By the Committee on Banking and Insurance; and Senator Carlton

311-1785-01

1 A bill to be entitled
2 An act relating to insurance; amending s.
3 215.555, F.S.; revising definitions; amending
4 s. 624.307, F.S.; authorizing the Department of
5 Insurance to adopt rules with respect to
6 required filings; amending s. 624.315, F.S.;
7 revising specified contents of certain reports;
8 amending s. 624.408, F.S.; deleting obsolete
9 provisions; amending ss. 624.423, 626.742,
10 626.8736, 626.907, 634.161, F.S.; providing for
11 alternative methods of service of process;
12 amending s. 624.424, F.S.; exempting certain
13 insurers from certain annual statement
14 requirements; providing exceptions;
15 transferring and renumbering s. 624.4435, F.S.,
16 as s. 624.4242, F.S.; amending s. 625.340,
17 F.S.; requiring certain foreign insurers to
18 comply with certain provisions; amending s.
19 626.8805, F.S.; exempting certain
20 administrators from certificate-of-authority
21 requirements; amending s. 627.7295, F.S.;
22 providing an additional exception to a
23 requirement that a minimum of 2 months' premium
24 be collected to issue a policy or binder for
25 motor vehicle insurance; amending s. 627.901,
26 F.S.; authorizing insurance agents and insurers
27 that finance premiums for certain policies to
28 charge interest or a service charge at a
29 specified rate on unpaid premiums on those
30 policies; amending s. 627.914, F.S.; clarifying
31 application of time-of-payment requirements to

1 self-insurance funds; deleting provisions
2 relating to certain required information
3 relating to workers' compensation insurance;
4 amending s. 627.915, F.S.; revising certain
5 reporting requirements concerning private
6 passenger automobile insurance information;
7 amending s. 641.19, F.S.; defining the term
8 "health care risk contract"; amending s.
9 641.26, F.S.; revising health maintenance
10 organization annual reporting requirements;
11 creating s. 641.263, F.S.; providing for
12 risk-based capital for health maintenance
13 organizations; providing for risk-based capital
14 reports; providing requirements for health
15 maintenance organizations upon the occurrence
16 of certain events; providing notice
17 requirements; requiring a risk-based capital
18 plan for such events; providing duties and
19 responsibilities of the department; providing
20 for department hearings of challenges by health
21 maintenance organizations; providing for notice
22 requirements; authorizing the department to
23 adopt rules; authorizing the department to
24 exempt certain health maintenance
25 organizations; providing for effect of certain
26 notices; providing for alternative requirements
27 for certain time periods; providing legislative
28 intent for the use of risk-based capital
29 reports and other related documents; creating
30 s. 641.265, F.S.; amending s. 641.35, F.S.;
31 including under liabilities the amounts of

1 certain claims in determinations of financial
2 health of health maintenance organizations;
3 amending ss. 641.2018, 641.495, 817.234,
4 817.50, F.S.; conforming cross-references;
5 repealing s. 641.2342, F.S., relating to
6 contract providers; providing effective dates.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Paragraph (c) of subsection (2) of section
11 215.555, Florida Statutes, is amended, and paragraph (n) is
12 added to that subsection, to read:
13 215.555 Florida Hurricane Catastrophe Fund.--
14 (2) DEFINITIONS.--As used in this section:
15 (c) "Covered policy" means any insurance policy
16 covering residential property in this state, including, but
17 not limited to, any homeowner's, mobile home owner's, farm
18 owner's, condominium association, condominium unit owner's,
19 tenant's, or apartment building policy, or any other policy
20 covering a residential structure or its contents issued by any
21 authorized insurer, including any joint underwriting
22 association or similar entity created pursuant to law or a
23 transferred policy as defined in paragraph (n). Additionally,
24 covered policies include policies covering the peril of wind
25 removed from the Florida Residential Property and Casualty
26 Joint Underwriting Association, created pursuant to s.
27 627.351(6), or from the Florida Windstorm Underwriting
28 Association, created pursuant to s. 627.351(2), by an
29 authorized insurer under the terms and conditions of an
30 executed assumption agreement between the authorized insurer
31 and either such association. Each assumption agreement between

