling a contract.

Section 21. Assets, liabilities, and investments

Currently in determining the financial condition of an HMO there are certain allowable assets. This section requires the HMO to revalue or replace unqualified assets within 30 days of notice from the department rather than 90. Regarding assets not allowed it includes agreements not to compete and advances to entities. It deletes the requirement that HMO deposit with the department be made in coin or currency. It requires the department to approve
investment in service companies and of exchange of facilities or assets with service companies. Finally, this section deletes provisions allowing ineligible assets to be counted as eligible while the HMO is attempting to dispose of the property.

Section 22. Dividends

This section restricts the payment of dividends to not more than 10% of surplus and strengthens the department's ability to regulate matters relating to dividends.

Section 23. Penalties

This section increases the penalty for violation of a cease and desist order from $50,000 to $200,000.

Section 24. Conversion on termination of eligibility

This section disallows the right of a subscriber to convert upon termination if the subscriber has left the geographic area with the intent to relocate elsewhere.

Section 25. Effective date

This act takes effect October 1, 1988.
Representative D. L. Jones offered the following amendment:

Amendment
On page 20, strike lines 21-25, and insert:

(e) Provides all services in a managed care system in which a primary care physician licensed under chapters 458 or 459, 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary.
<table>
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<tr>
<th>PRIME BILL NUMBER</th>
<th>TYPE OF BILL</th>
<th>SPONSOR</th>
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<tr>
<td>88/H1576 *</td>
<td>general</td>
<td>H. Health Care Committee</td>
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**PRIME BILL TITLE (short title)**

Health Maintenance Organizations - HMO

**SIMILAR/IDENTICAL BILL SUBSTITUTED BY PRIME BILL:** 88/S1009

**DOCUMENTATION REPRODUCED**

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**NOTE:** Consult the Final Legislative Bill Information (from Joint Legislative Management Committee, Division of Legislative Information, 1988) for more detailed bill history data. If prime bill number above is followed by an asterisk (*), it was amended on the floor, and the staff analysis for that bill may not be in accordance with the enacted law. The analyses reproduced here were supplied by the appropriate committee, who is solely responsible for their accuracy and completeness.

**ADDITIONAL INFORMATION:**
A bill to be entitled
An act relating to health care services;
creating part IV of chapter 631, F.S., relating
to health maintenance organizations guaranty of
health care services; providing for the purpose
and application of the part; providing
definitions; providing for a Florida Health
Maintenance Organization Guaranty Association;
providing for a board of directors; providing
for eligibility requirements; providing for
powers and duties of the association; providing
for assessments; providing for a plan of
operation; providing for powers and duties of
the Department of Insurance; providing for
records; providing for examination of the
association and annual report; providing for
tax exemptions; providing for immunity;
providing for extent of liability of
association; providing for health care
coverage; providing for prohibitions on
advertisements; providing for assessments
against income tax credits; providing for
rates; amending s. 641.19, F.S.; providing
definitions; amending s. 641.21, F.S.;
providing requirements for certificates of
authority; amending s. 641.22, F.S.; providing
management requirements; amending s. 641.225,
F.S.; modifying certain surplus requirements;
repealing s. 641.227, F.S., relating to the
Rehabilitation Administrative Expense Fund;
creating s. 641.228, F.S.; establishing the
Florida Health Maintenance Organization
Guaranty Association; amending s. 641.23, F.S.;
providing for certain HMO's to file corrective
action plans; modifying time limits for
ordering compliance by the department; creating
s. 641.234, F.S.; providing for administrative,
provider, and management contracts; creating s.
641.2342, F.S.; providing for financial
statements of certain contract providers;
amending s. 641.25, F.S.; increasing certain
penalties; amending s. 641.26, F.S.; modifying
certain annual report requirements; amending s.
641.27, F.S.; providing alternatives to
departmental examinations; repealing ss.
641.285, 641.286, F.S.; relating to insolvency
protection and levies upon HMO assets; amending
s. 641.29, F.S.; increasing certain fees;
amending s. 641.31, F.S.; providing approval
requirements for certain forms and deleting
certain requirements relating to Medicare
coverage; providing contract disclosure
requirements and establishing coverage
requirements relating to adopted children;
amending s. 641.311, F.S.; providing for review
of grievances by subscribers; creating s.
641.3111, F.S.; providing requirements for the
extension of certain subscriber benefits;
amending s. 641.315, F.S.; providing
requirements for provider contracts; amending
s. 641.35, F.S.; modifying certain time limits
for reevaluation of assets and specifying

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certain assets not allowed for reporting
purposes; modifying certain surplus and deposit
restrictions; requiring departmental approval
for certain activities; creating s. 641.365,
P.S.; providing restrictions on the payment of
dividends; amending s. 641.3913, P.S.;
increasing certain penalties; amending s.
641.3921, P.S.; providing for conversion of
coverage by certain subscribers; providing an
effective date.

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

Section 1. Part IV of chapter 631, Florida Statutes,
consisting of sections 631.811, 631.812, 631.813, 631.814,
631.829, 631.830, is created to read:

PART IV
HEALTH MAINTENANCE ORGANIZATION
GUARANTY OF HEALTH CARE SERVICES

631.811 Short title.--This part may be cited as the
"Florida Health Maintenance Organization Guaranty Association
Act."

631.812 Purpose; construction.--The purpose of this
part is to protect the subscribers of HMOs, subject to certain
limitations, against the failure of the HMO to perform its
contractual obligations due to its impairment, insolvency, or
revocation of its certificate of authority. This part shall
be liberally interpreted to carry out its purpose.

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631.813 Application of part.--This part shall apply to HMO contractual obligations to residents of Florida by HMOs possessing a valid certificate of authority issued by the Florida Department of Insurance as provided by chapter 641, part II. The provisions of this part do not apply to medical assistance programs created pursuant to s. 409.266.

631.814 Definitions.--As used in this part:

1. "Association" means the Florida Health Maintenance Organization Guaranty Association created by this part.
2. "Board" means the board of directors of the association.
4. "Covered policy" means any policy, contract, or evidence of coverage issued under chapter 641 by an HMO to a group or individual and which is in force at such time as a member HMO becomes impaired, insolvent, or has its license revoked after the effective date of this act.
5. "Date of insolvency" means the date a court of competent jurisdiction initially issues its order placing the department as the receiver of the HMO.
6. "Department" means the Department of Insurance.
7. "Health care services" means services, medical equipment, and supplies furnished by a provider, which may include, but which are not limited to, medical, surgical, and dental care; psychological, optometric, optic, chiropractic, podiatric, nursing, physical therapy, and pharmaceutical services; health education, preventive medical, rehabilitative, and home health services; inpatient and outpatient hospital services; extended care; nursing home care; convalescent institutional care; laboratory and

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ambulance services; appliances, drugs, medicines, and
supplies; and any other care, service, or treatment of
disease, correction of defects, or maintenance of the physical
and mental well-being of human beings.

(8) "HMO" means a health maintenance organization
possessing a valid certificate of authority issued by the
department pursuant to chapter 641, part II.

(9) "Indirect obligations" means any liability of an
HMO which was incurred to indirectly provide health care
services such as occupancy expenses, physician salaries, and
similar expenses.

(10) "Impaired HMO" means that the HMO is not
insolvent but its surplus does not comply with the
requirements of chapter 641, part II.

(11) "Insolvent HMO" means an HMO against which an
order of rehabilitation or liquidation has been entered by a
court of competent jurisdiction, with the department appointed
as receiver, even if such order has not become final by the
exhaustion of appellate reviews.

(12) "Person" means any individual, corporation,
partnership, association, or voluntary organization.

(13) "Provider contractual obligations" means any
liability to health care providers which was directly incurred
by the HMO to provide health care services for a subscriber
when the HMO has a contract with the provider which
specifically provides that the provider may not hold the
subscriber liable for payment of the services.

(14) "Subscriber" or "enrollee" means any resident of
this state who is enrolled for benefits provided by an HMO and
who makes premium payments or for whom premium payments are
made.

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"Affiliated provider" means a person who provides health care services to an HMO, which exercises control over or is controlled by the HMO, directly or indirectly through:

(a) Equity ownership of voting securities;
(b) Common managerial control; or
(c) Collusive participation by the management of the HMO and affiliate in the management of the HMO or the affiliate.

631.815 Florida Health Maintenance Organization Guaranty Association.--

(1) There is created a nonprofit legal entity to be known as the Florida Health Maintenance Organization Guaranty Association. All HMOs shall be and must remain members of the association as a condition of their authority to transact business in this state as an HMO. The association shall perform its functions under the plan of operations established and approved under the provisions of this part and shall exercise its powers through a board of directors established under the provisions of this part. The association shall come under the immediate supervision of the department and shall be subject to the applicable laws of this state except it shall be excluded from the requirements of possessing a certificate of authority or a health care provider certificate as set forth in chapter 641, parts II and IV, respectively.

631.816 Board of directors.--

(1) The board of directors of the association shall consist of not less than 5 or more than 9 persons serving terms as established in the plan of operation. The department shall approve and appoint to the board persons recommended by the member HMOs. In the event the department finds that any recommended person does not meet the qualifications for

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service on the board, the department shall request the member
HMOs to recommend another person. Each member shall serve for
a 4-year term and may be reappointed. Vacancies on the board
shall be filled for the remaining period of the term in the
same manner as initial appointments. If no members are
selected by October 31, 1988, the department may appoint the
initial members of the board of directors. To select the
initial board and initially organize the association, the
commissioner shall give notice to all HMO's of the time and
place of the organizational meeting. In determining voting
rights at the organizational meeting, each HMO is entitled to
one vote in person or in proxy.

(2) In appointing members to the board, the department
shall consider, among other things, whether all member HMOs
are fairly represented.

(3) Members of the board may be reimbursed from the
assets of the association for their services.

(4) The board of directors shall elect one of its
members as chairman.

(5) The board shall establish procedures under which
enrollees in the association may have grievances reviewed by
an impartial body and reported to the board.

(6) The board may contract with an administrator to
carry out the provisions of this part; however, this shall not
relieve the board of its duties and obligations under this
part.

631.817 Eligibility.--

(1) Except as provided in subsection (2), any resident
of this state who has lost or may lose their health care
services provided by an HMO due to impairment, insolvency, or
the revocation of the HMO's certificate of authority shall be
eligible for coverage by the association. Eligible persons include all persons who were eligible to receive health care services under that subscriber's contract with the HMO.

(2)(a) No person who is covered by the association and terminates the coverage shall again be eligible for coverage unless that person is a subscriber of a different HMO which subsequently, due to impairment, insolvency, or revocation, becomes subject to this part.

(b) A person shall cease to be covered by the association after the association has paid out $300,000 in covered benefits for that person.

(c) A person shall cease to be covered by the association upon failure to pay, or have paid on their behalf, premiums as set by the board. Coverage shall cease following a reasonable time period as set by the board.

(d) A person shall cease to be covered by the association when receiving comprehensive health care services through an HMO, or are covered by an insurer or self-insurer.

631.818 Powers and duties of the association.--

(1) If an HMO is impaired, the association may, subject to any conditions imposed by the association other than those which impair the contractual obligations of the impaired HMO, and subject to the approval of the impaired HMO and the department:

(a) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired HMO;

(b) Provide such moneys, pledges, notes, guarantees, or other means as are proper to effectuate paragraph (a) and assure payment of the contractual obligations of the impaired HMO pending action under paragraph (a);

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(c) Loan money to the impaired HMO.

(2) If an HMO is insolvent or its certificate of authority has been revoked, the association shall, upon instructions from the department:

(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of the insolvent HMO.

(b) Assume payment of the obligations of the HMO as follows:

1. All unaffiliated provider obligations, including contractual provider holdbacks.

2. Such indirect obligations as, in the judgment of the association, are necessary to be paid so that health care services can be provided until the association may make other arrangements for the health care of the enrollees.

(c) Provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge the association’s duties.

(d) Provide for the continuance of health care services of the subscribers as set forth elsewhere in this part.

(3) The association shall not pay affiliated provider obligations or any other obligation of the insolvent or revoked HMO not provided for in subsection (2).

(4) If the association fails to act within a reasonable period of time as provided in subsections (1) and (2), the department shall have the powers and duties of the association under this part.

(5) The association may render assistance and advice to the department, at the department’s request, concerning rehabilitation, payment of claims, continuance of coverage, or

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the performance of other contractual obligations of any impaired, insolvent, or revoked HMO.

(6) The association shall have standing to appear before any court in this state which has jurisdiction over an impaired, insolvent, or revoked HMO to which the association is or may become obligated under this part. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring or guaranteeing the covered policies of the impaired, insolvent, or revoked HMO and the determination of the covered policies and contractual obligations.

(7) The association shall pay, as instructed by the department, all costs, both direct and indirect, incurred by the department in connection with the liquidation, rehabilitation, or revocation, for reasons of insolvency, of an HMO.

(8) The association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this part.

(b) Sue or be sued, including the taking of any legal actions necessary or proper for the recovery of any unpaid assessments under this part.

(c) Borrow money to effect the purposes of this part. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers or HMOs and may be carried as admitted assets.

(d) Employ or retain such persons as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this part.
(e) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association.

(f) Take such legal action as may be necessary to avoid payment of improper claims.

(g) Exercise, for the purposes of this part and to the extent approved by the department, the powers of a health insurer or HMO, but in no case may the association issue policies or contracts other than those issued to satisfy the contractual obligations of the impaired, revoked, or insolvent HMO.

(9) The association's liability for the contractual obligations of the insolvent, impaired, or revoked HMO shall be no greater than the contractual obligations of the HMO in the absence of the insolvency, impairment, or revocation.

(10) The association may, in issuing or causing to be issued, replacement coverage for the subscriber, reasonably increase or decrease the health care services coverage for which the association is obligated as compared to the coverage previously provided by the HMO.

631.e19 Assessments.--

(1) There shall be two classes of assessments made by the board of directors, each of which shall be maintained in a separate fund:

(a) Class A assessments which shall be for the purpose of carrying out the powers and duties of the Guaranty Fund as they relate to non-Medicare and non-Medicaid subscribers for the member HMOs.

(b) Class B assessments which shall be for the purpose of carrying out the powers and duties of the Guaranty Fund as they relate to Medicare subscribers of the member HMOs.

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(c) Allocation of expenses to the two classes of funds under this subsection shall be based on the actual expenses of each class of membership and an allocation of all other expenses on a basis, as set by the board of directors, which is fair and has a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(2) Assessments for Medicare subscribers shall be collected only from the Health Care Financing Administration and shall be based on the Florida earned premium revenue for each year for all Medicare premium revenue.

(a) The Health Care Financing Administration shall have until January 1, 1989, to notify the department if it desires to have its Medicare subscribers covered by the association and receive the benefits of the association. Such notification shall obligate the Health Care Financing Administration to pay the Medicare portion of all assessments of the association. If the Health Care Financing Administration fails to notify the association of its intention to participate in the association, or notifies the department it does not desire to join the association, then Medicare subscribers of Florida HMO's shall not be eligible to participate in or receive the benefits of the association.

(b) If the Health Care Financing Administration declines to participate in the association, the assessments shall be applied to all Florida earned premiums for non-Medicare and non-Medicaid revenue only.

(3) Assessments shall be collected as follows:

(a) The board shall annually collect assessments from each HMO, not to exceed 1 percent of each HMO's total Florida earned premium revenue for Class A premiums each year, until the unencumbered fund balance of the association shall equal 5

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percent of the total Florida earned premium revenue for Class A premiums for all HMOs in Florida for the prior calendar year. Assessments shall cease when the association's unencumbered Class A fund balance equals 5 percent of the total Florida earned premium revenue for Class A premiums for the prior year. The assessment shall be collected only on premiums written for Florida residents.

(b) The board shall annually collect assessments from the Health Care Financing Administration or its designee, not to exceed 1 percent of each HMO's total Florida earned premium revenue for Class B premiums each year, until the unencumbered fund balance of the association shall equal 5 percent of the total Florida earned premium revenue for Class B premiums for all HMOs for the prior calendar year. Assessments shall cease when the association's unencumbered class fund balance equals 5 percent of the total Florida earned premium revenue for Class B premiums for the prior year. The assessment shall be collected only on premiums written for Florida subscribers.

(c) By January 1 of each year, following the effective date of this part, the department shall notify the association of the estimated Florida earned premium, by class of revenue, for that calendar year. The prior year-end unencumbered fund balance, by class, shall then be calculated as a percent of the estimated Florida earned premium revenue by class.

(d) Based on the amounts provided in paragraph (c), by January 31, the association shall establish and notify each HMO and the Health Care Financing Administration or its designee of the assessment rate for that year, not to exceed 1 percent of each HMO's total earned premium for Class A and B premiums, respectively.
(e) The association shall render each HMO and the Health Care Financing Administration or its designee an assessment notice by January 31 of the following year. Assessments, if any, are due and payable by July 1 of that year for the prior year's assessment.

(4) Assessments shall again commence when the association's unencumbered fund balance declines to less than 4 percent of the total Florida earned premium revenue for Class A or Class B premiums, respectively, for the prior calendar year.

(5) The association may waive assessments for any year if the amount to be assessed for any class would be less than $25,000 in total for all Florida HMOs.

(6) In addition to the assessment provided for in subsections (2) and (3), the association shall collect an initial assessment from all HMOs and from the Health Care Financing Administration or its designee of 1 percent of each HMO's total Florida earned premium for Class A and B premiums, respectively, for the period July 1 through December 31, 1988. This will be due and payable no later than July 1, 1989.

(7) The association may temporarily defer, in whole or in part, the assessment of a member HMO, if, in the opinion of the board, payment of the assessment would endanger the ability of the HMO to fulfill its contractual obligations.

(8) It shall be proper for any member HMO, in determining its premium rates, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(9) In addition to the assessments set forth in this section, all HMOs having a valid certificate of authority on the effective date of this law shall pay a special assessment.

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of $25,000 no later than November 1, 1988. The department shall not issue a certificate of authority on or after the effective date of this law unless the HMO has paid to the association a special assessment of $25,000.

631.820 Plan of operation.--

(1)(a) The association shall submit to the department a proposed plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The proposed plan of operation and any amendments thereto shall become effective upon approval in writing by the department.

(b) If the association fails to submit a suitable proposed plan of operation by December 31, 1988, or within an extension of time therefor as the department, for good cause, may grant, or if at any time thereafter the association fails to submit suitable amendments to the plan, the department shall, after notice and hearing, adopt such reasonable rules as are necessary to effectuate the provisions of this part. Such rules shall continue in force until modified by the department or superseded by a proposed plan submitted by the association and approved by the department.

(2) All member HMOs shall comply with the approved plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this part:

   (a) Establish procedures for handling the assets of the association.

   (b) Establish the amount and method of reimbursing members of the board of directors.

   (c) Establish regular places and times for meetings of the board of directors.
(d) Establish procedures for keeping records of all financial transactions of the association, its agents, and the board of directors.

(e) Establish procedures whereby selections for the board of directors shall be made and submitted to the department.

(f) Establish any additional procedures for assessments under this part.

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4)(a) The plan of operation may provide that any or all powers and duties of the association, except those under s. 631.818(7)(b) and (c), and s. 631.819, are delegated to an administrator which may be a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent.

(b) The board may select an administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board, which criteria shall include:

1. The administrator's proven ability to manage large group health insurance plans and HMOs.

2. The efficiency of the administrator's claims-paying procedures.

3. An estimate of total charges for administering the plan.

4. Any other reasonable factors as set by the board.

(c) The administrator shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association.
A delegation under this subsection shall take effect only with the approval of both the board of directors and the department and may be made only to an administrator which extends protection not substantially less favorable and effective than that provided by this part.

631.821 Powers and duties of the department.--

(1) The department may suspend or revoke, after notice and hearing, the certificate of authority of a member HMO that fails to pay an assessment when due or fails to comply with the approved plan of operation of the association.

(2) Any action of the board of directors of the association may be appealed to the department by any member HMO if such appeal is taken within 30 days of the action being appealed. Any final action or order of the department shall be subject to judicial review in a court of competent jurisdiction.

(3) The department may:

(a) Require that the association notify the subscriber of the insolvent, impaired, or revoked HMO and any other interested parties of the determination of insolvency, impairment, or revocation and of their rights under this part. Such notification shall be by mail at their last known addresses, when available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(b) Revoke the designation of any servicing facility or administrator if it finds claims are being handled unsatisfactorily.

631.822 Records of association.--Records shall be kept of all negotiations and meetings in which the association or its representatives discuss the activities of the association.

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in carrying out its powers and duties. Records of such
negotiations or meetings shall be made public upon the
termination of a liquidation, rehabilitation, or revocation
proceeding involving the HMO.

631.823 Examination of the association; annual
report.--The association shall be subject to examination and
regulation by the department. The board of directors shall
submit to the department, not later than May 1 of each year, a
financial report for the preceding calendar year in a form
approved by the department and a report of its activities
during the preceding calendar year.

631.824 Tax exemptions.--The association shall be
exempt from payment of all fees and all taxes levied by this
state or any of its subdivisions, except taxes levied on real
property.

631.825 Immunity.--There shall be no liability on the
part of, and no cause of action of any nature shall arise
against, any member HMO or its agents or employees, the
association or its agents or employees, members of the board
of directors, or the department or its representatives, for
any action taken by them in the performance of their powers
and duties under this part.

631.826 Extent of liability of association.--For the
purpose of carrying out its obligations under this part, the
association shall be deemed to be a priority creditor of the
impaired, insolvent, or revoked HMO. Assets of the impaired,
insolvent, or revoked HMO shall be used to continue all
covered policies and pay all contractual obligations of the
impaired, insolvent, or revoked HMO as permitted by this part,
to the extent such assets are available. If an HMO is
rehabilitated, the HMO shall repay to the association, such
funds expended by the association for or on behalf of that
HMO, together with interest at 12 percent per year. Such
repayment terms shall be as reasonably set by the board.

631.827 Health care coverage.--

(1) The primary purpose of the association is the
provision of health care services to eligible enrollees. This
health care may be provided in a reasonable manner, as
determined by the association, which is designed to
efficiently utilize the assets of the association while at the
same time assuring the provision of quality health care
services. The association may issue health insurance
policies, contract for the placement of eligible subscribers,
either temporarily or permanently, with health insurance
companies or health maintenance organizations, issue HMO
contracts and enter into contracts with providers to service
these contracts.

(2) In providing health care coverage, the association
may temporarily or permanently continue in effect the policies
of the subscribers or may offer its own HMO or health
insurance policies which comply with the Florida Insurance
Code, except the association is exempt from the requirements
to obtain a certificate of authority as an insurance company.

(3) Any subscriber receiving health care services
under this part shall be deemed to have assigned their rights
under the covered policy to the association to the extent of
the benefits received, whether the benefits are payments of
contractual obligations or continuation of coverage. The
association may require an assignment to it of such rights by
any policy or contract owner as a condition precedent to the
receipt of any rights or benefits conferred by this part upon
such subscribers. The association shall have subrogation

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rights against the assets of any insolvent HMO. The
subrogation rights of the association under this subsection
shall have the same priority against the assets of the
insolvent HMO as those possessed by the subscribers entitled
to receive benefits under this part.

(4) No preexisting condition exclusions or limitations
shall be contained in the coverage offered by the association
or coverage placed by the association with another entity,
except as specified in the policy issued by the insolvent,
impaired, or revoked HMO.

(5) If the assessment for member HMOs includes federal
Medicare HMO premium revenue, the association is empowered to
offer, or cause to be offered, Medicare supplement policies,
without preexisting conditions, to eligible subscribers, in
appropriate circumstances.

631.828 Prohibited advertisement.—No person,
including an HMO, agent, or affiliate of an HMO, shall make,
publish, disseminate, circulate, or place before the public,
or cause directly or indirectly to be made, published,
disseminated, circulated, or placed before the public, in any
newspaper, magazine, or other publication, or in the form of a
notice, circular, pamphlet, letter, or poster, or over any
radio station or television station, or in any other way, any
advertisement, announcement, or statement which uses the
existence of the Health Maintenance Organization Guaranty
Association of this state for the purpose of solicitation of
subscribers in health maintenance organizations; provided,
however, that this section shall not apply to the Florida

631.829 Assessments against member HMOs' income tax
credit for assessments paid.—Any provisions of the law to the

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contrary notwithstanding, a member HMO may offset against its
corporate income tax liability or other liabilities to the
state, on an individual or consolidated basis, as applicable,
any assessment described in section 631.819 to the extent of
20 percent of the amount of such assessment for each of the 5
calendar years following the year in which the assessment was
paid.

631.830 Rates.--
(1) All health maintenance contracts issued directly
by the association shall be subject to the provisions of s.
641.31.

(2) All health insurance policies issued directly by
the association shall be subject to ss. 627.410 and 627.411,
and parts VI and VII of chapter 627.

Section 2. Subsections (6), (7), (8), (9), (10), and
(11) of section 641.19, Florida Statutes, are amended and
subsection (16) is added to said section, to read:

641.19 Definitions.--As used in this part, the term:
(6) "Health maintenance organization" means any
organization authorized under this part which:
(a) Provides emergency care, inpatient hospital
services, and physician care including care provided by
physicians licensed under chapters 458, 459, 460, and 461,
ambulatory diagnostic treatment, and preventive health care
services and at least two of the other three "minimum
services" defined in subsection (8) to any of the subscribers
of the organization;
(b) Provides, either directly or through arrangements
with other persons, health care services to persons enrolled
with such organization, on a prepaid per capita or prepaid
aggregate fixed-sum basis;

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(c) Provides, either directly or through arrangements with other persons, those health care services which subscribers might reasonably require to maintain good health; and

(d) Provides physician services, by physicians licensed under chapters 458, 459, 460, and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians; and

(e) Provides all services in a managed care system in which a primary care physician is designated for each subscriber and is responsible for coordinating the health care of the subscriber and for referring the subscriber to other providers when necessary.

(7) "Insolvent" or "insolvency" means that all the statutory assets of the health maintenance organization, if made immediately available, would not be sufficient to discharge all of its liabilities or that the health maintenance organization is unable to pay its debts as they become due in the usual course of business. In the event that all the assets of the health maintenance organization, if made immediately available, would not be sufficient to discharge all of its liabilities, but the organization has a written guarantee of the type and subject to the same provisions as outlined in s. 641.225, the organization shall not be considered insolvent unless it is unable to pay its debts as they become due in the usual course of business.

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(8) "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state.

(9) "Statutory accounting principles" means generally accepted accounting principles except as modified by this part.

(10) "Subscriber" or "enrollee" means an individual who has contracted, or on whose behalf a contract has been entered into, with a health maintenance organization for health care services, or other persons who also receive health care services as a result of the contract.

(11) "Surplus" means total statutory assets in excess of total liabilities, except that assets pledged to secure debts not reflected on the books of the health maintenance organization shall not be included in surplus. Surplus includes capital stock, capital in excess of par, other contributed capital, retained earnings, and surplus notes.

(16) "Capitation" means the fixed amount paid by an HMO, to a health care provider under contract with the HMO, in exchange for the rendering of covered medical services.

Section 3. Paragraphs (c), (e), and (g) of subsection (1) of section 641.21, Florida Statutes, are amended, and paragraphs (h) and (i) are added to said subsection to read:

641.21 Application for certificate.--

(1) Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the department. The department shall accept and shall begin its review of an application for a certificate of authority

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anytime after an organization has filed an application for a Health Care Provider Certificate pursuant to part IV of this chapter. However, the department shall not issue a certificate of authority to any applicant which does not possess a valid Health Care Provider Certificate issued by the Department of Health and Rehabilitative Services. Each application for a certificate shall be on such form as the department shall prescribe and shall be accompanied by the following:

(c) A list of the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of the affairs of the health maintenance organization, including all officers, and directors, and owners of in excess of 5 percent of the common stock of the corporation. Such persons shall fully disclose to the department and the directors of the health maintenance organization the extent and nature of any contracts or arrangements between them and the health maintenance organization, including any possible conflicts of interest;

(e) Forms of all health maintenance contracts, certificates, and member handbooks the applicant proposes to offer the subscribers, showing the benefits to which they are entitled, together with a table of the rates charged, or proposed to be charged, for each form of such contract. A certified actuary shall:

1. Certify that the rates are neither inadequate, nor excessive, nor unfairly discriminatory.

2. Certify that the rates are appropriate for the classes of risks for which they have been computed; and
3. File an adequate description of the rating methodology showing that such methodology follows consistent and equitable actuarial principles:

(g) An audited financial statement prepared on the basis of statutory generally-accepted accounting principles and certified by an independent certified public accountant, except that surplus notes acceptable to the department and meeting the requirements of this act shall be included in the calculation of surplus.

(h) Such additional reasonable data, financial statements, and other pertinent information as the department may require with respect to the determination that the applicant can provide the services to be offered.

(i) A comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant. The study shall be for the greater of 3 years or until the HMO has been projected to be profitable for 12 consecutive months. The study must show that the HMO would not, at the end of any month of the projection period, have less than the minimum surplus as required by s. 641.225.

Section 4. Subsection (6) of section 641.22, Florida Statutes, is amended to read:

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

(6) The ownership, control, and 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 the department has good reason
to believe that the ownership, control, or management of the
organization includes 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.

Section 5. Section 641.225 Florida Statutes, is
amended to read:

641.225 Surplus requirements.--
(1) Each health maintenance organization shall at all
times have-and maintain a minimum surplus in an amount which
is the greater of $500,000 or 9 percent of total
liabilities. All HMO's which have a valid certificate of
authority before the effective date of this law and which do
not meet the minimum surplus requirement shall increase their
surplus as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 30, 1989</td>
<td>$200,000 or 6 percent of</td>
</tr>
<tr>
<td></td>
<td>total liabilities, whichever is greater</td>
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<tr>
<td>September 30, 1990</td>
<td>$350,000 or 8 percent of</td>
</tr>
<tr>
<td></td>
<td>total liabilities, whichever is greater</td>
</tr>
<tr>
<td>September 30, 1991</td>
<td>$500,000 or 10 percent of</td>
</tr>
<tr>
<td></td>
<td>total liabilities, whichever</td>
</tr>
</tbody>
</table>

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(2) The department shall not issue a certificate of authority on or after the effective date of this law unless the HMO has a minimum surplus in an amount which is the greater of:

(a) One million five hundred thousand dollars;

(b) Ten percent of their total liabilities based on their start-up actuarial projection as set forth in this part; or

(c) Five hundred thousand dollars plus all start-up losses, excluding profits, projected to be incurred on their start-up actuarial projection until the projection reflects statutory net profits for 12 consecutive months.

The department may adopt rules to set uniform standards and criteria for the early warning that the continued operation of any HMO might be hazardous to its subscribers, creditors, or the general public, and to set standards for evaluating the financial condition of any HMO.

(3) The department shall lower the surplus requirements to any level deemed appropriate by the department, but not less than $100,000 for an individual health maintenance organization, whenever the department is satisfied that:

(a) The organization has an adequate history of generating net income to assure its financial viability for the next year;

(b) The assets of the organization or its contracts with health care providers, governments, or other

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organizations are reasonably sufficient to assure the performance of the organization; and or

(c) The obligations of the organization are structured towards long-term payment so that a lower percentage requirement would prove adequate as a cushion against the payment of such obligations.

(4) In lieu of having any minimum surplus, the health maintenance organization may provide a written guarantee to assure payment of covered subscriber claims and all other liabilities of the HMO, provided that the written guarantee is made by a guaranteeing organization which:

(a) Has been in operation for 5 years or more and has a surplus, not including land, buildings, and equipment, of the greater of $2 million or 2 times the minimum surplus requirements of the health maintenance organization. In any determination of the financial condition of the guaranteeing organization, the definitions of assets, liabilities, and surplus set forth in this part shall apply, except that investments in or loans to any organizations guaranteed by the guaranteeing organization shall be excluded from surplus. 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.

(b) Submits a guarantee that is approved by the department as meeting the requirements of this part, provided that the written guarantee contains a provision which requires that the guarantee be irrevocable unless guaranteeing organization provide at least 6-months' notice to the department prior to cancellation of the guarantee, except that such period of notification may be shortened if the guaranteeing organization can demonstrate to the department...
that the cancellation of the guarantee will not result in the
insolvency of the health maintenance organization and the
department approves cancellation of the guarantee.

(c) Initially submits its audited financial
statements, certified by an independent certified public
accountant, prepared in accordance with generally accepted
accounting principles, covering its two most current annual
accounting periods.

(d) Submits annually, within 3 months after the end of
its fiscal year, an audited financial statement certified by
an independent certified public accountant, prepared in
accordance with generally accepted accounting principles. The
department may, as it deems necessary, require quarterly
financial statements from the guaranteeing organization.

Section 6. Section 641.227, Florida Statutes, is
repealed.

Section 7. Section 641.228, Florida Statutes, is
created to read:

641.228 Florida Health Maintenance Organization
Guaranty Association.--

(1) Upon the effective date of the Florida Health
Maintenance Organization Guaranty Association Act, all assets
and liabilities of the Rehabilitation and Administration Fund
shall be transferred to and become the sole property of the
No further refunds of an HMO's $10,000 deposit shall be
allowed for any HMO possessing a valid HMO certificate of
authority as of the effective date of the Florida Health

(2) The department shall not issue a certificate to
any HMO after the effective date of the Florida Health

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Maintenance Organization Guaranty Association Act until the applicant HMO has paid in full its special assessment as set forth in s. 631.819(9).

(3) No assessment paid to the Florida Health Maintenance Organization Guaranty Association shall be allowed as an asset of any HMO.

(4) The department may suspend or revoke the certificate of authority of any HMO which does not timely pay its assessment to the Florida Health Maintenance Organization Guaranty Association.

Section 8. Section 641.23, Florida Statutes, is amended to read:

641.23 Revocation or cancellation of certificate of authority; suspension of enrollment of new subscribers, terms of suspension.—

(1) The maintenance of a valid and current Health Care Provider Certificate issued pursuant to part IV of this chapter is a condition of the maintenance of a valid and current certificate of authority issued by the department to operate a health maintenance organization. Denial, revocation, or nonrenewal of a Health Care Provider Certificate shall be deemed to be an automatic and immediate cancellation of a health maintenance organization's certificate of authority.

(2) The department may suspend the authority of a health maintenance organization to enroll new subscribers or revoke any certificate issued to a health maintenance organization, or order compliance within 30 days, if it finds that any of the following conditions exists:

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

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

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

d) 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

e) The organization is insolvent.

Whenever the financial condition of the HMO is such that, if not modified or corrected, its continued operation would result in impairment or insolvency, the department may order the HMO to file with the department and implement a corrective action plan designed to do one or more of the following:

a. Reduce the total amount of present potential liability for benefits by reinsurance or other means.

b. Reduce the volume of new business being accepted.

c. Reduce the expenses of the HMO by specified methods.

d. Suspend or limit the writing of new business for a period of time.

e. Require an increase in the HMO's net worth.

If the HMO fails to submit a plan within 30 days of the department's order or submits a plan which is insufficient to correct the HMO's financial condition, the department may order the HMO to implement one or more of the corrective actions listed in this subsection.
The department shall, in its order suspending the authority of a health maintenance organization to enroll new subscribers, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the health maintenance organization prior to reinstatement of its authority to enroll new subscribers. The order of suspension is subject to rescission or modification by further order of the department prior to the expiration of the suspension period. Reinstatement shall not be made unless requested by the health maintenance organization; however, the department shall not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

Section 9. Section 641.234, Florida Statutes, is created to read:

641.234 Administrative, provider, and management contracts.--

(1) The department may require an HMO to submit any contract for administrative services, contract with a provider other than an individual physician, contract for management services, and contract with an affiliated entity, to the department if the department has information and belief that the HMO has entered into a contract which requires it to pay a fee which is unreasonably high in relation to the service provided.

(2) After review of a contract the department may order the HMO to cancel the contract in accordance with the terms of the contract and applicable law, if it determines that the fees to be paid by the HMO under the contract are so unreasonably high, as compared with similar contracts entered into by the HMO or as compared with similar contracts entered...
into by other HMOs in similar circumstances, that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the HMO.

(3) All contracts for administrative services, management services, provider services other than individual physician contracts, and with affiliated entities entered into, or renewed, by an HMO on or after October 1, 1988, shall contain a provision that the contract shall be canceled upon issuance of an order by the department pursuant to this section.

Section 10. Section 641.2342, Florida Statutes, is created to read:

641.2342 Contract providers.--Each HMO shall file, upon the request of the department, financial statements for all contract providers of comprehensive health care services who have assumed, through capitation or other means, more than 10 percent of the health care risks of the HMO. However, this provision shall not apply to any individual physician.

Section 11. Section 641.25, Florida Statutes, is amended to read:

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

Section 12. Section 641.26, Florida Statutes, is amended to read:

641.26 Annual report.--

(1) Every health maintenance organization shall, annually on or before April 1 or within 3 months after the end of its fiscal year reporting period, or within an extension of time therefor as the department, for good cause,

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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 immediately preceding reporting period. Such report shall include:

(a) An audited 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, prepared in accordance with statutory generally-accepted accounting principles;

(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;

(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) 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;

(f) An actuarial certification that:

1. The health maintenance organization is actuarially sound, which certification shall consider the rates, benefits,
and expenses of, and any other funds available for the payment
of obligations of, the organization;

2. The rates being charged or to be charged are
actuarially adequate to the end of the period for which rates
have been guaranteed; and

3. Incurred but not reported claims and claims
reported but not fully paid have been adequately provided for.

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

(2) Every health maintenance organization shall file
quarterly annuity, within 45 days after each of its quarterly
reporting periods period, an unaudited financial statement of
the organization.

(3) Any health maintenance organization which neglects
to file an annual report or quarterly report in the form and
within the time required by this section shall forfeit $1,000
for each day for the first 10 days during which the neglect
continues and shall forfeit $2,000 for each day after the
first 10 days during which the neglect continues; and, upon
notice by the department to that effect, the organization's
authority to enroll new subscribers or 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. The department shall not collect more
than $100,000 for each report.

(4) Each authorized HMO shall retain an independent
certified public accountant, hereinafter called "CPA," who
agrees by written contract with the HMO to comply with the provisions of this part. The contract shall state:

(a) The CPA shall provide to the HMO audited financial statements consistent with this part.

(b) Any determination by the CPA that the HMO does not meet minimum surplus requirements as set forth in this part shall be stated by the CPA, in writing, in the audited financial statement.

(c) The completed workpapers and any written communications between the CPA firm and the HMO relating to the audit of the HMO shall be made available for review on a visual inspection-only basis by the department at the offices of the HMO, at the department, or at any other reasonable place as mutually agreed upon between the department and the HMO. The CPA must retain for review the workpapers and written communications for a period of not less than 6 years.

The department may require that a health maintenance organization submit quarterly financial reports which are necessary to enable the department to determine continued compliance with the provisions of this part.

Section 13. Subsection (1) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department.--

(1) 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. In lieu of making its own financial examination, the department may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with the provisions of this part.
with this part. However, except when the medical records are
requested and copies furnished pursuant to s. 455.241, 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 department 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. In no event shall
expenses of all examinations exceed a maximum of $20,000 for
any 1-year period. 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 14. Sections 641.285 and 641.286, Florida
Statutes, are repealed.

Section 15. Subsection (1) of section 641.29, Florida
Statutes, is amended to read:

641.29 Fees.--Every health maintenance organization
shall pay to the department the following fees:
(1) For filing a copy of its application for a
certificate of authority or amendment thereto, a nonrefundable
fee in the amount of $1,000.

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Section 16. Subsections (3) and (13) of section 2641.31, Florida Statutes, are amended, and subsections (16) and (17) are added to said section, to read:

641.31 Health maintenance contracts.--

(3)(a) If a health maintenance organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to change any rate charged for the contract or to change any basic health maintenance contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form of renewal certificate, it may do so, upon filing with the department the proposed change, amendment, or change in rates. Any proposed change shall be effective immediately, subject to disapproval by the department. Following receipt of notice of such disapproval or withdrawal of approval, no health maintenance organization shall issue or use any form disapproved by the department or as to which the department has withdrawn approval.

(b) The department shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, only if the form:

1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.

2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

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3. Has any title, heading, or other indication of its provisions which is misleading.

4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.

5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.

6. Charges rates that are determined by the department to be inadequate, excessive, or unfairly discriminatory, or the rating methodology followed by the health maintenance organization is determined by the department to be inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding.

(c) It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.

(13) In addition to the requirements of this section, with respect to a person who is entitled to have payments for health care costs made under Medicare, Title XVIII of the Social Security Act ("Medicare"), Parts A and/or B:

(a) The health maintenance contract shall be accompanied by the April 1, 1985 edition of the Health Maintenance Organization-Medicare Contract Information Form, which shall be promulgated as a rule by the department.

(b) Delivery of the information form to such person shall be made prior to or at the time of application for membership in the health maintenance organization. However, if the application for membership is received by the health maintenance organization through the mail and is not a result of direct personal contact between the person and an agent or...
representative-of-the-organization, delivery-of-the
information-form shall be made prior to processing the
application and within 15 days of receipt of the application
by the organization. Acknowledgement of receipt or
certification of delivery or mailing of the information form
shall be maintained by the health maintenance organization
from the date of the most recent examination by the department
pursuant to 42 CFR part 422 until the date of completion of the
following examination:

(a) The health maintenance organization shall mail
or deliver notification to the Medicare beneficiary of the
date of enrollment in the health maintenance organization
within 10 days after receiving notification of enrollment
approval from the United States Department of Health and Human
Services, Health Care Financing Administration. When a
Medicare beneficiary who is a subscriber of the health
maintenance organization requests disenrollment from the
organization, the organization shall mail or deliver to the
beneficiary notice of the effective date of the disenrollment
within 10 days after receipt of the written disenrollment
request. The health maintenance organization shall forward
the disenrollment request to the United States Department of
Health and Human Services, Health Care Financing
Administration, in a timely manner so as to effectuate the
next available disenrollment date, as prescribed by such
federal agency.