1 either association and such authorized insurer must be
2 approved by the Florida Department of Insurance prior to the
3 effective date of the assumption, and the Department of
4 Insurance must provide written notification to the board
5 within 15 working days after such approval. "Covered policy"
6 does not include any policy that excludes wind coverage or
7 hurricane coverage or any reinsurance agreement and does not
8 include any policy otherwise meeting this definition which is
9 issued by a surplus lines insurer or a reinsurer.
10 (n) "Transferred policy" means a policy originally
11 written by an authorized insurer or joint underwriting
12 association which has been assumed by another authorized
13 insurer pursuant to an assumption and reinsurance agreement,
14 and meets all of the following conditions:
15 1. The policy was covered under a contract with the
16 fund immediately prior to the assumption.
17 2. The assumption and reinsurance agreement was
18 approved in advance by the Department of Insurance.
19 3. The assuming insurer is obligated to pay 100
20 percent of the losses of the policy.
21 4. An assumption notice that identifies the assuming
22 insurer is provided to each of the policyholders.
23 5. All premiums and assessments due to the fund from
24 the ceding insurer have been paid in full.
25 6. The assumption agreement provides for the full
26 payment of any premiums due to the fund for the transferred
27 policies for the balance of the contract period.
28 7. The assumption agreement clearly identifies
29 policies transferred and provides for the collection of any
30 data necessary for the fund to determine reimbursement under
31 the contract.

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1 8. In the case of an authorized insurer, the
2 assumption agreement provides for the transfer of all policies
3 covered under the existing contract with the fund.
4 9. The assumption agreement provides for the full
5 payment of any future assessments associated with the exposure
6 from the transferred policies.
7 10. The assumption agreement is filed with the fund by
8 the assuming insurer within 15 days after approval by the
9 department.
10 Section 2. Subsection (8) is added to section 624.307,
11 Florida Statutes, to read:
12 624.307 General powers; duties.--
13 (8) With respect to filings required under the code to
14 be furnished by a person issued a license or certificate of
15 authority, the department may specify by rule the format,
16 which may include an electronic format, and the rules may
17 include provisions governing electronic methodologies for use
18 in furnishing such filings. The department shall use generally
19 accepted data systems and shall not require information or
20 detail other than that required by statute. The department
21 shall implement this subsection in a manner that minimizes the
22 costs and administrative burden on insurers.
23 Section 3. Subsection (2) of section 624.315, Florida
24 Statutes, is amended to read:
25 624.315 Department; annual report.--
26 (2) The department shall maintain the following
27 information and make such information available upon request:
28 (a) Calendar year profitability, including investment
29 income from policyholders' unearned premium and loss reserves
30 (Florida and countrywide).
31 (b) Aggregate Florida loss reserves.

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(c) Premiums written (Florida and countrywide).

(d) Premiums earned (Florida and countrywide).

(e) Incurred losses (Florida and countrywide).

(f) Paid losses (Florida and countrywide).

(g) Allocated Florida loss adjustment expenses.

~~(h) Renewal ratio (countrywide).~~

~~(i) Variation of premiums charged by the industry as compared to rates promulgated by the Insurance Services Office (Florida and countrywide).~~

~~(j) An analysis of policy size limits (Florida and countrywide).~~

~~(k) Insureds' selection of claims-made versus occurrence coverage (Florida and countrywide).~~

(h)~~(l)~~ A subreport on the involuntary market in Florida encompassing such joint underwriting plans and assigned risk plans operating in the state.

(i)~~(m)~~ A subreport providing information relevant to emerging markets and alternate marketing mechanisms, such as self-insured trusts, risk retention groups, purchasing groups, and the excess-surplus lines market.

~~(n) Trends; emerging trends as exemplified by the percentage change in frequency and severity of both paid and incurred claims, and pure premium (Florida and countrywide).~~

~~(o) Fast track loss ratios as defined and assimilated by the Insurance Services Office (Florida and countrywide).~~

Section 4. Paragraph (b) of subsection (1) of section 624.408, Florida Statutes, is amended to read:

624.408 Surplus as to policyholders required; new and existing insurers.--

(1)

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(b) For any property and casualty insurer holding a certificate of authority on December 1, 1993, the following amounts apply instead of the $4 million required by subparagraph (a)5.:

~~1. On December 31, 1999, and until December 30, 2000, $2.5 million.~~

1.~~2.~~ On December 31, 2000, and until December 30, 2001, $2.75 million.