(b) The health maintenance contract, certificate,
or member handbook shall be delivered to the subscriber no
later than the earlier of 10 working days after the health
maintenance organization and the Health Care Financing
Administration of the United States Department of Health and

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Human Services approve the subscriber's enrollment application or the effective date of coverage of the subscriber under the health maintenance contract. However, if notice from the Health Care Financing Administration of its approval of the subscriber's enrollment application is received by the health maintenance organization after the effective coverage date prescribed by the Health Care Financing Administration, the health maintenance organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving such notice. When a Medicare recipient is enrolled in a health maintenance organization program, the contract, certificate, or member handbook shall be accompanied by a health maintenance organization identification sticker with instruction to the Medicare beneficiary to place the sticker on the Medicare identification card.

(16) The contract must clearly disclose the intent of the HMO as to the applicability or nonapplicability of coverage to preexisting conditions. If coverage of the contract is not to be applicable to preexisting conditions, the contract shall specify, in substance, that coverage pertains solely to accidental bodily injuries resulting from accidents occurring after the effective date of coverage and that sicknesses are limited to those which first manifest themselves subsequent to the effective date of coverage.

(17) All health maintenance contracts which provide coverage for a member of the family of the subscriber, shall, as to such family member's coverage, provide that coverage, benefits, or services applicable for children shall be provided with respect to an adopted child of the subscriber, which child is placed in compliance with chapter 63, from the moment of placement with the subscriber. In the case of a

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newborn child, coverage shall begin from the moment of birth
if a written agreement to adopt such child has been entered
into by the subscriber prior to the birth of the child,
whether or not such agreement is enforceable; provided,
however, that coverage for such child shall not be required in
the event that the child is not ultimately placed with the
subscriber in compliance with chapter 63.

Section 17. Paragraph (a) of subsection (1) of section
641.311, Florida Statutes, is amended to read:

641.311 Statewide Subscriber Assistance Program.--The
department shall adopt and implement a program to provide
assistance to subscribers, including those whose grievances
are not satisfactorily resolved by the health maintenance
organization. The program shall include the following:

(1)(a) A review panel which may periodically review,
consider, and recommend to the department any actions the
department should take concerning individual cases heard by
the panel as well as the types of subscriber grievances which
have not been satisfactorily resolved after the subscribers
follow the full grievance procedures of the health maintenance
organizations. The proceedings of the grievance panel shall
not be subject to the provisions of chapter 120. The review
panel shall consist of members employed by the department and
members employed by the Department of Health and
Rehabilitative Services, chosen by their respective agencies.
Outside qualified, impartial consultants may be consulted in
connection with the types of grievances outside the expertise
of the review panel.

Section 18. Section 641.3111, Florida Statutes, is
created to read:

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641.311 Extension of benefits.—Every health maintenance contract shall provide that termination of the contract by the health maintenance organization shall be without prejudice to any continuous loss which commenced while the contract was in force, but any extension of benefits beyond the period the contract was in force may be predicated upon the continuous total disability of the subscriber, and may be limited to the duration of the contract benefit period if greater than 3 months, or for a time period of not less than 3 months, or to the payment of the maximum benefits payable under the contract.

Section 19. Section 641.315, Florida Statutes, is amended to read:

641.315 Provider contracts.—

(1) 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 a subscriber, the health maintenance organization shall be liable for such fee or fees rather than the subscriber; and the contract shall so state.

(2) For all provider contracts executed after the effective date of this law and within 180 days after the effective date of this law for contracts in existence as of the effective date of this law:

(a) The contracts shall provide that the provider shall provide 60 days' advance written notice to the HMO and the department before canceling the contract with the HMO for any reason; and

(b) The contract must also provide that nonpayment for goods or services rendered by the provider to the HMO shall

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not be a valid reason for avoiding the 60-day advance notice of cancellation.

(3) Upon receipt by the HMO of a 60-day cancellation notice, the HMO may, if requested by the provider, terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent.

Upon receipt by the HMO of a 60-day cancellation notice, the HMO may, if requested by the provider, terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent.

Section 20. Subsections (1), (2), (5), (9), (10), (11), (12), and (17) of section 641.35, Florida Statutes, are amended to read:

641.35 Assets, liabilities, and investments.--

(1) ASSETS.--In any determination of the financial condition of a health maintenance organization, there shall be allowed as "assets" only those assets that are owned by the health maintenance organization and which assets consist of:

(a) Cash in the possession of the health maintenance organization, or in transit under its control, including the true balance of any deposit in a solvent bank, savings and loan association, or trust company which is domiciled in the United States.

(b) Investments, securities, properties, and loans acquired or held in accordance with this part, and in connection therewith the following items:

1. Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.

2. Declared and unpaid dividends on stock and shares, unless the amount of the dividends has otherwise been allowed as an asset.

3. Interest due or accrued upon a collateral loan which is not in default in an amount not to exceed 1 year's interest thereon.

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4. Interest due or accrued on deposits or certificates of deposit in solvent banks, savings and loan associations, and trust companies domiciled in the United States, and interest due or accrued on other assets, if such interest is in the judgment of the department a collectible asset.

5. Interest due or accrued on current mortgage loans, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal; but in no event shall interest accrued for a period in excess of 90 days be allowed as an asset.

6. Rent due or accrued on real property if such rent is not in arrears for more than 3 months. However, in no event shall rent accrued for a period in excess of 90 days be allowed as an asset.

7. The unaccrued portion of taxes paid prior to the due date on real property.

(c) Premiums in the course of collection, not more than 3 months past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by any governmental body in the United States or by any of their instrumentalities.

(d) The full amount of reinsurance recoverable from a solvent reinsurer, which reinsurance is authorized under s. 624.610.

(e) Furniture, fixtures, furnishings, vehicles, medical libraries, and equipment, if the original cost of each item is at least $200, which cost shall be amortized in full over a period not to exceed 5 calendar years, unless otherwise approved by the department.

(f) Pharmaceutical and medical supply inventories.
(g) The liquidation value of prepaid expenses.

(h) Other assets, not inconsistent with the provisions of this section, deemed by the department to be available for the payment of losses and claims, at values to be determined by it.

The department, upon determining that a health maintenance organization’s asset has not been evaluated according to applicable law or that it does not qualify as an asset, shall require the health maintenance organization to properly reevaluate the asset or replace the asset with an asset suitable to the department within 30 90 days of receipt of written notification by the department of this determination, if the removal of the asset from the organization’s assets would impair the organization’s solvency.

(2) ASSETS NOT ALLOWED.--In addition to assets impliedly excluded by the provisions of subsection (1), the following assets expressly shall not be allowed as assets in any determination of the financial condition of a health maintenance organization:

(a) Goodwill, subscriber lists, patents, trade names, agreements not to compete, and other like intangible assets.

(b) Advances to officers, directors, entities, whether an advance or investment, which are directly or indirectly controlled by the HMO parent or affiliated with the parent or the HMO, except as allowed in subsections (11) and (12) or and controlling stockholders, whether secured or not, and advances to employees, agents, or and other persons on personal security only.

(c) Stock of the health maintenance organization owned by it directly or owned by it through any entity in which the

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organization owns or controls, directly or indirectly, more than 25 percent of the ownership interest.

(d) Leasehold improvements, nonmedical libraries, stationery, literature, and nonmedical supply inventories, except that leasehold improvements made prior to October 1, 1985, shall be allowed as an asset and shall be amortized over the shortest of the following periods:

1. The life of the lease.
2. The useful life of the improvements.
3. The 3-year period following October 1, 1985.

(e) Furniture, fixtures, furnishings, vehicles, medical libraries, and equipment, other than those items authorized under paragraph (1)(e).

(f) Notes or other evidences of indebtedness which are secured by mortgages or deeds of trust which are in default and beyond the express period specified in the instrument for curing the default.

(g) Bonds in default for more than 60 days.

(h) Deferred costs other than the liquidation value of prepaid expenses.

(5) ELIGIBLE INVESTMENTS.--

(a) Health maintenance organizations shall invest in or lend their funds on the security of, and shall hold as invested assets, only eligible investments as prescribed in this part.

(b) Any particular investment held by a health maintenance organization on October 1, 1985, which was a legal investment at the time it was made and which the organization was legally entitled to possess immediately prior to October 1, 1985, shall be deemed to be an eligible investment.

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(c) The eligibility of an investment shall be determined as of the date of its making or acquisition, except as stated in paragraph (b).

(d) Any investment limitation based upon the amount of the organization's assets or particular funds shall relate to such assets or funds as shown by the organization's annual or quarterly report as of the end of the reporting period immediately preceding the date of acquisition of the investment by the organization or as shown by a current financial statement of the organization.

(9) SURPLUS AND DEPOSIT RESTRICTIONS.--Every health maintenance organization must maintain an amount equal to its required minimum surplus as well as any deposit made with the department in coin or currency of the United States on hand or on deposit in any solvent national or state bank, savings and loan association, or trust company or in eligible securities or obligations as follows:

(a) Nondemand obligations of certain financial institutions.--Direct, unconditional nondemand obligations for the payment of money issued by a solvent bank or by a mutual savings bank or trust company, savings and loan, building and loan, or credit union, subject to the following:

1. The financial institution is solvent.
2. The financial institution is incorporated under the laws of the United States or of any state thereof.
3. The obligations are of the type which are insured by an agency of the United States.
4. The investment is in the name of and owned by the health maintenance organization, unless the account is under a trusteeship with the organization named as the beneficiary.
(b) Obligations of the United States.--Direct obligations of the United States for the payment of money or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by the United States.

(c) Obligations of agencies and instrumentalities of the United States.--Direct obligations for the payment of money issued by an agency or instrumentality of the United States or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by an agency or instrumentality of the United States.

(d) Obligations of a state.--Direct, general obligations of any state of the United States for the payment of money, or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by full faith and credit of any state of the United States, on the following conditions:

1. The state has the power to levy taxes for the prompt payment of the principal and interest of such obligations.

2. The state is not in default in the payment of principal or interest on any of its direct, guaranteed, or insured general obligations at the date of such investment.

(e) Obligations of political subdivisions of a state.--Direct, general obligations of any political subdivision of any state of the United States for the payment of money, or obligations for the payment of money to the extent guaranteed as to the payment of principal and interest by any political subdivision of any state of the United States, on the following conditions:

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1. The obligations are payable or guaranteed from ad
valorem taxes.

2. The political subdivision is not in default in the
payment of principal or interest on any of its direct or
guaranteed obligations.

3. No investment shall be made under this paragraph in
obligations which are secured only by special assessments for
local improvements.

(10) PROPERTY USED IN THE HEALTH MAINTENANCE
ORGANIZATION'S BUSINESS.--Real estate, including leasehold
estates, for the convenient accommodation of the
organization's business operations, including home office,
branch administrative offices, hospitals, medical clinics,
medical professional buildings, and any other facility to be
used in the provision of health care services, or real estate
for rental to any health care provider under contract with the
organization to provide health care services which shall be
used in the provision of health care services to members of
the organization by that provider, on the following
conditions:

(a) Any parcel of real estate acquired under this
subsection may include excess space for rent to others if it
is reasonably anticipated that the excess will be required by
the health maintenance organization for expansion or if the
excess is reasonably required in order to have one or more
buildings that will function as an economic unit.

(b) The real estate may be subject to a mortgage.

(c) The greater of the admitted value of the asset, as
determined by statutory generally-accepted accounting
principles, or, if approved by the department, the health
maintenance organization's equity in the real estate plus all

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1 encumbrances on the real estate owned by the organization
2 under this subsection, when added to the value of all personal
3 and mixed property used in the organization’s business, shall
4 not exceed 75 percent of its admitted assets unless, with the
5 permission of the department, it finds that the percentage of
6 its admitted assets is insufficient to provide convenient
7 accommodation for the organization’s business and the
8 operations of the organization would not otherwise be
9 impaired.
10
11 (11) INVESTMENTS IN ADMINISTRATIVE AND MANAGEMENT
12 SERVICE ENTITIES AND OTHER HEALTH CARE PROVIDERS.—A health
13 maintenance organization may invest directly or indirectly in
14 real estate, common and preferred stocks, bonds or debentures,
15 including convertible debentures, or other evidences of debts
16 of or equity in an entity if the entity is owned by or, with
17 the approval of the department, under contract to the
18 organization to provide management services, administrative
19 services, or health care services for the organization, on the
20 following conditions:
21
22 (a) Investments authorized under this subsection shall
23 not exceed 50 percent of admitted assets, and these
24 investments shall be included in the calculation of the
25 overall limitation in paragraph (10)(c) relating to all real
26 and personal property.
27
28 (b) Investments may qualify under this section only
29 insofar as a provider of management, administrative, or health
30 care service relationship as defined herein exists. Upon
31 cessation of such relationship, each investment shall be
32 subject to the rules applicable to an investment of that type
33 and must qualify under the appropriate limitation or, failing
34
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that, become ineligible and subject to disposal under
subsection (17).

(12) EXCHANGES OF FACILITIES OR ASSETS.—Health care
or administrative service entities, if subsidiaries of or
under contract to the health maintenance organization to
provide administrative or health care services to the
organization's members, may exchange facilities or similar
assets to be used in the organization's business for stock of
the organization. However, any exchange involving an entity
under contract with the HMO must have the approval of the
department prior to the exchange. These facilities or assets
shall be valued in accordance with statutory generally
accepted accounting principles.

(17) TIME LIMIT FOR DISPOSAL OF INELIGIBLE PROPERTY
AND SECURITIES; EFFECT OF FAILURE TO DISPOSE.—
(a) Any property or securities lawfully acquired by a
health maintenance organization which it could not otherwise
have invested in or loaned its funds upon at the time of such
acquisition shall be disposed of within 6 months from the date
of acquisition, unless within such period the security has
attained to the standard of eligibility; except that any
security or property acquired under any agreement of merger or
consolidation may be retained for a longer period if so
provided in the plan for such merger or consolidation, as
approved by the department. Upon application by the
organization and proof to the department that forced sale of
any such property or security would materially injure the
interests of the health maintenance organization, the
department shall extend the disposal period for an additional
reasonable time.
(b) Notwithstanding the provisions of paragraph (a), any ineligible Any property or securities lawfully-acquired and-held-by-the-organization-after-expiration-of-the-period for-disposal-thereof-or-any-extension-of-such-period-granted by-the-department shall not be allowed as an asset of the organization.

Section 21. Section 641.365, Florida Statutes, is created to read:

641.365 Dividends.--

(1) An HMO shall not pay any dividend or distribute cash or other property to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and net realized capital gains. Dividend payments or distributions to stockholders shall not exceed 10 percent of such surplus in any one year unless otherwise approved by the department. In addition to such limited payments, an HMO may make dividend payments or distributions out of the HMO's entire net operating profits and realized net capital gains derived during the immediately preceding calendar or fiscal year, as applicable.

(2) The department shall not approve a dividend or distribution in excess of the maximum amount allowed in subsection (1) unless it determines that the distribution or dividend would not jeopardize the financial condition of the HMO.

(3) Any director of an HMO who knowingly votes for or concurs in declaration or payment of a dividend to stockholders when such declaration is in violation of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, and shall

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be jointly and severally liable, together with other such directors likewise voting for or concurring, for any loss thereby sustained by creditors of the HMO to the extent of such dividend.

(4) Any stockholder receiving such an illegal dividend shall be liable in the amount thereof to the HMO.

(5) The department may revoke or suspend the certificate of authority of an HMO which has declared or paid such an illegal dividend.

Section 22. Subsection (1) of section 641.3913, Florida Statutes, is amended to read:

641.3913 Penalty for violation of cease and desist orders.—Any person, entity, or health maintenance organization which violates a cease and desist order of the department under s. 641.3909 while such order is in effect, after notice and hearing as provided in s. 641.3907, shall be subject, at the discretion of the department, to any one or more of the following:

(1) A monetary penalty of not more than $200,000 as to all matters determined in such hearing.

Section 23. Subsection (7) is added to section 641.3921, Florida Statutes, to read:

641.3921 Conversion on termination of eligibility.—A group health maintenance contract delivered or issued for delivery in this state by a health maintenance organization shall provide that a subscriber or covered dependent whose coverage under the group health maintenance contract has been terminated for any reason, including discontinuance of the group health maintenance contract in its entirety or with respect to a covered class, and who has been continuously covered under the group health maintenance contract, and under

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any group health maintenance contract providing similar
benefits which it replaces, for at least 3 months immediately
prior to termination, shall be entitled to have issued to him
by the health maintenance organization a health maintenance
contract, hereafter referred to as a "converted contract." A
subscriber or covered dependent shall not be entitled to have
a converted contract issued to him if termination of his
coverage under the group health maintenance contract occurred
for any of the following reasons

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

Section 24. This act shall take effect October 1, 1981.

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SENATE SUMMARY

Creates the Florida Health Maintenance Organization
Guaranty Act to provide benefits for the subscribers and
enrollees of health maintenance organizations which fail
because of impairment, insolvency, or the revocation of
their certificate of authority. (See bill for details.)
A bill to be entitled
An act relating to health care services;
creating part IV of chapter 631, F.S.,
consisting of ss. 631.811-631.830, F.S.;
relating to health maintenance organizations
 guaranty of health care services; creating the
Florida Health Maintenance Organization
Guaranty Association Act; providing for the
purpose and application of the part; providing
definitions; providing for a Florida Health
Maintenance Organization Guaranty Association;
providing for a board of directors; providing for
eligibility requirements; providing for
powers and duties of the association; providing for
assessments; providing for a plan of
operation; providing for powers and duties of
the Department of Insurance; providing for
records of the association; providing for
examination of the association and annual
report; providing for tax exemptions; providing
for immunity; providing for extent of liability
of association; providing for health care
coverage; providing for prohibitions on
advertisements; providing for assessments
against income tax credits; providing for
rates; revising the Health Maintenance
Organization Act; amending s. 641.19, F.S.;
providing definitions; amending s. 641.21,
F.S.; providing additional criteria for
application for certificate; amending s.
641.22, F.S.; revising language with respect to

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issuance of certificate of authority; amending s. 641.225, F.S.; increasing the amount of surplus requirement; repealing s. 641.227, F.S.; relating to the Rehabilitation Administrative Expense Fund; creating s. 641.228, F.S.; creating the Florida Health Maintenance Organization Guaranty Association; amending s. 641.23, F.S.; reducing the time frame for the department to suspend the authority of an HMO to enroll new subscribers or revoke any certificate; providing for a corrective action plan for certain HMO's; creating s. 641.234, F.S.; providing for administrative, provider, and management contracts; creating s. 641.2342, F.S.; providing for contract providers of comprehensive health care services to file financial statements; amending s. 641.25, F.S.; increasing administrative penalties; amending s. 641.26, F.S.; revising language with respect to the required annual report; amending s. 641.27, F.S.; authorizing the department to accept an independent certified public accountant's audit report; repealing s. 641.285, F.S.; relating to insolvency protection; repealing s. 641.286, F.S.; relating to levies upon assets or securities held by the state; amending s. 641.29, F.S.; increasing fees; amending s. 641.31, F.S.; revising language with respect to health maintenance contracts; amending s. 641.311.
F.S.; clarifying language with respect to the
Statewide Subscriber Assistance Program;
creating s. 641.3111, F.S.; providing for
extension of benefits; amending s. 641.315,
F.S.; providing additional criteria for
provider contracts; amending s. 641.35, F.S.;
revising language with respect to assets,
liabilities, and assessments; creating s.
641.365, F.S.; providing for dividends;
amending s. 641.3913, F.S.; increasing a
monetary penalty; amending s. 641.3921, F.S.;
providing an additional criteria for denial of
a converted contract; providing for review and
repeal; providing an effective date.

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

Section 1. Part IV of chapter 631, Florida Statutes,
consisting of sections 631.811, 631.812, 631.813, 631.814,
631.829, and 631.830, is created to read:

PART IV

HEALTH MAINTENANCE ORGANIZATION

GUARANTY OF HEALTH CARE SERVICES

631.811 Short title.--This part may be cited as the
"Florida Health Maintenance Organization Guaranty Association Act."

631.812 Purpose; construction.--The purpose of this
part is to protect the subscribers of HMOs, subject to certain
limitations, against the failure of the HMO to perform its

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contractual obligations due to its impairment, insolvency, or revocation of its certificate of authority. This part shall be liberally interpreted to carry out its purpose.

631.813 Application of part.--This part shall apply to HMO contractual obligations to residents of Florida by HMOs possessing a valid certificate of authority issued by the Florida Department of Insurance as provided by part II of chapter 641. The provisions of this part shall not apply to medical assistance programs created pursuant to s. 409.266.