2.~~3.~~ On December 31, 2001, and until December 30, 2002, $3 million.

3.~~4.~~ On December 31, 2002, and until December 30, 2003, $3.25 million.

4.~~5.~~ On December 31, 2003, and until December 30, 2004, $3.6 million.

5.~~6.~~ On December 31, 2004, and thereafter, $4 million.

Section 5. Subsection (1) of section 624.423, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

624.423 Serving process.--

(1) Service of process upon the Insurance Commissioner and Treasurer as process agent of the insurer (under s. 624.422) shall be made by serving copies in triplicate of the process upon the Insurance Commissioner and Treasurer or upon her or his assistant, deputy, or other person in charge of her or his office. Upon receiving such service, the Insurance Commissioner and Treasurer shall file one copy in her or his office, return one copy with her or his admission of service, and promptly forward one copy of the process by registered or certified mail or by such other method of expeditious delivery determined to be appropriate by the department to the person last designated by the insurer to receive the same, as

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1 provided under s. 624.422(2)<u>; provided that, whether by mail</u>
2 <u>or other method, proof of service and admission of service are</u>
3 <u>accomplished</u>.
4 <u>(4) The department may prescribe by rule the method to</u>
5 <u>be used by the department in forwarding the process to the</u>
6 <u>person designated by the insurer and in returning a copy to</u>
7 <u>the plaintiff or the plaintiff's attorney with the admission</u>
8 <u>of service as described in this section.</u>
9 Section 6. Paragraph (b) of subsection (1) of section
10 624.424, Florida Statutes, is amended to read:
11 624.424 Annual statement and other information.--
12 (1)
13 (b)<u>1.</u> Each insurer's annual statement must contain a
14 statement of opinion on loss and loss adjustment expense
15 reserves made by a member of the American Academy of Actuaries
16 or by a qualified loss reserve specialist, under criteria
17 established by rule of the department. In adopting the rule,
18 the department must consider any criteria established by the
19 National Association of Insurance Commissioners. The
20 department may require semiannual updates of the annual
21 statement of opinion as to a particular insurer if the
22 department has reasonable cause to believe that such reserves
23 are understated to the extent of materially misstating the
24 financial position of the insurer. Workpapers in support of
25 the statement of opinion must be provided to the department
26 upon request. This <u>subparagraph</u> ~~paragraph~~ does not apply to
27 life insurance or title insurance.
28 <u>2. Any authorized insurer otherwise subject to this</u>
29 <u>paragraph having direct premiums written in this state of less</u>
30 <u>than $1 million in any calendar year and less than 1,000</u>
31 <u>policyholders or certificateholders of directly written</u>

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policies nationwide at the end of such calendar year is exempt from this section for such year unless the department makes a specific finding that compliance is necessary in order for the department to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit, by March 1 following the year to which the exemption applies, an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

Section 7. Section 624.4435, Florida Statutes, is transferred and renumbered as section 624.4242, Florida Statutes.

Section 8. Section 625.340, Florida Statutes, is amended to read:

625.340 Investments of foreign or alien insurers.--The investment portfolio of a foreign or alien insurer shall be as permitted by the laws of its domicile if of a quality substantially as high as that required under this chapter for similar funds of like domestic insurers. Foreign insurers that are commercially domiciled as defined in s. 624.075 shall comply with parts I and II of this chapter.

Section 9. Subsection (4) of section 626.742, Florida Statutes, is amended to read:

626.742 Nonresident agents; service of process.--

(4) Upon receiving such service, the Insurance Commissioner and Treasurer shall forthwith send one of the copies of the process, by ~~registered~~ mail or by such other method of expeditious delivery determined to be appropriate by the department ~~with return receipt requested~~, to the defendant