631.814 Definitions.--As used in this part:

(1) "Association" means the Florida Health Maintenance Organization Guaranty Association created by this part.

(2) "Board" means the board of directors of the association.

(3) "Contractual obligations" means any obligation arising out of a covered policy.

(4) "Covered policy" means any policy, contract, or evidence of coverage issued under chapter 641 by an HMO to a group or individual and which is in force at such time as a member HMO becomes impaired, insolvent, or has its license revoked after the effective date of this act.

(5) "Date of insolvency" means the date a court of competent jurisdiction initially issues its order placing the department as the receiver of the HMO.

(6) "Department" means the Florida Department of Insurance.

(7) "Health care services" means services, medical equipment, and supplies furnished by a provider, which may include, but which are not limited to, medical, surgical, and dental care; psychological, optometric, optic, chiropractic, podiatric, nursing, physical therapy, and pharmaceutical...
services; health education, preventive medical, rehabilitative, and home health services; inpatient and outpatient hospital services; extended care; nursing home care; convalescent institutional care; laboratory and ambulance services; appliances, drugs, medicines, and supplies; and any other care, service, or treatment of disease, correction of defects, or maintenance of the physical and mental well-being of human beings.

(8) "HMO" means a health maintenance organization possessing a valid certificate of authority issued by the department pursuant to part II of chapter 641.

(9) "Indirect obligations" means any liability of the HMO which was incurred to indirectly provide health care services such as occupancy expenses, physician salaries, and similar expenses.

(10) "Impaired HMO" means that the HMO is not insolvent, but its surplus does not comply with the requirements of part II of chapter 641.

(11) "Insolvent HMO" means an HMO against which an order of rehabilitation or liquidation has been entered by a court of competent jurisdiction, with the department appointed as receiver, even if such order has not become final by the exhaustion of appellate reviews.

(12) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(13) "Provider contractual obligations" means any liability to health care providers which was directly incurred by the HMO to provide health care services for a subscriber when the HMO has a contract with the provider which specifically provides that the provider may not hold the subscriber liable for payment of the services.

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(14) "Subscriber" or "enrollee" means any resident of this state who is enrolled for benefits provided by an HMO and who makes premium payments or for whom premium payments are made.

(15) "Affiliated provider" means a person who provides health care services to an HMO, which exercises control over or is controlled by the HMO, directly or indirectly through:

(a) Equity ownership of voting securities;

(b) Common managerial control; or

(c) Collusive participation by the management of the HMO and affiliate in the management of the HMO or the affiliate.

631.815 Florida Health Maintenance Organization Guaranty Association.—There is created a nonprofit legal entity to be known as the Florida Health Maintenance Organization Guaranty Association. All HMOs shall be and must remain members of the association as a condition of their authority to transact business in this state as an HMO. The association shall perform its functions under the plan of operations established and approved under the provisions of this part and shall exercise its powers through a board of directors established under the provisions of this part. The association shall come under the immediate supervision of the department and shall be subject to the applicable laws of this state except it shall be excluded from the requirements of possessing a certificate of authority or a health care provider certificate as set forth in parts II and IV of chapter 641, respectively.

631.816 Board of directors.—

(1) The board of directors of the association shall consist of not less than five or more than nine persons.
serving terms as established in the plan of operation. The
department shall approve and appoint to the board persons
recommended by the member HMOs. In the event the department
finds that any recommended person does not meet the
qualifications for service on the board, the department shall
request the member HMOs to recommend another person. Each
member shall serve for a 4-year term and may be reappointed.
Vacancies on the board shall be filled for the remaining
period of the term in the same manner as initial appointments.
If no members are selected by October 31, 1988, the department
may appoint the initial members of the board of directors. To
select the initial board of directors and initially organize
the association, the commissioner shall give notice to all
HMOs of the time and place of the organizational meeting. In
determining voting rights at the organizational meeting, each
HMO is entitled to one vote in person or in proxy.

(2) In appointing members to the board, the department
shall consider, among other things, whether all member HMOs
are fairly represented.

(3) Members of the board may be reimbursed from the
assets of the association for their services.

(4) The board of directors shall elect one of its
members as chairman.

(5) The board shall establish procedures under which
enrollees in the association may have grievances reviewed by
an impartial body and reported to the board.

(6) The board may contract with an administrator to
carry out the provisions of this part; however, this shall not
relieve the board of its duties and obligations under this
part.

631.817 Eligibility.
(1) Except as provided in subsection (2), any resident of this state who has lost or may lose their health care services provided by an HMO due to impairment, insolvency, or the revocation of the HMO's certificate of authority shall be eligible for coverage by the association. Eligible persons include all persons who were eligible to receive health care services under that subscriber's contract with the HMO.

(2)(a) No person who is covered by the association and terminates the coverage shall again be eligible for coverage unless that person is a subscriber of a different HMO which subsequently, due to impairment, insolvency, or revocation, becomes subject to this part.

(b) A person shall cease to be covered by the association after the association has paid out $300,000 in covered benefits for that person.

(c) A person shall cease to be covered by the association upon failure to pay, or have paid on their behalf, premiums as set by the board. Coverage shall cease following a reasonable time period as set by the board.

(d) A person shall cease to be covered by the association when receiving comprehensive health care services through an HMO, or are covered by an insurer or self-insurer.

631.818 Powers and duties of the association.--

(1) If an HMO is impaired, the association may, subject to any conditions imposed by the association other than those which impair the contractual obligations of the impaired HMO, and subject to the approval of the impaired HMO and the department:

(a) Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired HMO.
(b) Provide such moneys, pledges, notes, guarantees, or other means as are proper to effectuate paragraph (a) and assure payment of the contractual obligations of the impaired HMO pending action under paragraph (a).

(c) Loan money to the impaired HMO.

(2) If an HMO is insolvent or its certificate of authority has been revoked, the association shall, upon instructions from the department:

(a) Guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies of the insolvent HMO.

(b) Assume payment of the obligations of the HMO as follows:

1. All unaffiliated provider obligations, including contractual provider holdbacks.

2. Such indirect obligations as, in the judgment of the association, are necessary to be paid so that health care services can be provided until the association may make other arrangements for the health care of the enrollees.

(c) Provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge the association's duties.

(d) Provide for the continuance of health care services of the subscribers as set forth elsewhere in this part.

(3) The association shall not pay affiliated provider obligations or any other obligation of the insolvent or revoked HMO not provided for in subsection (2).

(4) If the association fails to act within a reasonable period of time as provided in subsections (1) and

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1. The department shall have the powers and duties of the
association under this part.

(5) The association may render assistance and advice
to the department, at the department's request, concerning
rehabilitation, payment of claims, continuance of coverage, or
the performance of other contractual obligations of any
impaired, insolvent, or revoked HMO.

(6) The association shall have standing to appear
before any court in this state which has jurisdiction over an
impaired, insolvent, or revoked HMO to which the association
is or may become obligated under this part. Such standing
shall extend to all matters germane to the powers and duties
of the association, including, but not limited to, proposals
for reinsuring or guaranteeing the covered policies of the
impaired, insolvent, or revoked HMO and the determination of
the covered policies and contractual obligations.

(7) The association shall pay, as instructed by the
department, all costs, both direct and indirect, incurred by
the department in connection with the liquidation,
rehabilitation, or revocation, for reasons of insolvency, of
an HMO.

(8) The association may:
(a) Enter into such contracts as are necessary and
proper to carry out the provisions and purposes of this part.
(b) Sue or be sued, including the taking of any legal
actions necessary or proper for the recovery of any unpaid
assessments under this part.
(c) Borrow money to effect the purposes of this part.

Any notes or other evidence of indebtedness of the association
not in default shall be legal investments for domestic
insurers or HMOs and may be carried as admitted assets.
(d) Employ or retain such persons as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this part.

(e) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association.

(f) Take such legal action as may be necessary to avoid payment of improper claims.

(g) Exercise, for the purposes of this part and to the extent approved by the department, the powers of a health insurer or HMO, but in no case may the association issue policies or contracts other than those issued to satisfy the contractual obligations of the impaired, revoked, or insolvent HMO.

(9) The association's liability for the contractual obligations of the insolvent, impaired, or revoked HMO shall be no greater than the contractual obligations of the HMO in the absence of the insolvency, impairment, or revocation.

(10) In issuing or causing to be issued replacement coverage for the subscriber, the association may reasonably increase or decrease the health care services coverage for which the association is obligated as compared to the coverage previously provided by the HMO.

631.819 Assessments.--

(1) There shall be two classes of assessments made by the board of directors, each of which shall be maintained in a separate fund:

(a) Class A assessments, which shall be for the purpose of carrying out the powers and duties of the Guaranty

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Fund as they relate to non-Medicare and non-Medicaid subscribers for the member HMOs.

(b) Class B assessments, which shall be for the purpose of carrying out the powers and duties of the Guaranty Fund as they relate to Medicare subscribers of the member HMOs.

(c) Allocation of expenses to the two classes of funds under this subsection shall be based on the actual expenses of each class of membership and an allocation of all other expenses on a basis, as set by the board of directors, which is fair and has a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(2) Assessments for Medicare subscribers shall be collected only from the Health Care Financing Administration and shall be based on the Florida earned premium revenue for each year for all Medicare premium revenue.

(a) The Health Care Financing Administration shall have until January 1, 1989, to notify the Department of Insurance if it desires to have its Medicare subscribers covered by the association and receive the benefits of the association. Such notification shall obligate the Health Care Financing Administration to pay the Medicare portion of all assessments of the association. If the Health Care Financing Administration fails to notify the association of its intention to participate in the association, or notifies the department that it does not desire to join the association, then Medicare subscribers of Florida HMOs shall not be eligible to participate in or receive the benefits of the association.

(b) If the Health Care Financing Administration declines to participate in the association, the assessments...
shall apply to all Florida earned premiums for non-Medicare and non-Medicaid revenue only.

(3) Assessments shall be collected as follows:

(a) The board shall annually collect assessments from each HMO, not to exceed 1 percent of each HMO's total Florida earned premium revenue for Class A premiums each year, until the unencumbered fund balance of the association shall equal 5 percent of the total Florida earned premium revenue for Class A premiums for all HMOs in Florida for the prior calendar year. Assessments shall cease when the association's unencumbered Class A fund balance equals 5 percent of the total earned Florida premium revenue for Class A premiums for the prior year. The assessment shall be collected only on premiums written for Florida residents.

(b) The board shall annually collect assessments from the Health Care Financing Administration, not to exceed 1 percent of each HMO's total Florida earned premium revenue for Class B premiums each year, until the unencumbered fund balance of the association shall equal 5 percent of the total Florida earned premium revenue for Class B premiums for all HMOs for the prior calendar year. Assessments shall cease when the association's unencumbered class fund balance equals 5 percent of the total earned Florida premium revenue for Class B premiums for the prior year. The assessment shall be collected only on premiums written for Florida subscribers.

(c) By January 1 of each year, following the effective date of this act, the department shall notify the association of the estimated Florida earned premium, by class of revenue, for that calendar year. The prior year end unencumbered fund balance, by class, shall then be calculated as a percent of the estimated Florida earned premium revenue by class.

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(d) Based on the amounts provided in paragraph (c), by January 31, the association shall establish and notify each HMO and the Health Care Financing Administration of the assessment rate for that year, not to exceed 1 percent of each HMO's total earned premium for Class A and B premiums respectively.

(e) The association shall render each HMO and the Health Care Financing Administration an assessment notice by January 31 of the following year. Assessments, if any, are due and payable by July 1 of that year for the prior-year assessment.

(f) Assessments shall again commence when the association's unencumbered fund balance declines to less than 4 percent of the total Florida earned premium revenue for Class A or B premiums respectively for the prior calendar year.

(5) The association may waive assessments for any year if the amount to be assessed for any class would be less than $25,000 in total for all Florida HMOs.

(6) In addition to the assessment provided for in subsections (2) and (3), the association shall collect an initial assessment from all HMOs and from the Health Care Financing Administration of 1 percent of each HMO's total earned Florida premium for Class A and B premiums respectively for the period July 1 through December 31, 1988. This will be due and payable no later than July 1, 1989.

(7) The association may temporarily defer in whole or in part the assessment of a member HMO if, in the opinion of the board, payment of the assessment would endanger the ability of the HMO to fulfill its contractual obligations.

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(8) It shall be proper for any member HMO, in determining its premium rates, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(9) In addition to the assessments set forth in this section, all HMOs having a valid certificate of authority on the effective date of this act shall pay a special assessment of $25,000 no later than November 1, 1988. The department shall not issue a certificate of authority on or after the effective date of this act unless the HMO has paid to the association a special assessment of $25,000.

631.820 Plan of operation.--

(1)(a) The association shall submit to the department a proposed plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The proposed plan of operation and any amendments thereto shall become effective upon approval in writing by the department.

(b) If the association fails to submit a suitable proposed plan of operation by December 31, 1988, or within an extension of time therefor as the department, for good cause, may grant, or if at any time thereafter the association fails to submit suitable amendments to the plan, the department shall, after notice and hearing, adopt such reasonable rules as are necessary to effectuate the provisions of this part. Such rules shall continue in force until modified by the department or superseded by a proposed plan submitted by the association and approved by the department.

(2) All member HMOs shall comply with the approved plan of operation.

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The plan of operation shall, in addition to requirements enumerated elsewhere in this part:

(a) Establish procedures for handling the assets of the association.

(b) Establish the amount and method of reimbursing members of the board of directors.

(c) Establish regular places and times for meetings of the board of directors.

(d) Establish procedures for keeping records of all financial transactions of the association, its agents, and the board of directors.

(e) Establish procedures whereby selections for the board of directors shall be made and submitted to the department.

(f) Establish any additional procedures for assessments under this part.

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(a) The plan of operation may provide that any or all powers and duties of the association, except those enumerated under s. 631.818(8)(b) and (c) and s. 631.819, are delegated to an administrator, which may be a corporation, association, or other organization which performs or will perform functions similar to those of this association or its equivalent.

(b) The board may select an administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board, which criteria shall include:

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1. The administrator's proven ability to manage large
   group health insurance plans and HMOs.
2. The efficiency of the administrator's claims-paying
   procedures.
3. An estimate of total charges for administering the
   plan.
4. Any other reasonable factors as set by the board.
   (c) The administrator shall be reimbursed for any
   payments made on behalf of the association and shall be paid
   for its performance of any function of the association.
   (d) A delegation under this subsection shall take
   effect only with the approval of both the board of directors
   and the department and may be made only to an administrator
   which extends protection not substantially less favorable and
   effective than that provided by this part.
631.821 Powers and duties of the department.--
(1) The department may suspend or revoke, after notice
and hearing, the certificate of authority of a member HMO that
fails to pay an assessment when due or fails to comply with
the approved plan of operation of the association.
(2) Any action of the board of directors of the
association may be appealed to the department by any member
HMO if such appeal is taken within 30 days of the action being
appealed. Any final action or order of the department shall
be subject to judicial review in a court of competent
jurisdiction.
(3) The department may:
   (a) Require that the association notify the subscriber
   of the insolvent, impaired, or revoked HMO and any other
   interested parties of the determination of insolvency,
   impairment, or revocation and of their rights under this part.

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Such notification shall be by mail at their last known addresses, when available, but if a sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(b) Revoke the designation of any servicing facility or administrator if it finds claims are being handled unsatisfactorily.

631.822. Records of association.--Records shall be kept of all negotiations and meetings in which the association or its representatives discuss the activities of the association in carrying out its powers and duties. Records of such negotiations or meetings shall be made public upon the termination of a liquidation, rehabilitation, or revocation proceeding involving the HMO.

631.823. Examination of the association; annual report.--The association shall be subject to examination and regulation by the department. The board of directors shall submit to the department, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the department and a report of its activities during the preceding calendar year.

631.824. Tax exemptions.--The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

631.825. Immunity.--There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member HMO or its agents or employees, the association or its agents or employees, members of the board of directors, or the department or its representatives for any
1 action taken by them in the performance of their powers and
duties under this part.

631.826 Extent of liability of association.--For the
purpose of carrying out its obligations under this part, the
association shall be deemed to be a priority creditor of the
impaired, insolvent, or revoked HMO. Assets of the impaired,
insolvent, or revoked HMO shall be used to continue all
covered policies and pay all contractual obligations of the
impaired, insolvent, or revoked HMO as permitted by this part,
to the extent such assets are available. If an HMO is
rehabilitated, the HMO shall repay to the association such
funds expended by the association for or on behalf of that
HMO, together with interest at 12 percent per year. Such
repayment terms shall be reasonably set by the board.

631 827 Health care coverage.--
(1) The primary purpose of the association is the
provision of health care services to eligible enrollees. This
health care may be provided in a reasonable manner, as
determined by the association, which is designed to
efficiently utilize the assets of the association, while at
the same time assuring the provision of quality health care
services. The association may issue health insurance
policies, contract for the placement of eligible subscribers,
either temporarily or permanently, with health insurance
companies or health maintenance organizations, issue HMO
contracts and enter into contracts with providers to service
these contracts.

(2) In providing health care coverage, the association
may temporarily or permanently continue in effect the policies
of the subscribers or may offer its own HMO or health
insurance policies which comply with the Florida Insurance

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Code, except that the association is exempt from the
requirements to obtain a certificate of authority as an
insurance company.

(3) Any subscriber receiving health care services
under this part shall be deemed to have assigned their rights
under the covered policy to the association to the extent of
the benefits received, whether the benefits are payments of
contractual obligations or continuation of coverage. The
association may require an assignment to it of such rights by
any policy or contract owner as a condition precedent to the
receipt of any rights or benefits conferred by this part upon
such subscriber. The association shall have subrogation
rights against the assets of any insolvent HMO. The
subrogation rights of the association under this subsection
shall have the same priority against the assets of the
insolvent HMO as those possessed by the subscribers entitled
to receive benefits under this part.

(4) No pre-existing conditions, exclusions, or
limitations shall be contained in the coverage offered by the
association or coverage placed by the association with another
entity, except as specified in the policy issued by the
insolvent, impaired, or revoked HMO.

(5) If the assessment for member HMOs includes federal
Medicare HMO premium revenue, the association is empowered to
offer, or cause to be offered, Medicare supplement policies
without pre-existing conditions to eligible subscribers in
appropriate circumstances.

631.828 Prohibited advertisement.—No person,
including an HMO, agent, or affiliate of an HMO shall make,
publish, disseminate, circulate, or place before the public,
or cause directly or indirectly to be made, published,

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disseminated, circulated, or placed before the public in any newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster or over any radio station or television station or in any other way, any advertisement, announcement, or statement which uses the existence of the Health Maintenance Organization Guaranty Association of this state for the purpose of solicitation of subscribers in health maintenance organizations; provided, however, that this section shall not apply to the Florida Health Maintenance Organization Guaranty Association.

631.829 Assessments against member HMOs' income tax credit for assessments paid -- Any provisions of the law to the contrary notwithstanding, a member HMO may offset against its corporate income tax liability or other liabilities to the state, on an individual or consolidated basis, as applicable, any assessment described in s. 631.819 to the extent of 20 percent of the amount of such assessment for each of the 5 calendar years following the year in which such assessment was paid.

631.830 Rates.--
(1) All health maintenance contracts issued directly by the association shall be subject to the provisions of s. 641.31.
(2) All health insurance policies issued directly by the association shall be subject to ss. 627.410 and 627.411 and parts VI and VII of chapter 627.

Section 2. Paragraphs (a), (c), and (d) of subsection (6), subsections (7), (8), (9), (10), and (11) of section 641.19, Florida Statutes, are amended, and paragraph (e) is added to subsection (6), and subsection (16) is added to said section, to read:

CODING: Words stricken are deletions; words underlined are additions.
641.19 Definitions.--As used in this part, the terms:

(6) "Health maintenance organization" means any organization authorized under this part which:

(a) Provides emergency care, inpatient hospital services, physician care including care provided by physicians licensed under chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, and preventive health care services and at least two of the other three "minimum services" defined in subsection (8) to any of the subscribers of the organization;

(c) Provides, either directly or through arrangements with other persons, those health care services which subscribers might reasonably require to maintain good health;

and

(d) Provides physician services, by physicians licensed under chapters 458, 459, 460, and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians; and

(e) Provides all services in a managed care system in which a primary care physician licensed under chapter 458 or chapter 459 and chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary.

(7) "Insolvent" or "insolvency" means that all the statutory assets of the health maintenance organization, if made immediately available, would not be sufficient to discharge all of its liabilities or that the health

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maintenance organization is unable to pay its debts as they become due in the usual course of business. In the event that all the assets of the health maintenance organization, if made immediately available, would not be sufficient to discharge all of its liabilities, but the organization has a written guarantee of the type and subject to the same provisions as outlined in s. 641.225, the organization shall not be considered insolvent unless it is unable to pay its debts as they become due in the usual course of business.

(8) "Minimum services" includes any of the following:
emergency care, inpatient hospital services, physician care provided by physicians licensed under chapters 458, 459, 460, and 461; ambulatory diagnostic and preventive health care services.

(9) "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state.

(9) "Statutory accounting principles" means generally accepted accounting principles, except as modified by this part.

(9) "Subscriber" or "enrollee" means an individual who has contracted, or on whose behalf a contract has been entered into, with a health maintenance organization for health care services or other persons who also receive health care services as a result of the contract.

(11) "Surplus" means total statutory assets in excess of total liabilities, except that assets pledged to secure debts not reflected on the books of the health maintenance organization shall not be included in surplus. Surplus
includes capital stock, capital in excess of par, other contributed capital, retained earnings, and surplus notes.

(16) "Capitation" means the fixed amount paid by an HMO to a health care provider under contract with the health maintenance organization, in exchange for the rendering of covered medical services.

Section 3 Paragraphs (c), (e), (f), and (g) of subsection (1) of section 641.21, Florida Statutes, are amended, paragraph (h) is added to said subsection, and subsection (4) is added to said section, to read:

641.21 Application for certificate.--

(1) Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the department. The department shall accept and shall begin its review of an application for a certificate of authority anytime after an organization has filed an application for a Health Care Provider Certificate pursuant to part IV of this chapter. However, the department shall not issue a certificate of authority to any applicant which does not possess a valid Health Care Provider Certificate issued by the Department of Health and Rehabilitative Services. Each application for a certificate shall be on such form as the department shall prescribe and shall be accompanied by the following:

(c) A list of the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of the affairs of the health maintenance organization, including all officers, and directors and owners of in excess of 5 percent of the common stock of the corporation. Such persons shall fully disclose to the department and the directors of the health maintenance
organization the extent and nature of any contracts or
arrangements between them and the health maintenance
organization, including any possible conflicts of interest;
(e) Forms of all health maintenance contracts,
certificates, and member handbooks the applicant proposes to
offer the subscribers, showing the benefits to which they are
entitled, together with a table of the rates charged, or
proposed to be charged, for each form of such contract. A
certified actuary shall:

1. Certify that the rates are neither inadequate nor
excessive nor unfairly discriminatory;

2. Certify that the rates are appropriate for the
classes of risks for which they have been computed; and

3. File an adequate description of the rating
methodology showing that such methodology follows consistent
and equitable actuarial principles;

(f) A statement describing with reasonable certainty
the geographic area or areas to be served by the health
maintenance organization; and

(g) An audited financial statement prepared on the
basis of statutory generally-accepted accounting principles
and certified by an independent certified public accountant,
except that surplus notes acceptable to the department and
meeting the requirements of this act shall be included in the
calculation of surplus; and;

(h) Such additional reasonable data, financial
statements, and other pertinent information as the department
may require with respect to the determination that the
applicant can provide the services to be offered.

(4) A comprehensive feasibility study, performed by a
certified actuary in conjunction with a certified public
accountant. The study shall be for the greater of 3 years or until the health maintenance organization has been projected to be profitable for 12 consecutive months. The study must show that the health maintenance organization would not, at the end of any month of the projection period, have less than the minimum surplus as required by s. 641.225.

Section 4. Subsection (6) of section 641.22, Florida Statutes, is amended to read:

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

(6) The ownership, control, and 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 the department has good reason to believe that the ownership, control, or management of the organization includes 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.

Section 5. Section 641.225, Florida Statutes, is amended to read:

641.225 Surplus requirements.--

(1) Each health maintenance organization shall at all times have-and maintain a minimum surplus in an amount which

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is the greater of $500,000 $100,000 or 10 5 percent of total liabilities. All health maintenance organizations which have a valid certificate of authority before the effective date of this act and which do not meet the minimum surplus requirement, shall increase their surplus as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>September 30, 1989</td>
<td>$200,000 or 6 percent of total liabilities, whichever is greater</td>
</tr>
<tr>
<td>September 30, 1990</td>
<td>$350,000 or 8 percent of total liabilities, whichever is greater</td>
</tr>
<tr>
<td>September 30, 1991</td>
<td>$500,000 or 10 percent of total liabilities, whichever is greater</td>
</tr>
</tbody>
</table>

(2) The department shall not issue a certificate of authority on or after the effective date of this act unless the health maintenance organization has a minimum surplus in an amount which is the greater of:

(a) $1,500,000;

(b) 10 percent of their total liabilities based on their start-up actuarial projection as set forth in this part;

(c) $500,000 plus all start-up losses, excluding profits, projected to be incurred on their start-up actuarial

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projection until the projection reflects statutory net profits for 12 consecutive months.

The department may adopt rules to set uniform standards and criteria for the early warning that the continued operation of any health maintenance organization might be hazardous to its subscribers, creditors, or the general public, and to set standards for evaluating the financial condition of any health maintenance organization.

[3] The department shall lower the surplus requirements to any level deemed appropriate by the department, but not less than $100,000 for an individual health maintenance organization, whenever the department is satisfied that:

(a) The organization has an adequate history of generating net income to assure its financial viability for the next year;

(b) The assets of the organization or its contracts with health care providers, governments, or other organizations are reasonably sufficient to assure the performance of the organization; and

(c) The obligations of the organization are structured towards long-term payment so that a lower percentage requirement would prove adequate as a cushion against the payment of such obligations.

[4][2] In lieu of having any minimum surplus, the health maintenance organization may provide a written guarantee to assure payment of covered subscriber claims and all other liabilities of the health maintenance organization, provided that the written guarantee is made by a guaranteeing organization which:

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(a) Has been in operation for 5 years or more and has a surplus, not including land, buildings, and equipment, of the greater of $2 million or 2 times the minimum surplus requirements of the health maintenance organization. In any determination of the financial condition of the guaranteeing organization, the definitions of assets, liabilities, and surplus set forth in this part shall apply, except that investments in or loans to any organizations guaranteed by the guaranteeing organization shall be excluded from surplus. 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.

(b) Submits a guarantee that is approved by the department as meeting the requirements of this part, provided that the written guarantee contains a provision which requires that the guarantee be irrevocable unless guaranteeing organization provide at least 6 months' notice to the department prior to cancellation of the guarantee, except that such period of notice may be shortened if the guaranteeing organization can demonstrate to the department that the cancellation of the guarantee will not result in the insolvency of the health maintenance organization and the department approves cancellation of the guarantee.

(c) Initially submits its audited financial statements, certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles, covering its two most current annual accounting periods.

(d) Submits annually, within 3 months after the end of its fiscal year, an audited financial statement certified by an independent certified public accountant, prepared in

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accordance with generally accepted accounting principles. The department may, as it deems necessary, require quarterly financial statements from the guaranteeing organization.

Section 6. Section 641.227, Florida Statutes, is hereby repealed.

Section 7. Section 641.228, Florida Statutes, is created to read:

641.228 Florida Health Maintenance Organization Guaranty Association.—

(1) Upon the effective date of this act, all assets and liabilities of the Rehabilitation and Administration Fund shall be transferred to and become the sole property of the Florida Health Maintenance Organization Guaranty Association. No further refunds of a health maintenance organization's $10,000 deposit shall be allowed for any health maintenance organization possessing a valid health maintenance organization certificate of authority as of the effective date of this act.

(2) The department shall not issue a certificate to any health maintenance organization after the effective date of this act until the applicant health maintenance organization has paid in full its special assessment as set forth in s. 631.819.

(3) No assessment paid to the Florida Health Maintenance Organization Guaranty Association shall be allowed as an asset of any health maintenance organization.

(4) The department may suspend or revoke the certificate of authority of any health maintenance organization which does not timely pay its assessment to the Florida Health Maintenance Organization Guaranty Association.
Section 8. Subsection (2) of section 641.23, Florida Statutes, is amended, present subsection (3) is renumbered as subsection (4), and a new subsection (3) is added to said section, to read:

641.23 Revocation or cancellation of certificate of authority; suspension of enrollment of new subscribers; terms of suspension.--

(2) The department may suspend the authority of a health maintenance organization to enroll new subscribers or revoke any certificate issued to a health maintenance organization, or order compliance within 30 60 days, if it finds that any of the following conditions exists:

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

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

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

(d) 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

(e) The organization is insolvent.

(3) Whenever the financial condition of the health maintenance organization is such that, if not modified or corrected, its continued operation would result in impairment or insolvency, the department may order the health maintenance organization to file with the department and implement a

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corrective action plan designed to do one or more of the following:

(a) Reduce the total amount of present potential liability for benefits by reinsurance or other means.
(b) Reduce the volume of new business being accepted.
(c) Reduce the expenses of the health maintenance organization by specified methods.
(d) Suspend or limit the writing of new business for a period of time.
(e) Require an increase in the health maintenance organization's net worth.

If the health maintenance organization fails to submit a plan within 30 days of the department's order or submits a plan which is insufficient to correct the health maintenance organization's financial condition, the department may order the health maintenance organization to implement one or more of the corrective actions listed in this subsection.

Section 9. Section 641.234, Florida Statutes, is created to read:

641.234 Administrative, provider, and management contracts --

(1) The department may require a health maintenance organization to submit any contract for administrative services, contract with a provider other than an individual physician, contract for management services, and contract with an affiliated entity to the department, if the department has information and belief that the health maintenance organization has entered into a contract which requires it to pay a fee which is unreasonably high in relation to the service provided.
(2) After review of a contract the department may order the health maintenance organization to cancel the contract in accordance with the terms of the contract and applicable law, if it determines that the fees to be paid by the health maintenance organization under the contract are so unreasonably high as compared with similar contracts entered into by the health maintenance organization or as compared with similar contracts entered into by other health maintenance organizations in similar circumstances that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the health maintenance organization.

(3) All contracts for administrative services, management services, provider services other than individual physician contracts, and with affiliated entities entered into or renewed by a health maintenance organization on or after October 1, 1988, shall contain a provision that the contract shall be canceled upon issuance of an order by the department pursuant to this section.

Section 10. Section 641.2342, Florida Statutes, is created to read:

641.2342 Contract providers -- Each health maintenance organization shall file, upon the request of the department, financial statements for all contract providers of comprehensive health care services who have assumed, through capitation or other means, more than 10 percent of the health care risks of the health maintenance organization. However, this provision shall not apply to any individual physician.

Section 11. Section 641.25, Florida Statutes, is amended to read:

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

Section 12. Section 641.26, Florida Statutes, is
amended to read:

641.26 Annual report.—
(1) Every health maintenance organization shall,
anually on or before April 1 or within 3 months after the
end of its fiscal year reporting period, or within an
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 organization, showing its
condition on the last day of the immediately preceding
reporting period. Such report shall include:
(a) An audited 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, prepared in accordance with
statutory generally-accepted accounting principles;
(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;

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(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) 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;
(f) An actuarial certification that:
1. The health maintenance organization is actuarially
sound, which certification shall consider the rates, benefits,
and expenses of, and any other funds available for the payment
of obligations of, the organization; and
2. The rates being charged or to be charged are
actuarially adequate to the end of the period for which rates
have been guaranteed;
3. Incurred but not reported claims and claims
reported but not fully paid have been adequately provided for;
and
(g) Such other information relating to the performance
of health maintenance organizations as is required by the
department.
(2) Every health maintenance organization shall file
quarterly annually, within 45 days after each of its quarterly
reporting periods period, an unaudited financial statement of
the organization.
(3) Any health maintenance organization which neglects
to file an annual report or quarterly report in the form and
within the time required by this section shall forfeit $1,000
for each day for the first 10 days during which the neglect
continues and shall forfeit $2,000 for each day after the
first 10 days during which the neglect continues; and, upon
notice by the department to that effect, the organization's
authority to enroll new subscribers or 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. The department shall not collect more
than $100,000 for each report.

(4) Each authorized health maintenance organization
shall retain an independent certified public accountant,
hereinafter referred to as "CPA," who agrees by written
contract with the health maintenance organization to comply
with the provisions of this part. The contract shall state:

(a) The CPA shall provide to the HMO audited financial
statements consistent with this part.

(b) Any determination by the CPA that the health
maintenance organization does not meet minimum surplus
requirements as set forth in this part shall be stated by the
CPA, in writing, in the audited financial statement.

(c) The completed work papers and any written
communications between the CPA firm and the health maintenance
organization relating to the audit of the health maintenance
organization shall be made available for review on a visual
inspection-only basis by the department at the offices of the
health maintenance organization, at the department, or at any
other reasonable place as mutually agreed between the
department and the health maintenance organization. The CPA
must retain for review the work papers and written
communications for a period of not less than 6 years.

(4) The department may require that a health
maintenance-organization submit quarterly financial reports

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which are necessary to enable the department to determine continued compliance with the provisions of this part:

Section 13. Subsection (1) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department. --

(1) 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. In lieu of making its own financial examination, the department may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with this part. However, except when the medical records are requested and copies furnished pursuant to s. 455.24(1), 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 department 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. In no event shall expenses of all examinations exceed a maximum of $20,000 for any 1-year period. 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 14. Section 641.285, Florida Statutes, is hereby repealed.

Section 15. Section 641.286, Florida Statutes, is hereby repealed.

Section 16. Subsection (1) of section 641.29, Florida Statutes, is amended to read:

641.29 Fees.--Every health maintenance organization shall pay to the department the following fees:

(1) For filing a copy of its application for a certificate of authority or amendment thereto, a nonrefundable fee in the amount of $1,000.

Section 17. Paragraph (b) of subsection (3) and paragraph (a) of subsection (13) of section 641.31, Florida Statutes, are amended, and subsections (16) and (17) are added to said section, to read:

641.31 Health maintenance contracts.--

(3) The department shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, only if the form:

1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.

2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

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3. Has any title, heading, or other indication of its provisions which is misleading.

4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.

5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.

6. Charges rates that are determined by the department to be inadequate, excessive, or unfairly discriminatory, or the rating methodology followed by the health maintenance organization is determined by the department to be inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding.

(13) In addition to the requirements of this section, with respect to a person who is entitled to have payments for health care costs made under Medicare, Title XVIII of the Social Security Act ("Medicare"), Parts A and/or B:

(a) The health maintenance contract shall be accompanied by the April 1985 edition of the Health Maintenance Organization-Medicare Contract Information Form, which shall be promulgated as a rule by the department.

(b) Delivery of the information form to such person shall be made prior to or at the time of application for membership in the health maintenance organization. However, if the application for membership is received by the health maintenance organization through the mail and is not a result of direct personal contact between the person and an agent or representative of the organization, delivery of the information form shall be made prior to processing the application and within 15 days of receipt of the application.

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by-the-organization.--Acknowledgement-of-receipt-or
certification-of-delivery-or-mailing-of-the-information-form
shall-be-maintained-by-the-health-maintenance-organization
from-the-date-of-the-most-recent-examination-by-the-department
pursuant-to-section-641:27-until-the-date-of-completion-of-the
following-examination:

(16) The contract must clearly disclose the intent of
the health maintenance organization as to the applicability or
nonapplicability of coverage to pre-existing conditions. If
coverage of the contract is not to be applicable to pre-
existing conditions, the contract shall specify, in substance,
that coverage pertains solely to accidental bodily injuries
resulting from accidents occurring after the effective date of
coverage and that sicknesses are limited to those which first
manifest themselves subsequent to the effective date of
coverage.

(17) All health maintenance contracts which provide
coverage for a member of the family of the subscriber, shall,
as to such family member's coverage, provide that coverage,
benefits, or services applicable for children shall be
provided with respect to an adopted child of the subscriber,
which child is placed in compliance with chapter 63, from the
moment of placement with the subscriber. In the case of a
newborn child, coverage shall begin from the moment of birth
if a written agreement to adopt such child has been entered
into by the subscriber prior to the birth of the child,
whether or not such agreement is enforceable; provided,
however, that coverage for such child shall not be required in
the event that the child is not ultimately placed with the
subscriber in compliance with chapter 63.
Section 18. Paragraph (a) of subsection (1) of section 641.311, Florida Statutes, is amended to read:

641.311 Statewide Subscriber Assistance Program.--The department shall adopt and implement a program to provide assistance to subscribers, including those whose grievances are not satisfactorily resolved by the health maintenance organization. The program shall include the following:

(1)(a) A review panel which may periodically review, consider, and recommend to the department any actions the department should take concerning individual cases heard by the panel as well as the types of subscriber grievances which have not been satisfactorily resolved after the subscribers follow the full grievance procedures of the health maintenance organizations. The proceedings of the grievance panel shall not be subject to the provisions of chapter 120. The review panel shall consist of members employed by the department and members employed by the Department of Health and Rehabilitative Services, chosen by their respective agencies. Outside qualified, impartial consultants may be consulted in connection with the types of grievances outside the expertise of the review panel.

Section 19. Section 641.3111, Florida Statutes, is created to read:

641.3111 Extension of benefits.--Every health maintenance contract shall provide that termination of the contract by the health maintenance organization shall be without prejudice to any continuous loss which commenced while the contract was in force, but any extension of benefits beyond the period the contract was in force may be predicated upon the continuous total disability of the subscriber, and may be limited to the duration of the contract benefit period.

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Section 20. Section 641.315, Florida Statutes, is amended to read:

641.315 Provider contracts.--

(1) 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 a subscriber, the health maintenance organization shall be liable for such fee or fees rather than the subscriber, and the contract shall so state.

(2) For all provider contracts executed after the effective date of this act and within 180 days after the effective date of this act for contracts in existence as of the effective date of this act:

(a) The contracts shall provide that the provider shall provide 60 days' advance written notice to the health maintenance organization and the department before canceling the contract with the health maintenance organization for any reason and

(b) The contract must also provide that nonpayment for goods or services rendered by the provider to the health maintenance organization shall not be a valid reason for avoiding the 60-day advance notice of cancellation.

(3) Upon receipt by the health maintenance organization of a 60-day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than 60 days if the health maintenance organization is not financially impaired or insolvent.

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Section 21. Subsection (1), paragraphs (a) and (b) of subdivision (2), paragraph (d) of subsection (5), subsection (9), paragraph (c) of subsection (10), subsections (11) and (12), and paragraph (b) of subsection (17) of section 641.35, Florida Statutes, are amended to read:

641.35 Assets, liabilities, and investments.--

(1) ASSETS.--In any determination of the financial condition of a health maintenance organization, there shall be allowed as "assets" only those assets that are owned by the health maintenance organization and which assets consist of:

(a) Cash in the possession of the health maintenance organization, or in transit under its control, including the true balance of any deposit in a solvent bank, savings and loan association, or trust company which is domiciled in the United States.

(b) Investments, securities, properties, and loans acquired or held in accordance with this part, and in connection therewith the following items:

1. Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.

2. Declared and unpaid dividends on stock and shares, unless the amount of the dividends has otherwise been allowed as an asset.

3. Interest due or accrued upon a collateral loan which is not in default in an amount not to exceed 1 year's interest thereon.

4. Interest due or accrued on deposits or certificates of deposit in solvent banks, savings and loan associations, and trust companies domiciled in the United States, and

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interest due or accrued on other assets, if such interest is
in the judgment of the department a collectible asset.

5. Interest due or accrued on current mortgage loans,
in an amount not exceeding in any event the amount, if any, of
the excess of the value of the property less delinquent taxes
thereon over the unpaid principal; but in no event shall
interest accrued for a period in excess of 90 days be allowed
as an asset.

6. Rent due or accrued on real property if such rent
is not in arrears for more than 3 months. However, in no
event shall rent accrued for a period in excess of 90 days be
allowed as an asset.

7. The unaccrued portion of taxes paid prior to the
due date on real property.

(c) Premiums in the course of collection, not more
than 3 months past due, less commissions payable thereon. The
foregoing limitation shall not apply to premiums payable
directly or indirectly by any governmental body in the United
States or by any of their instrumentalities.

(d) The full amount of reinsurance recoverable from a
solvent reinsurer, which reinsurance is authorized under s.
624.610.

(e) Furniture, fixtures, furnishings, vehicles,
medical libraries, and equipment, if the original cost of each
item is at least $200, which cost shall be amortized in full
over a period not to exceed 5 calendar years, unless otherwise
approved by the department.

(f) Pharmaceutical and medical supply inventories.

(g) The liquidation value of prepaid expenses

(h) Other assets, not inconsistent with the provisions
of this section, deemed by the department to be available for

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the payment of losses and claims, at values to be determined
by it.

The department, upon determining that a health maintenance
organization's asset has not been evaluated according to
applicable law or that it does not qualify as an asset, shall
require the health maintenance organization to properly
reevaluate the asset or replace the asset with an asset
suitable to the department within 30 90 days of receipt of
written notification by the department of this determination,
if the removal of the asset from the organization's assets
would impair the organization's solvency.

(2) ASSETS NOT ALLOWED.—In addition to assets
impliedly excluded by the provisions of subsection (1), the
following assets expressly shall not be allowed as assets in
any determination of the financial condition of a health
maintenance organization:

(a) Goodwill, subscriber lists, patents, trade names,
agreements not to compete and other like intangible assets.