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1 agent at his or her last address of record with the
2 department.
3 Section 10. Subsection (4) of section 626.8736,
4 Florida Statutes, is amended to read:
5 626.8736 Nonresident independent or public adjusters;
6 service of process.--
7 (4) Upon receiving the service, the Insurance
8 Commissioner and Treasurer shall forthwith send one of the
9 copies of the process, by ~~registered~~ mail or by such other
10 method of expeditious delivery determined to be appropriate by
11 the department ~~with return receipt requested~~, to the defendant
12 nonresident independent or public adjuster at his or her last
13 address of record with the department.
14 Section 11. Effective January 1, 2002, subsection (7)
15 is added to section 626.8805, Florida Statutes, to read:
16 626.8805 Certificate of authority to act as
17 administrator.--
18 (7) An administrator is not required to hold a
19 certificate of authority pursuant to this section if:
20 (a) The administrator has its principal place of
21 business in another state.
22 (b) The administrator is not soliciting business as an
23 administrator in this state.
24 (c) In the case of any group policy or plan of
25 insurance serviced by the administrator, the lesser of 5
26 percent of or 100 certificateholders reside in this state.
27 Section 12. Subsection (1) of section 626.907, Florida
28 Statutes, is amended to read:
29 626.907 Service of process; judgment by default.--
30 (1) Service of process upon an insurer or person
31 representing or aiding such insurer pursuant to s. 626.906

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1 shall be made by delivering to and leaving with the Insurance
2 Commissioner and Treasurer or some person in apparent charge
3 of his or her office two copies thereof. The Insurance
4 Commissioner and Treasurer shall ~~forthwith~~ mail by certified
5 or registered mail, or by such other method of expeditious
6 delivery determined to be appropriate by the department,
7 provided that proof of service and admission of service are
8 accomplished, send, ~~by registered mail~~ one of the copies of
9 such process to the defendant at the defendant's last known
10 principal place of business and shall keep a record of all
11 process so served upon him or her. The service of process is
12 sufficient, provided notice of such service and a copy of the
13 process are sent within 10 days thereafter by registered mail
14 by plaintiff or plaintiff's attorney to the defendant at the
15 defendant's last known principal place of business, and the
16 defendant's receipt, or receipt issued by the post office with
17 which the letter is registered, showing the name of the sender
18 of the letter and the name and address of the person to whom
19 the letter is addressed, and the affidavit of the plaintiff or
20 plaintiff's attorney showing a compliance herewith are filed
21 with the clerk of the court in which the action is pending on
22 or before the date the defendant is required to appear, or
23 within such further time as the court may allow.
24 Section 13. Subsection (7) of section 627.7295,
25 Florida Statutes, is amended to read:
26 627.7295 Motor vehicle insurance contracts.--
27 (7) A policy of private passenger motor vehicle
28 insurance or a binder for such a policy may be initially
29 issued in this state only if the insurer or agent has
30 collected from the insured an amount equal to 2 months'
31 premium. An insurer, agent, or premium finance company may

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1 not directly or indirectly take any action resulting in the
2 insured having paid from the insured's own funds an amount
3 less than the 2 months' premium required by this subsection.
4 This subsection applies without regard to whether the premium
5 is financed by a premium finance company or is paid pursuant
6 to a periodic payment plan of an insurer or an insurance
7 agent. This subsection does not apply if an insured or member
8 of the insured's family is renewing or replacing a policy or a
9 binder for such policy written by the same insurer or a member
10 of the same insurer group. This subsection does not apply to
11 an insurer that issues private passenger motor vehicle
12 coverage primarily to active duty or former military personnel
13 or their dependents. This subsection does not apply if all
14 policy payments are paid pursuant to a payroll deduction plan
15 or an automatic electronic funds transfer payment plan from
16 the policyholder, provided that the first policy payment is
17 made by cash, cashier's check, check, or a money order. This
18 subsection and subsection (4) do not apply if all policy
19 payments to an insurer are paid pursuant to an automatic
20 electronic funds transfer payment plan from an agent or a
21 managing general agent, or if the policy is issued pursuant to
22 the transfer of a book of business by an agent from one
23 insurer to another, provided that ~~and if~~ the policy includes,
24 at a minimum, personal injury protection pursuant to ss.
25 627.730-627.7405; motor vehicle property damage liability
26 pursuant to s. 627.7275; and bodily injury liability in at
27 least the amount of $10,000 because of bodily injury to, or
28 death of, one person in any one accident and in the amount of
29 $20,000 because of bodily injury to, or death of, two or more
30 persons in any one accident. This subsection and subsection
31 (4) do not apply if an insured has had a policy in effect for