(b) Advances to officers, directors, entities, whether
an advance or investment, which are directly or indirectly
controlled by the health maintenance organization parent or
affiliated with the parent or the health maintenance
organization, except as allowed in subsections (11) and (12)
or and controlling stockholders, whether secured or not, and
advances to employees, agents, or and other persons on
personal security only.

(5) ELIGIBLE INVESTMENTS.—

(d) Any investment limitation based upon the amount of
the organization's assets or particular funds shall relate to
such assets or funds as shown by the organization's annual or

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quarterly report as of the end of the reporting period immediately preceding the date of acquisition of the investment by the organization or as shown by a current financial statement of the organization.

(9) SURPLUS AND DEPOSIT RESTRICTIONS.--Every health maintenance organization must maintain an amount equal to its required minimum surplus, as well as any deposit made with the department, in coin or currency of the United States on hand or on deposit in any solvent national or state bank, savings and loan association, or trust company or in eligible securities or obligations as follows:

(a) Nondemand obligations of certain financial institutions.--Direct, unconditional nondemand obligations for the payment of money issued by a solvent bank or by a mutual savings bank or trust company, savings and loan, building and loan, or credit union, subject to the following:

1. The financial institution is solvent.
2. The financial institution is incorporated under the laws of the United States or of any state thereof.
3. The obligations are of the type which are insured by an agency of the United States.
4. The investment is in the name of and owned by the health maintenance organization, unless the account is under a trusteeship with the organization named as the beneficiary.

(b) Obligations of the United States.--Direct obligations of the United States for the payment of money or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by the United States.

(c) Obligations of agencies and instrumentalities of the United States.--Direct obligations for the payment of

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money issued by an agency or instrumentality of the United States or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by an agency or instrumentality of the United States.

(d) Obligations of a state.--Direct, general obligations of any state of the United States for the payment of money, or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by full faith and credit of any state of the United States, on the following conditions:

1. The state has the power to levy taxes for the prompt payment of the principal and interest of such obligations.

2. The state is not in default in the payment of principal or interest on any of its direct, guaranteed, or insured general obligations at the date of such investment.

(e) Obligations of political subdivisions of a state.--Direct, general obligations of any political subdivision of any state of the United States for the payment of money, or obligations for the payment of money to the extent guaranteed as to the payment of principal and interest by any political subdivision of any state of the United States, on the following conditions:

1. The obligations are payable or guaranteed from ad valorem taxes.

2. The political subdivision is not in default in the payment of principal or interest on any of its direct or guaranteed obligations.

3. No investment shall be made under this paragraph in obligations which are secured only by special assessments for local improvements.
(10) PROPERTY USED IN THE HEALTH MAINTENANCE ORGANIZATION'S BUSINESS.--Real estate, including leasehold estates, for the convenient accommodation of the organization's business operations, including home office, branch administrative offices, hospitals, medical clinics, medical professional buildings, and any other facility to be used in the provision of health care services, or real estate for rental to any health care provider under contract with the organization to provide health care services which shall be used in the provision of health care services to members of the organization by that provider, on the following conditions:

(c) The greater of the admitted value of the asset, as determined by statutory generally-accepted accounting principles, or, if approved by the department, the health maintenance organization's equity in the real estate plus all encumbrances on the real estate owned by the organization under this subsection, when added to the value of all personal and mixed property used in the organization's business, shall not exceed 75 percent of its admitted assets unless, with the permission of the department, it finds that the percentage of its admitted assets is insufficient to provide convenient accommodation for the organization's business and the operations of the organization would not otherwise be impaired.

(11) INVESTMENTS IN ADMINISTRATIVE AND MANAGEMENT SERVICE ENTITIES AND OTHER HEALTH CARE PROVIDERS.--A health maintenance organization may invest directly or indirectly in real estate, common and preferred stocks, bonds or debentures, including convertible debentures, or other evidences of debts of or equity in an entity if the entity is owned by or, with

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the approval of the department, under contract to the
organization to provide management services, administrative
services, or health care services for the organization, on the
following conditions:

(a) Investments authorized under this subsection shall
not exceed 50 percent of admitted assets, and these
investments shall be included in the calculation of the
overall limitation in paragraph (10)(c) relating to all real
and personal property.

(b) Investments may qualify under this section only
insofar as a provider of management, administrative, or health
care service relationship as defined herein exists. Upon
cessation of such relationship, each investment shall be
subject to the rules applicable to an investment of that type
and must qualify under the appropriate limitation or, failing
that, become ineligible and subject to disposal under
subsection (17).

(12) EXCHANGES OF FACILITIES OR ASSETS.--Health care
or administrative service entities, if subsidiaries of or
under contract to the health maintenance organization to
provide administrative or health care services to the
organization's members, may exchange facilities or similar
assets to be used in the organization's business for stock of
the organization. However, any exchange involving an entity
under contract with the health maintenance organization must
have the approval of the department prior to the exchange.

These facilities or assets shall be valued in accordance with
statutory generally-accepted accounting principles.

(17) TIME LIMIT FOR DISPOSAL OF INELIGIBLE PROPERTY
AND SECURITIES; EFFECT OF FAILURE TO DISPOSE.--
(b) Notwithstanding the provisions of paragraph (a), any ineligible Any property or securities lawfully-acquired and-held-by-the-organization-after-expiration-of-the-period for-disposal-thereof-or-any-extension-of-such-period-granted by-the-department shall not be allowed as an asset of the organization.

Section 22. Section 641.365, Florida Statutes, is created to read:

641.365 Dividends.--

(1) A health maintenance organization shall not pay any dividend or distribute cash or other property to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and net realized capital gains. Dividend payments or distributions to stockholders shall not exceed 10 percent of such surplus in any 1 year unless otherwise approved by the department. In addition to such limited payments, a health maintenance organization may make dividend payments or distributions out of the health maintenance organization's entire net operating profits and realized net capital gains derived during the immediately preceding calendar or fiscal year, as applicable.

(2) The department shall not approve a dividend or distribution in excess of the maximum amount allowed in subsection (1) unless it determines that the distribution or dividend would not jeopardize the financial condition of the health maintenance organization.

(3) Any director of a health maintenance organization who knowingly votes for or concurs in declaration or payment of a dividend to stockholders when such declaration is in violation of this section is guilty of a misdemeanor of the

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second degree, punishable as provided in s. 775.082 or s. 775.083, and shall be jointly and severally liable, together with other such directors likewise voting for or concurring, for any loss thereby sustained by creditors of the health maintenance organization to the extent of such dividend.

(4) Any stockholder receiving such an illegal dividend shall be liable in the amount thereof to the health maintenance organization.

(5) The department may revoke or suspend the certificate of authority of a health maintenance organization which has declared or paid such an illegal dividend.

Section 23. Subsection (1) of section 641.3913, Florida Statutes, is amended to read:

641.3913 Penalty for violation of cease and desist orders.—Any person, entity, or health maintenance organization which violates a cease and desist order of the department under s. 641.3909 while such order is in effect, after notice and hearing as provided in s. 641.3907, shall be subject, at the discretion of the department, to any one or more of the following:

(1) A monetary penalty of not more than $200,000 as to all matters determined in such hearing.

Section 24. Subsection (7) is added to section 641.3921, Florida Statutes, to read:

641.3921 Conversion on termination of eligibility.—A group health maintenance contract delivered or issued for delivery in this state by a health maintenance organization shall provide that a subscriber or covered dependent whose coverage under the group health maintenance contract has been terminated for any reason, including discontinuance of the group health maintenance contract in its entirety or with

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respect to a covered class, and who has been continuously
covered under the group health maintenance contract, and under
any group health maintenance contract providing similar
benefits which it replaces, for at least 3 months immediately
prior to termination, shall be entitled to have issued to him
by the health maintenance organization a health maintenance
contract, hereafter referred to as a "converted contract." A
subscriber or covered dependent shall not be entitled to have
a converted contract issued to him if termination of his
coverage under the group health maintenance contract occurred
for any of the following reasons:

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

Section 25. Part IV of chapter 631, Florida Statutes,
as created by this act, is repealed on October 1, 1991, and
shall be reviewed by the Legislature pursuant to s. 11.61,
Florida Statutes.

Section 26. Each section which is added to chapter
641, Florida Statutes, by this act is repealed on October 1,
1991, and shall be reviewed by the Legislature pursuant to s.
11.61, Florida Statutes.

Section 27. This act shall take effect October 1,

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Create the Florida Health Maintenance Organization Guaranty Association Act to protect the subscribers of HMOs against the failure of the HMO to perform its contractual obligations due to its impairment, insolvency, or revocation of its certificate of authority. Substantially revises the Health Maintenance Organization Act along these same lines, increasing required surpluses, penalties, and fees to protect HMO subscribers. See bill for details.

This publication was produced at an average cost of 1.12 cents per single page in compliance with the Rules and for the information of members of the Legislature and the public.

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A bill to be entitled
An act relating to health care services;
creating part IV of chapter 631, F.S.,
consisting of ss. 631.811-631.828, F.S.,
relating to health maintenance organizations
assistance to consumers; creating the Florida
Health Maintenance Organization Consumer
Assistance Plan; providing for the purpose and
application of the part; providing definitions;
providing for a Florida Health Maintenance
Organization Consumer Assistance Plan;
providing for a board of directors; providing
for eligibility requirements; providing for
powers and duties of the plan; providing for
assessments; providing for a plan of operation;
providing for powers and duties of the
Department of Insurance; providing for records
of the plan; providing for examination of the
plan and annual report; providing for tax
exemptions; providing for immunity; providing
for extent of liability of the plan; providing
for prohibitions on advertisements; providing
for assessments against member HMOs; revising
the Health Maintenance Organization Act;
amending s. 641.19, F.S.; providing
definitions; amending s. 641.21, F.S.;
providing additional criteria for application
for certificate; amending s. 641.22, F.S.;
revising language with respect to issuance of
certificate of authority; amending s. 641.225,
F.S.; increasing the amount of surplus

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requirement; creating s. 641.228, F.S.;
creating the Florida Health Maintenance
Organization Consumer Assistance Plan; amending
s. 641.23, F.S.; reducing the time frame for
the department to suspend the authority of an
HMO to enroll new subscribers or revoke any
certificate; providing for a corrective action
plan for certain HMO's; creating s. 641.234,
F.S.; providing for administrative, provider,
and management contracts; creating s. 641.2342,
F.S.; providing for contract providers of
comprehensive health care services to file
financial statements; amending s. 641.25, F.S.;
increasing administrative penalties; amending
s. 641.26, F.S.; revising language with respect
to the required annual report; amending s.
641.27, F.S.; authorizing the department to
accept an independent certified public
accountant's audit report; amending s. 641.29,
F.S.; increasing fees; amending s. 641.31,
F.S.; revising language with respect to health
maintenance contracts; amending s. 641.311,
F.S.; clarifying language with respect to the
Statewide Subscriber Assistance Program;
creating s. 641.3111, F.S.; providing for
extension of benefits; amending s. 641.315,
F.S.; providing additional criteria for
provider contracts; amending s. 641.35, F.S.;
revising language with respect to assets,
liabilities, and investments; creating s.
641.365, F.S.; providing for dividends;

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amending s. 641.3913, F.S.; increasing a
monetary penalty; amending s. 641.3921, F.S.;
providing an additional criterion for denial of
a converted contract; amending s. 220.02, F.S.;
providing for order of credits; providing for
review and repeal; providing an effective date.

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

Section 1. Part IV of chapter 631, Florida Statutes,
consisting of sections 631.811, 631.812, 631.813, 631.814,
631.822, 631.823, 631.824, 631.825, 631.826, 631.827, and
631.828, is created to read:

PART IV
HEALTH MAINTENANCE ORGANIZATION
CONSUMER ASSISTANCE PLAN

§31,811 Short title.--This part may be cited as the
"Florida Health Maintenance Organization Consumer Assistance
Plan."

§31,812 Purpose; construction.--The purpose of this
part is to protect the subscribers of HMOs, subject to certain
limitations, against the failure of the HMO to perform its
contractual obligations due to its insolvency. This part
shall be liberally interpreted to carry out its purpose.

§31,813 Application of part.--This part shall apply to
HMO contractual obligations to residents of Florida by HMOs
possessing a valid certificate of authority issued by the
Florida Department of Insurance as provided by part II of
chapter 641. The provisions of this part shall not apply to

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persons participating in medical assistance programs created pursuant to s. 409.266.

631.614 Definitions. — As used in this part:

1. "Plan" means the Florida Health Maintenance Organization Consumer Assistance Plan created by this part.

2. "Board" means the board of directors of the plan.


4. "Covered policy" means any policy or contract issued by an HMO for health care services.

5. "Date of insolvency" means the date a court of competent jurisdiction initially issues its order placing the department as the receiver of the HMO.

6. "Department" means the Florida Department of Insurance.

7. "Health care services" means services, medical equipment, and supplies furnished by a provider, which may include, but which are not limited to, medical, surgical, and dental care; psychological, ophthalmic, optic, chiropractic, podiatric, nursing, physical therapy, and pharmaceutical services; health education, preventive medical, rehabilitative, and home health services; inpatient and outpatient hospital services; extended care; nursing home care; convalescent institutional care; laboratory and ambulance services; appliances, drugs, medicines, and supplies; and any other care, service or treatment of disease, correction of defects, or maintenance of the physical and mental well-being of human beings.

8. "HMO" means a health maintenance organization possessing a valid certificate of authority issued by the department pursuant to part II of chapter 641.
(9) "Insolvent HMO" means an HMO against which an order of rehabilitation or liquidation has been entered by a court of competent jurisdiction, with the department appointed as receiver, even if such order has not become final by the exhaustion of appellate review.

(10) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(11) "Subscriber" means any resident of this state who is enrolled for benefits provided by an HMO and who makes premium payments or for whom premium payments are made.

631.815 Florida Health Maintenance Organization Consumer Assistance Plan.--There is created a nonprofit legal entity to be known as the Florida Health Maintenance Organization Consumer Assistance Plan. All HMOs shall be and must remain members of the plan as a condition of their authority to transact business in this state as an HMO. The plan shall perform its functions under the plan of operations established and approved under the provisions of this part and shall exercise its powers through a board of directors established under the provisions of this part. The plan shall come under the immediate supervision of the department and shall be subject to the applicable laws of this state except it shall be excluded from the requirements of possessing a certificate of authority or a health care provider certificate as set forth in part II and part IV of chapter 641, respectively.

631.816 Board of directors.--

(1) The board of directors of the plan shall consist of not less than five or more than nine persons serving terms as established in the plan of operation. The department shall approve and appoint to the board persons recommended by the

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member HMOs. In the event the department finds that any
recommended person does not meet the qualifications for
service on the board, the department shall request the member
HMOs to recommend another person. Each member shall serve for
a 4-year term and may be reappointed. Vacancies on the board
shall be filled for the remaining period of the term in the
same manner as initial appointments. If no members are
selected by October 31, 1988, the department may appoint the
initial members of the board of directors. To select the
initial board of directors and initially organize the plan,
the Insurance Commissioner shall give notice to all HMOs of
the time and place of the organizational meeting. In
determining voting rights at the organizational meeting, each
HMO is entitled to vote on the basis of cumulative weighted
voting based on the net written premium for non-Medicare and
non-Medicaid policies.

(2) In appointing members to the board, the department
shall consider, among other things, whether all member HMOs
are fairly represented.

(3) Members of the board may be reimbursed from the
assets of the plan for expenses incurred by them as members of
the board of directors, but members of the board shall not
otherwise be compensated by the plan for their services.

(4) The board of directors shall elect one of its
members as chairman.

(5) The board may contract with an administrator to
carry out the provisions of this part; however, this shall not
relieve the board of its duties and obligations under this
part.

(6) The board shall collect assessments from all HMOs
as set forth in this part.
631.817 Eligibility.--

(1) Except as provided in subsection (2), any person of this state who has lost their health care services provided in an HMO due to insolvency shall be eligible to obtain coverage as provided herein. Eligible persons include all persons who were eligible to receive health care services under that subscriber's contract with the HMO.

(2)(a) A person shall cease to be covered by the plan after the plan has paid out $300,000 in covered benefits for that person.

(b) A person shall cease to be covered by the plan upon failure to pay, or have paid on their behalf, premiums as set by the board. Coverage shall cease following a reasonable time period as set by the board.

631.818 Powers and duties of the plan.--

(1) In the event that an HMO is insolvent, the plan shall:

(a) Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, all of the covered policies of the insolvent HMO.

(b) Consult with all HMOs in the same geographical area as the insolvent HMO and any other HMO willing to begin providing services in the same geographical area in order to obtain coverage for all subscribers of the insolvent HMO.

(c) In the event that the plan is unable to obtain coverage voluntarily for any subscriber within 15 days of the date of insolvency, an open enrollment process shall be offered to eligible subscribers by all HMOs operating in the same or similar geographical area as the insolvent HMO.

1. Each eligible person who continues to reside in the service area shall be permitted to elect coverage from one of

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the available HMOs. The premium, services, benefits and
exclusions provided to each eligible person shall be the same
as offered by the HMO in its current individual policy, or if
the HMO does not offer individual policies, then the same as
offered by the HMO in its current conversion policy; however
no waiting periods or preexisting conditions or limitation
shall apply.

2. The open enrollment process shall be conducted over
a 30-day period commencing on the date set by the plan. The
plan shall be responsible for giving notice to each eligible
person of the rights provided under this section.

3. During the open enrollment process, each
participating organization shall accept for enrollment in its
conversion plan all eligible subscribers who apply for
coverage, regardless of age, sex, race, color, creed, marital
status or national origin, until such organization fills its
enrollment quota as determined by the plan. To be accepted,
an eligible person must meet any applicable health screening
requirements and submit a completed enrollment application and
the first month premium to an available HMO within the 30-day
enrollment period.

4. The plan shall determine the enrollment quota for
each HMO by determining the total number of eligible
subscribers from the insolvent HMO and calculating the
proportionate market share for all HMOs available in the
service area. No HMO shall be required to enroll more
eligible subscribers than its proportionate market share.
Market share shall be calculated based upon the total number
of subscribers covered through health care plans offered by
each HMO in the service area, as reported in the most recent
quarterly report submitted to the department.

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5. Once enrolled, an eligible subscriber may not be terminated from coverage by the HMO for a period of 6 months, except for one of the following reasons:

a. Nonpayment of premiums.

b. Attainment of Medicare eligibility.

c. Nonresidency in the service area.

d. Abusive and disruptive behavior.

e. Fraud.

(d) Appoint an HMO in the same geographical area to provide health care services in accordance with a conversion policy to any subscriber in the event that all HMOs refuse to enroll the subscriber.

(e) Pay for the cost of all services provided by an HMO appointed to provide services which exceed the amount of premium or contribution paid by the subscriber.

(f) Pay for all services which would have been covered by the subscriber's contract with the insolvent HMO during any period of time from the date of insolvency until the date that the plan obtains coverage for the subscriber with another HMO or other entity which provides health care services.

(g) Defend any claim filed contrary to the provisions of s. 641.315 against a subscriber of an insolvent HMO asserted by a health care provider for services covered by the HMO contract. In the event that a provider obtains a judgment despite the provisions of s. 641.315, the plan shall pay the judgment.

(h) Levy and collect assessments from HMOs pursuant to s. 631.619.

(1) The plan may consult with insurers to obtain coverage for subscribers or enrollees of an insolvent HMO.

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3. The plan's responsibility for the payment of services rendered to individuals by an HMO appointed by the plan to provide services shall terminate at the end of the subscriber's contract period with the prior HMO or after 6 months, whichever is later; however, if at the time the plan's responsibility would otherwise terminate, an individual is under treatment for an injury which occurred or an illness which was diagnosed while the individual was covered by the insolvent HMO, the plan shall remain responsible for treatment of such injury or illness until treatment has been completed.

4. The plan shall determine the amount of the premium that an HMO appointed pursuant to paragraph (1)(e) shall charge to subscribers assigned to the HMO by the plan. The premium shall be set at a level comparable to the premium charged to individual subscribers by HMOs which voluntarily offer individual policies. The amount of premium to be charged shall be filed with and approved by the department prior to use.

5. Coverage obtained by the plan, whether voluntary or involuntary, shall not exclude a preexisting condition not excluded by the policy of the insolvent HMO.

6. If the plan fails to act within a reasonable period of time as provided in subsections (1) and (2), the department shall have the powers and duties of the plan under this part.

7. The plan may render assistance and advice to the department, at the department's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any insolvent HMO.

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(8) The plan shall have standing to appear before any court in this state which has jurisdiction over an insolvent HMO to which the plan is or may become obligated under this part. Such standing shall extend to all matters germane to the powers and duties of the plan, including, but not limited to, proposals for reinsuring or guaranteeing the covered policies of the insolvent HMO and the determination of the covered policies and contractual obligations.

(9) The plan may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this part.

(b) Sue or be sued, including the taking of any legal actions necessary or proper for the recovery of any unpaid assessments under this part.

(c) Borrow money to effect the purposes of this part. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for domestic insurers or HMOs and may be carried as admitted assets.

(d) Employ or retain such persons as are necessary to handle the financial transactions of the plan and to perform such other functions as become necessary or proper under this part.

(e) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the plan.

(f) Take such legal action as may be necessary to avoid payment of improper claims.

631.819 Assessments, --

(1) For the purposes of providing the funds necessary to carry out the powers and duties of the plan, the board of directors shall assess the member HMOs and the Health Care

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Financing Administration separately, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than 30 days after written notice to the member insurers.

(2) There shall be two classes of assessments made by the board of directors, each of which shall be maintained in a separate fund:

(a) Class A assessments which shall be for the purposes of carrying out the powers and duties of the plan as they relate to non-Medicare and non-Medicaid subscribers for the member HMOs.

(b) Class B assessments which shall be for the purpose of carrying out the powers and duties of the plan as they relate to Medicare subscribers of the member HMOs.

(c) Allocation of expenses to the two classes of funds under this subsection shall be based on the actual expenses of each class of membership and an allocation of all other expenses on a basis as set by the board of directors, which is fair and has a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(3) Assessments for Medicare subscribers shall be collected only from the Health Care Financing Administration and shall be based on the Florida earned premium revenue for each year for all Florida Medicare HMO premium revenue.

(a) The Health Care Financing Administration shall have until January 1, 1989, to notify the plan if it desires to have its Medicare subscribers covered by the plan and receive the benefits of the plan. Such notification shall obligate the Health Care Financing Administration to pay the Medicare portion of all assessments of the plan. If the Health Care Financing Administration fails to notify the plan

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of its intention to participate in the plan or notifies the
plan it does not desire to join the plan by January 1, 1989;
then Medicare subscribers of Florida HMOs shall not be
eligible to participate in or receive any benefits of the
plan.

(b) If the Health Care Financing Administration
declines to participate in the association, the assessments
shall apply to all Florida earned premiums for non-Medicare
and non-Medicaid premium revenue only.

(4) Assessments for funds to meet the requirements of
the plan with respect to an insolvent HMO shall not be made
until necessary to implement the purposes of this part. In
order to carry out its duties and powers under this part, upon
the insolvency of an HMO, the plan shall levy and collect
assessments follows:

(a) Each HMO possessing a certificate of authority on
the effective date of this act shall pay an assessment of
$25,000 to the plan by January 1, 1989.

(b) If the funds provided under paragraph (a) are
insufficient to carry out the powers and duties of the plan,
the plan shall levy an assessment directly against all HMOs.

(5) All assessments against HMOs shall be levied as a
percentage of annual earned premium revenue for non-Medicare
and non-Medicaid contracts. In no event may the plan assess
in any calendar year more than one-half of 1 percent of each
HMO's annual earned premium revenue for non-Medicare and non-
Medicaid contracts.

(6) The plan may temporarily defer, in whole or in
part, the assessment of a member HMO, if, in the opinion of
the board, payment of the assessment would endanger the
ability of the HMO to fulfill its contractual obligations.

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(7) It shall be proper for any member HMO, in determining its premium rates, to consider the amount reasonably necessary to meet its assessment obligations under this part.

631.020 Plan of operation.--

(a) The plan shall submit to the department a proposed plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the plan. The proposed plan of operation and any amendments thereto shall become effective upon approval in writing by the department.

(b) If the plan fails to submit a suitable proposed plan of operation by December 31, 1986, or within an extension of time therefore as the department, for good cause, may grant, or if at any time thereafter the plan fails to submit suitable amendments to the plan, the department shall, after notice and hearing, adopt such reasonable rules as are necessary to effectuate the provisions of this part. Such rules shall continue in force until modified by the department or superseded by a proposed plan submitted by the plan and approved by the department.

(2) All member HMOs shall comply with the approved plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this part:

(a) Establish procedures for handling the assets of the plan.

(b) Establish the amount and method of reimbursing members of the board of directors.

(c) Establish regular places and times for meetings of the board of directors.

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(d) Establish procedures for keeping records of all financial transactions of the plan, its agents, and the board of directors.

(e) Establish procedures whereby selections for the board of directors shall be made and submitted to the department.

(f) Establish any additional procedures for assessments under this part.

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the plan.

(4)(a) The plan of operation may provide that any or all powers and duties of the plan, except those under s. 631.819(2)(b) and (c) and s. 631.819, are delegated to an administrator which may be a corporation, association, or other organization which performs or will perform functions similar to those of this plan, or its equivalent.

(b) The board may select an administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board, which criteria shall include:

1. The administrator's proven ability to manage large group health insurance plans and HMOs.

2. The efficiency of the administrator's claims-paying procedures.

3. An estimate of total charges for administering the plan.

4. Any other reasonable factors as set by the board.

(c) The administrator shall be reimbursed for any payments made on behalf of the plan and shall be paid for its performance of any function of the plan.

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(d) A delegation under this subsection shall take
affect only with the approval of both the board of directors
and the department and may be made only to an administrator
which extends protection not substantially less favorable and
effective than that provided by this part.

631.821 Powers and duties of the department.--

1. The department may suspend or revoke, after notice
and hearing, the certificate of authority of a member HMO that
fails to pay an assessment when due or fails to comply with
the approved plan of operation of the plan.

2. Any action of the board of directors of the plan
may be appealed to the department by any member HMO if such
appeal is taken within 30 days of the action being appealed.
Any appeal shall be promptly determined by the department and
final action or order of the department shall be subject to
judicial review in a court of competent jurisdiction.

3. The department may:

(a) Require that the plan notify the subscriber of the
insolvent HMO and any other interested parties of the
determination of insolvency and of their rights under this
part. Such notification shall be by mail at their last known
address, when available, but if sufficient information for
notification by mail is not available, notice by publication
in a newspaper of general circulation shall be sufficient.

(b) Revoke the designation of any servicing facility
or administrator if it finds claims are being handled
unsatisfactorily.

631.822 Records of plan.--Records shall be kept of all
negotiations and meetings in which the plan or its
representatives discuss the activities of the plan in carrying
out its powers and duties. Records of such negotiations or

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meetings shall be made public upon the termination of a
liquidation, rehabilitation, or revocation proceeding
involving the HMO.

§31.823 Examination of the plan; annual report.--The
plan shall be subject to examination and regulation by the
department. The board of directors shall submit to the
department, not later than May 1 of each year, a financial
report for the preceding calendar year in a form approved by
the department and a report of its activities during the
preceding calendar year.

§31.824 Tax exemptions.--The plan shall be exempt from
payment of all fees and all taxes levied by this state or any
of its subdivisions, except taxes levied on real property.

§31.825 Immunity.--There shall be no liability on the part of;
and no cause of action of any nature shall arise
against any member, HMO or its agents or employees, the plan
or its agents or employees, members of the board of directors,
or the department or its representatives for any action taken
by them in the performance of their powers and duties under
this part.

§31.826 Extent of liability of plan.--For the purpose
of carrying out its obligations under this part, the plan
shall be deemed to be a priority creditor of the insolvent
HMO. Assets of the insolvent HMO shall be used to continue
all covered policies of the insolvent HMO as permitted by this
part, to the extent such assets are available. If an HMO is
rehabilitated, the HMO shall repay to the plan such funds
expended by the association for or on behalf of that HMO,
together with interest at 12 percent per year. Such repayment
terms shall be as reasonably set by the board.
631.827 Prohibited advertisement.--No person, including an HMO, agent, or affiliate of an HMO shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement which uses the existence of the Health Maintenance Organization Consumer Assistance Plan of this state for the purpose of solicitation of subscribers in health maintenance organizations, provided, however, that this section shall not apply to the Florida Health Maintenance Organization Consumer Assistance Plan.

631.828 Assessments against member HMOs; income tax credit for assessments paid.--Any provisions of the law to the contrary notwithstanding, a member HMO may offset against its corporate income tax liability or other liabilities, on an individual or consolidated basis, as applicable, any assessment described in s. 631.819 to the extent of 20 percent of the amount of such assessment for each of the 5 calendar years following the year in which such assessment was paid.

Section 2. Paragraphs (a), (c), and (d) of subsection (6), and subsections (7), (8), (9), (10), and (11) of section 641.19, Florida Statutes, are amended, paragraph (e) is added to subsection (6), and subsection (16) is added to said section, to read:

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

(6) "Health maintenance organization" means any organization authorized under this part which:

CODING: Words stricken are deletions; words underlined are additions.
(a) Provides emergency care, inpatient hospital services, physician care including care provided by physicians licensed under chapters 458, 459, 460, and 461; ambulatory diagnostic treatment, and preventive health care services and at least two of the ether three "minimum services" defined in subsection (8) to any of the subscribers of the organization.

(c) Provides, either directly or through arrangements with other persons, those health care services which subscribers might reasonably require to maintain good health; and

(d) Provides physician services, by physicians licensed under chapters 458, 459, 460, and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians; and

(e) If an HMO offers services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or chapter 459 and chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary.

(7) "Insolvent" or "insolvency" means that all the statutory assets of the health maintenance organization, if made immediately available, would not be sufficient to discharge all of its liabilities or that the health maintenance organization is unable to pay its debts as they become due in the usual course of business. In the event that

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all the assets of the health maintenance organization, if made
immediately available, would not be sufficient to discharge
all of its liabilities, but the organization has a written
guarantee of the type and subject to the same provisions as
outlined in s. 641.225, the organization shall not be
considered insolvent unless it is unable to pay its debts as
they become due in the usual course of business.

(8) "Minimum-services" includes any of the following:
emergency-care-inpatient-hospital-services-physician-care
provided-by-physicians-licensed-under-chapters-458-459-460,
and-461-ambulatory-diagnostic-treatment-and-preventive
health-care-services.

(9) "Provider" means any physician, hospital, or
other institution, organization, or person that furnishes
health care services and is licensed or otherwise authorized
to practice in the state.

(9) "Statutory accounting principles" means generally
accepted accounting principles, except as modified by this
part.

(10) "Subscriber" or "enrolled" means an individual
who has contracted, or on whose behalf a contract has been
entered into, with a health maintenance organization for
health care services or other persons who also receive health
care services as a result of the contract.

(11) "Surplus" means total statutory assets in excess
of total liabilities, except that assets pledged to secure
debts not reflected on the books of the health maintenance
organization shall not be included in surplus. Surplus
includes capital stock, capital in excess of par, other
contributed capital, retained earnings, and surplus notes.

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(16) "Capitation" means the fixed amount paid by an HMO to a health care provider under contract with the health maintenance organization, in exchange for the rendering of covered medical services.

Section 3. Paragraphs (c), (e), (f), and (g) of subsection (1) of section 641.21, Florida Statutes, are amended, paragraph (h) is added to said subsection, and subsection (4) is added to said section, to read:

641.21 Application for certificate.--

(1) Before any entity may operate a health maintenance organization, it shall obtain a certificate of authority from the department. The department shall accept and shall begin its review of an application for a certificate of authority anytime after an organization has filed an application for a Health Care Provider Certificate pursuant to part IV of this chapter. However, the department shall not issue a certificate of authority to any applicant which does not possess a valid Health Care Provider Certificate issued by the Department of Health and Rehabilitative Services. Each application for a certificate shall be on such form as the department shall prescribe and shall be accompanied by the following:

(c) A list of the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of the affairs of the health maintenance organization, including all officers, and directors and owners of in excess of 5 percent of the common stock of the corporation. Such persons shall fully disclose to the department and the directors of the health maintenance organization the extent and nature of any contracts or

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arrangements between them and the health maintenance organization, including any possible conflicts of interest;

(e) Forms of all health maintenance contracts, certificates, and member handbooks the applicant proposes to offer the subscribers, showing the benefits to which they are entitled, together with a table of the rates charged, or proposed to be charged, for each form of such contract. A certified actuary shall:

1. Certify that the rates are neither inadequate nor excessive nor unfairly discriminatory;

2. Certify that the rates are appropriate for the classes of risks for which they have been computed; and

3. File an adequate description of the rating methodology showing that such methodology follows consistent and equitable actuarial principles;

(f) A statement describing with reasonable certainty the geographic area or areas to be served by the health maintenance organization; and

(g) An audited financial statement prepared on the basis of statutory generally-accepted accounting principles and certified by an independent certified public accountant, except that surplus notes acceptable to the department and meeting the requirements of this act shall be included in the calculation of surplus; and

(h) Such additional reasonable data, financial statements, and other pertinent information as the department may require with respect to the determination that the applicant can provide the services to be offered.

(i) A comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant. The study shall be for the greater of 3 years or
until the health maintenance organization has been projected
to be profitable for 12 consecutive months. The study must
show that the health maintenance organization would not, at
the end of any month of the projection period, have less than
the minimum surplus as required by s. 641.225.

Section 4. Subsection (6) of section 641.22, Florida
Statutes, is amended to read:

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

(6) The ownership, control, and 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 the department has good reason
to believe that the ownership, control, or management of the
organization includes 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.

Section 5. Section 641.225, Florida Statutes, is
amended to read:

641.225 Surplus requirements.--
(1) Each health maintenance organization shall at all
times have and maintain a minimum surplus in an amount which
is the greater of $500,000 $100,000 or 10 5 percent of total

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All health maintenance organizations which have a valid certificate of authority before the effective date of this act, or an entity described in paragraph (2)(d), and which do not meet the minimum surplus requirement, shall increase their surplus as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 30, 1989</td>
<td>$200,000 or 6 percent of total liabilities, whichever is greater</td>
</tr>
<tr>
<td>September 30, 1990</td>
<td>$350,000 or 6 percent of total liabilities, whichever is greater</td>
</tr>
<tr>
<td>September 30, 1991</td>
<td>$500,000 or 10 percent of total liabilities, whichever is greater</td>
</tr>
</tbody>
</table>

(2) The department shall not issue a certificate of authority on or after the effective date of this act, except as provided in paragraphs (d) and (e), unless the health maintenance organization has a minimum surplus in an amount which is the greater of:

(a) $1,500,000

(b) 10 percent of their total liabilities based on their start-up actuarial projection as set forth in this part or

(c) $500,000 plus all start-up losses, excluding profits, projected to be incurred on their start-up actuarial

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projection until the projection reflects statutory net profit for 12 consecutive months.

(d) An entity providing prepaid capitated services exempt under s. 641.48(3) which was providing such services prior to the effective date of this act shall be subject to the minimum surplus requirements contained in subsection (l).

(e) An entity that began providing prepaid capitated services exempt under s. 641.48(3) after the effective date of this act, has been providing such services for the preceding 12 months, and makes application for a certificate of authority shall meet minimum surplus and enrollment requirements as follows:

1. At the time the certificate of authority is issued, $100,000 or 5 percent of total liabilities, whichever is greater;

2. Twelve months from the date a certificate of authority is issued, the greater of $200,000 or 6 percent of total liabilities, and a nonexempt enrollment not to exceed 50 percent of the HMO's exempt enrollment;

3. Twenty-four months from the date a certificate of authority is issued, the greater of $350,000 or 6 percent of total liabilities, and a nonexempt enrollment not to exceed 75 percent of the HMO's exempt enrollment;

4. Thirty-six months from the date a certificate of authority is issued, the greater of $500,000 or 10 percent of total liabilities and no limitation on nonexempt enrollment;

5. An HMO subject to the requirements of this paragraph which exceeds the maximum enrollment levels established herein shall then be subject to the minimum surplus requirements set forth in paragraphs (a) through (b).
The department may adopt rules to set uniform standards and criteria for the early warning that the continued operation of any health maintenance organization might be hazardous to its subscribers, creditors, or the general public, and to set standards for evaluating the financial condition of any health maintenance organization.

(3) The department shall lower the surplus requirements to any level deemed appropriate by the department, but not less than $100,000 for an individual health maintenance organization, whenever the department is satisfied that:

(a) The organization has an adequate history of generating net income to assure its financial viability for the next year;

(b) The assets of the organization or its contracts with health care providers, governments, or other organizations are reasonably sufficient to assure the performance of the organization; and or

(c) The obligations of the organization are structured towards long-term payment so that a lower percentage requirement would prove adequate as a cushion against the payment of such obligations.

(d) In lieu of having any minimum surplus, the health maintenance organization may provide a written guarantee to assure payment of covered subscriber claims and all other liabilities of the health maintenance organization, provided that the written guarantee is made by a guaranteeing organization which:

(a) Has been in operation for 5 years or more and has a surplus, not including land, buildings, and equipment, of

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the greater of $2 million or 2 times the minimum surplus requirements of the health maintenance organization. In any determination of the financial condition of the guaranteeing organization, the definitions of assets, liabilities, and surplus set forth in this part shall apply, except that investments in or loans to any organizations guaranteed by the guaranteeing organization shall be excluded from surplus. 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.

(b) Submits a guarantee that is approved by the department as meeting the requirements of this part, provided that the written guarantee contains a provision which requires that the guarantee be irrevocable unless guaranteeing organization provide at least 6 months' notice to the department prior to cancellation of the guarantee, except that such period of notification may be shortened if the guaranteeing organization can demonstrate to the department that the cancellation of the guarantee will not result in the insolvency of the health maintenance organization and the department approves cancellation of the guarantee.

(c) Initially submits its audited financial statements, certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles, covering its two most current annual accounting periods.

(d) Submits annually, within 3 months after the end of its fiscal year, an audited financial statement certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles. The

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department may, as it deems necessary, require quarterly financial statements from the guaranteeing organization.

Section 6. Section 641.228, Florida Statutes, is created to read:

641.228 Florida Health Maintenance Organization Consumer Assistance Plan.--

(1) The department shall not issue a certificate to any health maintenance organization after the effective date of this act until the applicant health maintenance organization has paid in full its special assessment as set forth in s. 631.819(4)(a).

(2) No assessment paid to the Florida Health Maintenance Organization Consumer Assistance Plan shall be allowed as an asset of any health maintenance organization.

(3) The department may suspend or revoke the certificate of authority of any health maintenance organization which does not timely pay its assessment to the Florida Health Maintenance Organization Consumer Assistance Plan.

Section 7. Subsection (2) of section 641.23, Florida Statutes, is amended, present subsection (3) is renumbered as subsection (4), and a new subsection (3) is added to said section, to read:

641.23 Revocation or cancellation of certificate of authority; suspension of enrollment of new subscribers; terms of suspension.--

(2) The department may suspend the authority of a health maintenance organization to enroll new subscribers or revoke any certificate issued to a health maintenance organization, or order compliance within 30 60 days, if it finds that any of the following conditions exists:

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1. (a) The organization is not operating in compliance
2. with this part;
3. (b) The plan is no longer actuarially sound or the
4. organization does not have the minimum surplus as required by
5. this part;
6. (c) The existing contract rates are excessive,
7. inadequate, or unfairly discriminatory;
8. (d) The organization has advertised, merchandised, or
9. attempted to merchandise its services in such a manner as to
10. misrepresent its services or capacity for service or has
11. engaged in deceptive, misleading, or unfair practices with
12. respect to advertising or merchandising; or
13. (e) The organization is insolvent.

3. Whenever the financial condition of the health
4. maintenance organization is such that, if not modified or
5. corrected, its continued operation would result in impairment
6. or insolvency, the department may order the health maintenance
7. organization to file with the department and implement a
8. corrective action plan designed to do one or more of the
9. following:
10. (a) Reduce the total amount of present potential
11. liability for benefits by reinsurance or other means.
12. (b) Reduce the volume of new business being accepted,
13. (c) Reduce the expenses of the health maintenance
14. organization by specified methods,
15. (d) Suspend or limit the writing of new business for a
16. period of time,
17. (e) Require an increase in the health maintenance
18. organization’s net worth.

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If the health maintenance organization fails to submit a plan within 30 days of the department's order or submits a plan which is insufficient to correct the health maintenance organization's financial condition, the department may order the health maintenance organization to implement one or more of the corrective actions listed in this subsection.

Section 8. Section 641.234, Florida Statutes, is created to read:

441.234 Administrative, provider, and management contracts.--

1. The department may require a health maintenance organization to submit any contract for administrative services, contract with a provider other than an individual physician, contract for management services, and contract with an affiliated entity to the department, if the department has information and belief that the health maintenance organization has entered into a contract which requires it to pay a fee which is unreasonably high in relation to the service provided.

2. After review of a contract the department may order the health maintenance organization to cancel the contract in accordance with the terms of the contract and applicable law, if it determines that the fees to be paid by the health maintenance organization under the contract are so unreasonably high as compared with similar contracts entered into by the health maintenance organization or as compared with similar contracts entered into by other health maintenance organizations in similar circumstances that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the health maintenance organization.

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(3) All contracts for administrative services, management services, provider services other than individual physician contracts, and with affiliated entities entered into or renewed by a health maintenance organization on or after October 1, 1988, shall contain a provision that the contract shall be canceled upon issuance of an order by the department pursuant to this section.

Section 9. Section 641.2342, Florida Statutes, is created to read:

641.2342 Contract providers.--Each health maintenance organization shall file, upon the request of the department, financial statements for all contract providers of comprehensive health care services who have assumed, through capitation or other means, more than 10 percent of the health care risks of the health maintenance organization. However, this provision shall not apply to any individual physician.