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1 at least 6 months, the insured's agent is terminated by the
2 insurer that issued the policy, and the insured obtains
3 coverage on the policy's renewal date with a new company
4 through the terminated agent.
5 Section 14. Subsection (1) of section 627.901, Florida
6 Statutes, is amended to read:
7 627.901 Premium financing by an insurance agent or
8 agency.--
9 (1) A general lines agent may make reasonable service
10 charges for financing insurance premiums on policies issued or
11 business produced by such an agent or agency, s. 626.9541
12 notwithstanding. The service charge shall not exceed $1 per
13 installment, or a $6 total service charge per year, for any
14 premium balance of $120 or less. For any premium balance
15 greater than $120 but not more than $220, the service charge
16 shall not exceed $9 per year. The maximum service charge for
17 any premium balance greater than $220 shall not exceed $12 per
18 year. In lieu of such service charges, an insurance agent or
19 agency may charge interest or service charges, which may be
20 level amounts and subject to endorsement changes, which in the
21 aggregate do not exceed ~~a rate of interest not to exceed~~ 18
22 percent simple interest per year on the average unpaid balance
23 as billed over the term of the policy.
24 Section 15. Section 627.914, Florida Statutes, is
25 amended to read:
26 627.914 Reports of information by workers'
27 compensation insurers required.--
28 (1) The department shall promulgate rules and
29 statistical plans which shall thereafter be used by each
30 insurer and self-insurance fund as defined in s. 624.461 in
31 the recording and reporting of loss, expense, and claims

experience, in order that the experience of all insurers and self-insurance funds ~~self-insurers~~ may be made available at least annually in such form and detail as may be necessary to aid the department in determining whether Florida experience for workers' compensation insurance is sufficient for establishing rates.

~~(2) Any insurer authorized to write a policy of workers' compensation insurance shall transmit the following information to the department each year with its annual report, and such information shall be reported on a net basis with respect to reinsurance for nationwide experience and on a direct basis for Florida experience:~~

~~(a) Premiums written;~~

~~(b) Premiums earned;~~

~~(c) Dividends paid or credited to policyholders;~~

~~(d) Losses paid;~~

~~(e) Allocated loss adjustment expenses;~~

~~(f) The ratio of allocated loss adjustment expenses to losses paid;~~

~~(g) Unallocated loss adjustment expenses;~~

~~(h) The ratio of unallocated loss adjustment expenses to losses paid;~~

~~(i) The total of losses paid and unallocated and allocated loss adjustment expenses;~~

~~(j) The ratio of losses paid and unallocated and allocated loss adjustment expenses to premiums earned;~~

~~(k) The number of claims outstanding as of December 31 of each year;~~

~~(l) The total amount of losses unpaid as of December 31 of each year;~~

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~~(m) The total amount of allocated and unallocated loss adjustment expenses unpaid as of December 31 of each year; and~~

~~(n) The total of losses paid and allocated loss adjustment expenses and unallocated loss adjustment expenses, plus the total of losses unpaid as of December 31 of each year and loss adjustment expenses unpaid as of December 31 of each year.~~

~~(3) A report of the information required in subsection (2) shall be filed no later than April 1 of each year and shall include the information for the preceding year ending December 31. All reports shall be on a calendar-accident year basis, and each calendar-accident year shall be reported at eight stages of development.~~

(2)~~(4)~~ Each insurer and self-insurance fund as defined in s. 624.461 authorized to write a policy of workers' compensation insurance shall transmit the following information ~~for paragraphs (a), (b), (d), and (e)~~annually on both Florida experience and nationwide experience separately:

(a) Payrolls by classification.

(b) Manual premiums by classification.

(c) Standard premiums by classification.

(d) Losses by classification and injury type.

(e) Expenses.

A report of this information shall be filed no later than July ~~April~~ 1 of each year. All reports shall be filed in accordance with standard reporting procedures for insurers, which procedures have received approval by the department, and shall contain data for the most recent policy period available. A statistical or rating organization may be used by insurers or self-insurance funds to report the data

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required by this section. The statistical or rating organization shall report each data element in the aggregate only for insurers and self-insurance funds required to report under this section who elect to have the rating organization report on their behalf. Such insurers and self-insurance funds shall be named in the report.