Section 10. Section 641.25, Florida Statutes, is amended to read:

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

Section 11. Section 641.26, Florida Statutes, is amended to read:

641.26 Annual report.--

(1) Every health maintenance organization shall, annually on or before April 15 of the fiscal year, or within 3 months after the end of its fiscal year reporting period, or within an extension of time thereafter 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

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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 immediately preceding reporting period. Such report shall include:

(a) An audited 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, prepared in accordance with statutory generally-accepted accounting principles;

(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;

(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) 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;

(f) An actuarial certification that the health maintenance organization is actuarially sound, which certification shall consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of, the organization; and

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2. The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed.

3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided for and

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

(2) Every health maintenance organization shall file quarterly annually, within 45 days after each of its quarterly reporting periods period, an unaudited financial statement of the organization.

(3) Any health maintenance organization which neglects to file an annual report or quarterly report in the form and within the time required by this section shall forfeit $1,000 for each day for the first 10 days during which the neglect continues and shall forfeit $2,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the department to that effect, the organization's authority to enroll new subscribers or 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. The department shall not collect more than $100,000 for each report.

(4) Each authorized health maintenance organization shall retain an independent certified public accountant, hereinafter referred to as "CPA," who agrees by written contract with the health maintenance organization to comply with the provisions of this part. The contract shall state:

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The CPA shall provide to the HMO audited financial statements consistent with this part.

(b) Any determination by the CPA that the health maintenance organization does not meet minimum surplus requirements as set forth in this part shall be stated by the CPA, in writing, in the audited financial statement.

(c) The completed work papers and any written communications between the CPA firm and the health maintenance organization relating to the audit of the health maintenance organization shall be made available for review on a visual inspection-only basis by the department at the offices of the health maintenance organization, at the department, or at any other reasonable place as mutually agreed between the department and the health maintenance organization. The CPA must retain for review the work papers and written communications for a period of not less than 6 years.

(4) The department may require that a health maintenance organization submit quarterly financial reports which are necessary to enable the department to determine continued compliance with the provisions of this part.

Section 12. Subsection (1) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department.--

(1) 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. In lieu of making its own financial examination, the department may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with the provisions of this part.
with this part. However, except when the medical records are
requested and copies furnished pursuant to s. 455.241, 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 department 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. In no event shall
expenses of all examinations exceed a maximum of $20,000 for
any 1-year period. 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 13. Subsection (1) of section 641.29, Florida
Statutes, is amended to read:

641.29 Fees.—Every health maintenance organization
shall pay to the department the following fees:

(1) For filing a copy of its application for a
certificate of authority or amendment thereto, a nonrefundable
fee in the amount of $1,000 $240.

Section 14. Paragraph (b) of subsection (3) and
subsection (13) of section 641.31, Florida Statutes, are

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amended, and subsections (16) and (17) are added to said
section, to read:

641.31 Health maintenance contracts.--

(b) The department shall disapprove any form filed
under this subsection, or withdraw any previous approval
thereof, only if the form:

1. Is in any respect in violation of, or does not
comply with, any provision of this part or rule adopted
thereunder.

2. Contains or incorporates by reference, where such
incorporation is otherwise permissible, any inconsistent,
ambiguous, or misleading clauses or exceptions and conditions
which deceptively affect the risk purported to be assumed in
the general coverage of the contract.

3. Has any title, heading, or other indication of its
provisions which is misleading.

4. Is printed or otherwise reproduced in such a manner
as to render any material provision of the form substantially
illegible.

5. Contains provisions which are unfair, inequitable,
or contrary to the public policy of this state or which
encourage misrepresentation.

6. Charges rates that are determined by the department
to be inadequate, excessive, or unfairly discriminatory, or
the rating methodology followed by the health maintenance
organization is determined by the department to be
inconsistent, indeterminate, ambiguous, or encouraging
misrepresentation or misunderstanding.

(13) In addition to the requirements of this section,
with respect to a person who is entitled to have payments for

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health care costs made under Medicare, Title XVIII of the Social Security Act ("Medicare"), Parts A and/or B:

(a) The health maintenance contract shall be accompanied by the April 1985 edition of the Health Maintenance Organization-Medicare-Contract Information Form, which shall be promulgated as a rule by the department.

Delivery of the information form to such person shall be made prior to or at the time of application for membership in the health maintenance organization. However, if the application for membership is received by the health maintenance organization through the mail and is not a result of direct, personal contact between the person and an agent or representative of the organization, delivery of the information form shall be made prior to processing the application and within 15 days of receipt of the application by the organization. Acknowledgment of receipt or certification of delivery or mailing of the information form shall be maintained by the health maintenance organization from the date of the most recent examination by the department pursuant to s. 641.67 until the date of completion of the following examination:

(b) The health maintenance organization shall mail or deliver notification to the Medicare beneficiary of the date of enrollment in the health maintenance organization within 10 days after receiving notification of enrollment approval from the United States Department of Health and Human Services, Health Care Financing Administration. When a Medicare beneficiary who is a subscriber of the health maintenance organization requests disenrollment from the organization, the organization shall mail or deliver to the beneficiary notice of the effective date of the disenrollment.

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within 10 days after receipt of the written disenrollment request. The health maintenance organization shall forward the disenrollment request to the United States Department of Health and Human Services, Health Care Financing Administration, in a timely manner so as to effectuate the next available disenrollment date, as prescribed by such federal agency.

(b)(c) The health maintenance contract, certificate, or member handbook shall be delivered to the subscriber no later than the earlier of 10 working days after the health maintenance organization and the Health Care Financing Administration of the United States Department of Health and Human Services approve the subscriber's enrollment application or the effective date of coverage of the subscriber under the health maintenance contract. However, if notice from the Health Care Financing Administration of its approval of the subscriber's enrollment application is received by the health maintenance organization after the effective coverage date prescribed by the Health Care Financing Administration, the health maintenance organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving such notice. When a Medicare recipient is enrolled in a health maintenance organization program, the contract, certificate, or member handbook shall be accompanied by a health maintenance organization identification sticker with instruction to the Medicare beneficiary to place the sticker on the Medicare identification card.

(16) The contract must clearly disclose the intent of the health maintenance organization as to the applicability or nonapplicability of coverage to pre-existing conditions. If coverage of the contract is not to be applicable to pre-
existing conditions, the contract shall specify, in substance, that coverage pertains solely to accidental bodily injuries resulting from accidents occurring after the effective date of coverage and that sicknesses are limited to those which first manifest themselves subsequent to the effective date of coverage.

(17) All health maintenance contracts which provide coverage for a member of the family of the subscriber, shall, as to such family member's coverage, provide that coverage, benefits, or services applicable for children shall be provided with respect to an adopted child of the subscriber, which child is placed in compliance with chapter 63, from the moment of placement with the subscriber. In the case of a newborn child, coverage shall begin from the moment of birth if a written agreement to adopt such child has been entered into by the subscriber prior to the birth of the child.

whether or not such agreement is enforceable; provided, however, that coverage for such child shall not be required in the event that the child is not ultimately placed with the subscriber in compliance with chapter 63.

Section 15. Paragraph (a) of subsection (1) of section 641.311, Florida Statutes, is amended to read:

641.311 Statewide Subscriber Assistance Program.—The department shall adopt and implement a program to provide assistance to subscribers, including those whose grievances are not satisfactorily resolved by the health maintenance organization. The program shall include the following:

(1)(a) A review panel which may periodically review, consider, and recommend to the department any actions the department should take concerning individual cases heard by the panel as well as the types of subscriber grievances which
have not been satisfactorily resolved after the subscribers
follow the full grievance procedures of the health maintenance
organizations. The proceedings of the grievance panel shall
not be subject to the provisions of chapter 120. The review
panel shall consist of members employed by the department and
members employed by the Department of Health and
Rehabilitative Services, chosen by their respective agencies.
Outside qualified, impartial consultants may be consulted in
connection with the types of grievances outside the expertise
of the review panel.

Section 16. Section 641.3111, Florida Statutes, is
created to read:

641.3111 Extension of benefits.--Every health
maintenance contract shall provide that termination of the
contract by the health maintenance organization shall be
without prejudice to any continuous loss which commenced while
the contract was in force, but any extension of benefits
beyond the period the contract was in force may be predicated
upon the continuous total disability of the subscriber, and
may be limited to the duration of the contract benefit period
if greater than 3 months, or for a time period of not less
than 3 months, or to the payment of the maximum benefits
payable under the contract.

Section 17. Section 641.315, Florida Statutes, is
amended to read:

641.315 Provider contracts.—
(1) 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 a subscriber, the health maintenance organization

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shall be liable for such fee or fees rather than the
subscriber; and the contract shall so state.

(2) No subscriber of an HMO shall be liable to any
provider of health care services for any services covered by
the HMO.

(3) No provider of services or any representative of
such provider shall collect or attempt to collect from an HMO
subscriber any money for services covered by an HMO and no
provider or representative of such provider may maintain any
action at law against a subscriber of an HMO to collect money
owed to such provider by an HMO.

(4) Every contract between an HMO and a provider of
health care services shall be in writing, and shall contain a
provision that the subscriber shall not be liable to the
provider for any services covered by the subscriber's or
enrollee's contract with the HMO.

(5) The provisions of this section shall not be
construed to apply to the amount of any deductible or
copayment which is not covered by the contract of the HMO.

(6) For all provider contracts executed after the
effective date of this act and within 180 days after the
effective date of this act for contracts in existence as of
the effective date of this act:

(a) The contracts shall provide that the provider
shall provide 30 days' advance written notice to the health
maintenance organization and the department before canceling
the contract with the health maintenance organization for any
reason; and

(b) The contract must also provide that nonpayment for
goods or services rendered by the provider to the health

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maintenance organization shall not be a valid reason for avoiding the 30-day advance notice of cancellation.

(7) Upon receipt by the health maintenance organization of a 30-day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than 30 days if the health maintenance organization is not financially impaired or insolvent.

Section 18. Subsection (1), paragraphs (a) and (b) of subsection (2), paragraph (d) of subsection (5), subsection (9), paragraph (c) of subsection (10), subsections (11) and (12), and paragraph (b) of subsection (17) of section 641.35, Florida Statutes, are amended to read:

641.35 Assets, liabilities, and investments.--
(1) ASSETS.--In any determination of the financial condition of a health maintenance organization, there shall be allowed as "assets" only those assets that are owned by the health maintenance organization and which assets consist of:
(a) Cash in the possession of the health maintenance organization, or in transit under its control, including the true balance of any deposit in a solvent bank, savings and loan association, or trust company which is domiciled in the United States.
(b) Investments, securities, properties, and loans acquired or held in accordance with this part, and in connection therewith the following items:
1. Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.

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2. Declared and unpaid dividends on stock and shares, unless the amount of the dividends has otherwise been allowed as an asset.

3. Interest due or accrued upon a collateral loan which is not in default in an amount not to exceed 1 year's interest thereon.

4. Interest due or accrued on deposits or certificates of deposit in solvent banks, savings and loan associations, and trust companies domiciled in the United States, and interest due or accrued on other assets, if such interest is in the judgment of the department a collectible asset.

5. Interest due or accrued on current mortgage loans, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal; but in no event shall interest accrued for a period in excess of 90 days be allowed as an asset.

6. Rent due or accrued on real property if such rent is not in arrears for more than 3 months. However, in no event shall rent accrued for a period in excess of 90 days be allowed as an asset.

7. The unaccrued portion of taxes paid prior to the due date on real property.

(c) Premiums in the course of collection, not more than 3 months past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by any governmental body in the United States or by any of their instrumentalities.

(d) The full amount of reinsurance recoverable from a solvent reinsurer, which reinsurance is authorized under s. 624.610.

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(e) Furniture, fixtures, furnishings, vehicles, medical libraries, and equipment, if the original cost of each item is at least $200, which cost shall be amortized in full over a period not to exceed 5 calendar years, unless otherwise approved by the department.

(f) Pharmaceutical and medical supply inventories.

(g) The liquidation value of prepaid expenses.

(h) Other assets, not inconsistent with the provisions of this section, deemed by the department to be available for the payment of losses and claims, at values to be determined by it.

The department, upon determining that a health maintenance organization’s asset has not been evaluated according to applicable law or that it does not qualify as an asset, shall require the health maintenance organization to properly reevaluate the asset or replace the asset with an asset suitable to the department within 30 days of receipt of written notification by the department of this determination, if the removal of the asset from the organization’s assets would impair the organization’s solvency.

(2) ASSETS NOT ALLOWED.—In addition to assets impliedly excluded by the provisions of subsection (1), the following assets expressly shall not be allowed as assets in any determination of the financial condition of a health maintenance organization:

(a) Goodwill, subscriber lists, patents, trade names, agreements not to compete and other like intangible assets.

(b) Advances to officers, directors, entities, whether an advance or investment, which are directly or indirectly controlled by the health maintenance organization, parent or
affiliated with the parent or the health maintenance
organization, except as allowed in subsections (11) and (12)
or and controlling stockholders, whether secured or not, and
advances to employees, agents, or and other persons on
personal security only.

(5) ELIGIBLE INVESTMENTS.--

(d) Any investment limitation based upon the amount of
the organization's assets or particular funds shall relate to
such assets or funds as shown by the organization's annual or
quarterly report as of the end of the reporting period
immediately preceding the date of acquisition of the
investment by the organization or as shown by a current
financial statement of the organization.

(9) SURPLUS AND DEPOSIT RESTRICTIONS.--Every health
maintenance organization must maintain an amount equal to its
required minimum surplus, as well as any deposit made with the
department, in coin or currency of the United States on hand
or on deposit in any solvent national or state bank, savings
and loan association, or trust company or in eligible
securities or obligations as follows:

(a) Nondemand obligations of certain financial
institutions.--Direct, unconditional nondemand obligations for
the payment of money issued by a solvent bank or by a mutual
savings bank or trust company, savings and loan, building and
loan, or credit union, subject to the following:

1. The financial institution is solvent.

2. The financial institution is incorporated under the
laws of the United States or of any state thereof.

3. The obligations are of the type which are insured
by an agency of the United States.
4. The investment is in the name of and owned by the health maintenance organization, unless the account is under a trusteeship with the organization named as the beneficiary.

(b) Obligations of the United States.--Direct obligations of the United States for the payment of money or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by the United States.

(c) Obligations of agencies and instrumentalities of the United States.--Direct obligations for the payment of money issued by an agency or instrumentality of the United States or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by an agency or instrumentality of the United States.

(d) Obligations of a state.--Direct, general obligations of any state of the United States for the payment of money, or obligations for the payment of money to the extent guaranteed or insured as to the payment of principal and interest by full faith and credit of any state of the United States, on the following conditions:

1. The state has the power to levy taxes for the prompt payment of the principal and interest of such obligations.

2. The state is not in default in the payment of principal or interest on any of its direct, guaranteed, or insured general obligations at the date of such investment.

(e) Obligations of political subdivisions of a state.--Direct, general obligations of any political subdivision of any state of the United States for the payment of money, or obligations for the payment of money to the extent guaranteed as to the payment of principal and interest...
by any political subdivision of any state of the United States, on the following conditions:

1. The obligations are payable or guaranteed from ad valorem taxes.
2. The political subdivision is not in default in the payment of principal or interest on any of its direct or guaranteed obligations.
3. No investment shall be made under this paragraph in obligations which are secured only by special assessments for local improvements.

(10) PROPERTY USED IN THE HEALTH MAINTENANCE ORGANIZATION'S BUSINESS.--Real estate, including leasehold estates, for the convenient accommodation of the organization's business operations, including home office, branch administrative offices, hospitals, medical clinics, medical professional buildings, and any other facility to be used in the provision of health care services, or real estate for rental to any health care provider under contract with the organization to provide health care services which shall be used in the provision of health care services to members of the organization by that provider, on the following conditions:

(c) The greater of the admitted value of the asset, as determined by statutory generally-accepted accounting principles, or, if approved by the department, the health maintenance organization's equity in the real estate plus all encumbrances on the real estate owned by the organization under this subsection, when added to the value of all personal and mixed property used in the organization's business, shall not exceed 75 percent of its admitted assets unless, with the permission of the department, it finds that the percentage of

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its admitted assets is insufficient to provide convenient accommodation for the organization's business and the operations of the organization would not otherwise be impaired.

(11) INVESTMENTS IN ADMINISTRATIVE AND MANAGEMENT SERVICE ENTITIES AND OTHER HEALTH CARE PROVIDERS.--A health maintenance organization may invest directly or indirectly in real estate, common and preferred stocks, bonds or debentures, including convertible debentures, or other evidences of debts of or equity in an entity if the entity is owned by or, with the approval of the department, under contract to the organization to provide management services, administrative services, or health care services for the organization, on the following conditions:

(a) Investments authorized under this subsection shall not exceed 50 percent of admitted assets, and these investments shall be included in the calculation of the overall limitation in paragraph (10)(c) relating to all real and personal property.

(b) Investments may qualify under this section only insofar as a provider of management, administrative, or health care service relationship as defined herein exists. Upon cessation of such relationship, each investment shall be subject to the rules applicable to an investment of that type and must qualify under the appropriate limitation or, failing that, become ineligible and subject to disposal under subsection (17).

(12) EXCHANGES OF FACILITIES OR ASSETS.--Health care or administrative service entities, if subsidiaries of or under contract to the health maintenance organization to provide administrative or health care services to the

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organization's members, may exchange facilities or similar assets to be used in the organization's business for stock of the organization. However, any exchange involving an entity under contract with the health maintenance organization must have the approval of the department prior to the exchange.

These facilities or assets shall be valued in accordance with statutory generally-accepted accounting principles.

(17) TIME LIMIT FOR DISPOSAL OF INELIGIBLE PROPERTY AND SECURITIES; EFFECT OF FAILURE TO DISPOSE.--

(b) Notwithstanding the provisions of paragraph (a), any ineligible Any property or securities lawfully-acquired and-held-by-the-organization-after-expiration-of-the-period for-disposal-thereof-or-any-extension-of-such-period-granted by-the-department shall not be allowed as an asset of the organization.

Section 19. Section 641.365, Florida Statutes, is created to read:

441.365 Dividends.--

(1) A health maintenance organization shall not pay any dividend or distribute cash or other property to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and net realized capital gains. Dividend payments or distributions to stockholders shall not exceed 10 percent of such surplus in any 1 year unless otherwise approved by the department. In addition to such limited payments, a health maintenance organization may make dividend payments or distributions out of the health maintenance organization's entire net operating profits and realized net capital gains derived during the immediately preceding calendar or fiscal year, as applicable.

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(2) The department shall not approve a dividend or distribution in excess of the maximum amount allowed in subsection (1) unless it determines that the distribution or dividend would not jeopardize the financial condition of the health maintenance organization.

(3) Any director of a health maintenance organization who knowingly votes for or concurs in declaration or payment of a dividend to stockholders when such declaration is in violation of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, and shall be jointly and severally liable, together with other such directors likewise voting for or concurring, for any loss thereby sustained by creditors of the health maintenance organization to the extent of such dividend.

(4) Any stockholder receiving such an illegal dividend shall be liable in the amount thereof to the health maintenance organization.

(5) The department may revoke or suspend the certificate of authority of a health maintenance organization which has declared or paid such an illegal dividend.

Section 20. Subsection (1) of section 641.3913, Florida Statutes, is amended to read:

641.3913 Penalty for violation of cease and desist orders.—Any person, entity, or health maintenance organization which violates a cease and desist order of the department under s. 641.3909 while such order is in effect, after notice and hearing as provided in s. 641.3907, shall be subject, at the discretion of the department, to any one or more of the following:

(1) A monetary penalty of not more than $200,000
(2) $50,000 as to all matters determined in such hearing.

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Section 21. Subsection (7) is added to section 641.3921, Florida Statutes, to read:

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

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

Section 22. Subsection (9) of section 220.02, Florida Statutes, is amended to read:

220.02 Legislative intent.--

(9) It is the intent of the Legislature that credits against either the corporate income tax or the franchise tax be applied in the following order: those enumerated in s. 220.68, those enumerated in s. 631.719(1), those enumerated in 

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s. 631.575, those enumerated in s. 440.385(13), those
enumerated in s. 220.18, those enumerated in s. 631.823; those
enumerated in s. 220.181, those enumerated in s. 220.183,
those enumerated in s. 220.182, those enumerated in s.
220.189, those enumerated in s. 221.02, those enumerated in s.
220.184, and those enumerated in s. 220.186.

Section 23. Part IV of chapter 631, Florida Statutes,
as created by this act, is repealed on October 1, 1981, and
shall be reviewed by the Legislature pursuant to s. 11.61,
Florida Statutes.

Section 24. Each section which is added to chapter
641, Florida Statutes, by this act is repealed on October 1,
1981, and shall be reviewed by the Legislature pursuant to s.
11.61, Florida Statutes.

Section 25. This act shall take effect October 1, 1988.

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