(3)~~(5)~~ Individual self-insurers ~~authorized to transact workers' compensation insurance~~ as provided in s. 440.02(23)(a)shall report only Florida data as prescribed in ~~paragraphs (a)-(e) of~~ subsection(2)~~(4)~~to the Division of Workers' Compensation of the Department of Labor and Employment Security.

(a) The Division of Workers' Compensation shall publish the dates and forms necessary to enable individual self-insurers to comply with this section.

(b) The Division of Workers' Compensation shall report the information collected under this section to the Department of Insurance in a manner prescribed by the department.

(c) A statistical or rating organization may be used by individual self-insurers for the purposes of reporting the data required by this section and calculating experience ratings.

(4)~~(6)~~ The department shall provide a summary of information provided pursuant to subsection ~~subsections~~ (2) ~~and (4)~~in its annual report.

Section 16. Subsection (1) of section 627.915, Florida Statutes, is amended to read:

627.915 Insurer experience reporting.--

(1) Each insurer transacting private passenger automobile insurance in this state shall report certain information annually to the department. The information will

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be due on or before July 1 of each year. The information shall be divided into the following categories: bodily injury liability; property damage liability; uninsured motorist; personal injury protection benefits; medical payments; comprehensive and collision. The information given shall be on direct insurance writings in the state alone and shall represent total limits data. The information set forth in paragraphs (a)-(d)~~(f)~~is applicable to voluntary private passenger and Joint Underwriting Association private passenger writings and shall be reported for each of the latest 3 calendar-accident years, with an evaluation date of March 31 of the current year. The information set forth in paragraphs (e)-(h)~~(g)-(j)~~is applicable to voluntary private passenger writings and shall be reported on a calendar-accident year basis ultimately seven times at seven different stages of development.

(a) Premiums earned for the latest 3 calendar-accident years.

~~(b) Loss development factors and the historic development of those factors.~~

(b)~~(c)~~ Policyholder dividends incurred.

(c)~~(d)~~ Expenses for other acquisition and general expense.

(d)~~(e)~~ Expenses for agents' commissions and taxes, licenses, and fees.

~~(f) Profit and contingency factors as utilized in the insurer's automobile rate filings for the applicable years.~~

(e)~~(g)~~ Losses paid.

(f)~~(h)~~ Losses unpaid.

(g)~~(i)~~ Loss adjustment expenses paid.

(h)~~(j)~~ Loss adjustment expenses unpaid.

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1 Section 17. Subsection (1) of section 634.161, Florida
2 Statutes, is amended to read:
3 634.161 Service of process; method.--
4 (1) Service of process upon the Insurance Commissioner
5 and Treasurer as process agent of the company shall be made by
6 serving copies in triplicate of the process upon the Insurance
7 Commissioner and Treasurer or upon her or his assistant,
8 deputy, or other person in charge of her or his office. Upon
9 receiving such service, the Insurance Commissioner and
10 Treasurer shall file one copy with the department, return one
11 copy with her or his admission of service, and promptly
12 forward one copy of the process by registered or certified
13 mail or by such other method of expeditious delivery
14 determined to be appropriate by the department, provided that
15 proof of service and admission of service are accomplished,to
16 the person last designated by the company to receive the same,
17 as provided under s. 634.151.
18 Section 18. Present subsections (12) through (21) of
19 section 641.19, Florida Statutes, are renumbered as
20 subsections (13) through (22), respectively, and a new
21 subsection (12) is added to that section to read:
22 641.19 Definitions.--As used in this part, the term:
23 (12) "Health care risk contract" means a contract
24 under which a person or entity receives consideration or other
25 compensation in an amount greater than 1 percent of the health
26 maintenance organization's annual gross written premium in
27 exchange for providing to the health maintenance organization
28 a provider network and other services, which may include
29 administrative services.
30 Section 19. Subsection (1) of section 641.2018,
31 Florida Statutes, is amended to read:

641.2018 Limited coverage for home health care authorized.--

(1) Notwithstanding other provisions of this chapter, a health maintenance organization may issue a contract that limits coverage to home health care services only. The organization and the contract shall be subject to all of the requirements of this part that do not require or otherwise apply to specific benefits other than home care services. To this extent, all of the requirements of this part apply to any organization or contract that limits coverage to home care services, except the requirements for providing comprehensive health care services as provided in ss. 641.19(4),~~(12), and~~ (13), and (14),and 641.31(1), except ss. 641.31(9), (12), (17), (18), (19), (20), (21), and (24) and 641.31095.

Section 20. Subsections (1) and (3) of section 641.26, Florida Statutes, are amended to read:

641.26 Annual report.--

(1) Every health maintenance organization shall, annually by April 1 ~~within 3 months after the end of its fiscal year~~, or within an extension of time therefor as the department, for good cause, may grant, in a form prescribed by the department, file a report with the department, verified by the oath of two officers of the organization or, if not a corporation, of two persons who are principal managing directors of the affairs of the organization, properly notarized, showing its condition on the last day of the immediately preceding reporting period. Such report shall include:

(a) A financial statement of the health maintenance organization filed on a computer diskette using a format acceptable to the department.

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1 (b) A financial statement of the health maintenance
2 organization filed on forms acceptable to the department.
3 (c) An audited financial statement of the health
4 maintenance organization, including its balance sheet and a
5 statement of operations for the preceding year certified by an
6 independent certified public accountant, prepared in
7 accordance with statutory accounting principles.
8 (d) The number of health maintenance contracts issued
9 and outstanding and the number of health maintenance contracts
10 terminated.
11 (e) The number and amount of damage claims for medical
12 injury initiated against the health maintenance organization
13 and any of the providers engaged by it during the reporting
14 year, broken down into claims with and without formal legal
15 process, and the disposition, if any, of each such claim.
16 (f) An actuarial certification that:
17 1. The health maintenance organization is actuarially
18 sound, which certification shall consider the rates, benefits,
19 and expenses of, and any other funds available for the payment
20 of obligations of, the organization.
21 2. The rates being charged or to be charged are
22 actuarially adequate to the end of the period for which rates
23 have been guaranteed.
24 3. Incurred but not reported claims and claims
25 reported but not fully paid have been adequately provided for,
26 including claims arising for services provided to subscribers
27 if these services are provided under health care risk
28 contracts unless the obligations under such contracts are
29 secured by a financial instrument acceptable to the
30 department. Such instrument shall be certified as complying
31 with the requirements of this subsection. This requirement

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1 shall not apply to a contract with a provider where the
2 contract is limited to services provided by such provider
3 under the scope of that provider's license.
4 (g) A report prepared by the certified public
5 accountant and filed with the department describing material
6 weaknesses in the health maintenance organization's internal
7 control structure as noted by the certified public accountant
8 during the audit. The report must be filed with the annual
9 audited financial report as required in paragraph (c). The
10 health maintenance organization shall provide a description of
11 remedial actions taken or proposed to correct material
12 weaknesses, if the actions are not described in the
13 independent certified public accountant's report.
14 (h) Such other information relating to the performance
15 of health maintenance organizations as is required by the
16 department.
17 (3) Every health maintenance organization shall file
18 ~~quarterly, within 45 days after each of its quarterly~~
19 ~~reporting periods,~~ an unaudited quarterly financial statement
20 for each quarter except the fourth quarter ~~of the organization~~
21 ~~as described in paragraphs (1)(a) and (b)~~. The report shall be
22 as described in paragraphs (1)(a) and (b) and shall be due
23 within 45 days after the end of the quarter. The quarterly
24 report shall be verified by the oath of two officers of the
25 organization, properly notarized.
26 Section 21. Section 641.263, Florida Statutes, is
27 created to read:
28 641.263 Risk-based capital.--
29 (1) For purposes of this section:
30
31

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1 (a) "Adjusted risk-based capital report" means a
2 risk-based capital report which has been adjusted by the
3 department in accordance with paragraph (2)(b).
4 (b) "Association" means the National Association of
5 Insurance Commissioners.
6 (c) "Corrective order" means an order issued by the
7 department specifying corrective actions which the department
8 has determined are required.
9 (d) "Risk-based capital instructions" means the
10 risk-based capital report including risk-based capital
11 instructions adopted by the association, as these risk-based
12 capital instructions may be amended by the association from
13 time to time in accordance with the procedures adopted by the
14 association.
15 (e) "Risk-based capital level" means a health
16 maintenance organization's company action level risk-based
17 capital, regulatory action level risk-based capital,
18 authorized control level risk-based capital, or mandatory
19 control level risk-based capital. For purposes of this
20 section:
21 1. "Company action level risk-based capital" means the
22 product of 2.0 and the health maintenance organization's
23 authorized control level risk-based capital.
24 2. "Regulatory action level risk-based capital" means
25 the product of 1.5 and the health maintenance organization's
26 authorized control level risk-based capital.
27 3. "Authorized control level risk-based capital" means
28 the number determined under the risk-based capital formula in
29 accordance with the risk-based capital instructions.
30
31

1 4. "Mandatory control level risk-based capital" means
2 the product of .70 and the authorized control level risk-based
3 capital.
4 (f) "Risk-based capital plan" means a comprehensive
5 financial plan containing the elements specified in paragraph
6 (3)(b). If the department rejects the risk-based capital plan,
7 and the plan is revised by the health maintenance
8 organization, with or without the department's recommendation,
9 the plan shall be called the "revised risk-based capital
10 plan."
11 (g) "Risk-based capital report" means the report
12 required in subsection (2).
13 (h) "Total adjusted capital" means the sum of:
14 1. A health maintenance organization's net worth,
15 consisting of its statutory capital and surplus, as determined
16 in accordance with the statutory accounting applicable to the
17 annual financial statements required to be filed under s.
18 641.26; and
19 2. Such other items, if any, as the risk-based capital
20 instructions may provide.
21 (2)(a) A health maintenance organization shall, on or
22 prior to April 1 of each year, prepare and submit to the
23 department a report of its risk-based capital levels as of the
24 end of the calendar year just ended, in a form and containing
25 such information as is required by the risk-based capital
26 instructions. In addition, a health maintenance organization
27 shall file its risk-based capital report:
28 1. With the association in accordance with the
29 risk-based capital instructions; and
30 2. With the chief insurance regulatory official in any
31 state in which the health maintenance organization is

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1 authorized to do business, if such official has notified the
2 health maintenance organization of his or her request in
3 writing, in which case the health maintenance organization
4 shall file its risk-based capital report not later than the
5 later of 15 days after the receipt of notice to file its
6 risk-based capital report with that state or April 1.
7 (b) A health maintenance organization's risk-based
8 capital shall be determined in accordance with the formula set
9 forth in the risk-based capital instructions. The formula
10 shall take into account and may adjust for the covariance
11 between:
12 1. Asset risks;
13 2. Credit risks;
14 3. Underwriting risks; and
15 4. All other business risks and such other relevant
16 risks as are set forth in the risk-based capital instructions,
17
18 determined in each case by applying the factors in the manner
19 set forth in the risk-based capital instructions.
20 (c) The Legislature finds that an excess of capital
21 over the amount produced by the risk-based capital
22 requirements contained in this section and the formulas,
23 schedules, and instructions referenced in this section is
24 desirable in the health maintenance organization business.
25 Accordingly, health maintenance organizations should seek to
26 maintain capital above the risk-based capital levels required
27 by this section. Additional capital is used and useful in the
28 health maintenance organization business and helps to secure a
29 health maintenance organization against various risks inherent
30 in, or affecting, said business and not accounted for or only
31

1 partially measured by the risk-based capital requirements
2 contained in this section.
3 (d) If a health maintenance organization files a
4 risk-based capital report that in the judgment of the
5 department is inaccurate, the department shall adjust the
6 risk-based capital report to correct the inaccuracy and shall
7 notify the health maintenance organization of the adjustment.
8 The notice shall contain a statement of the reason for the
9 adjustment. A risk-based capital report as so adjusted is
10 referred to as an "adjusted risk-based capital report."
11 (3)(a) A company action level event includes:
12 1. The filing of a risk-based capital report by a
13 health maintenance organization that indicates that the health
14 maintenance organization's total adjusted capital is greater
15 than or equal to its regulatory action level risk-based
16 capital but less than its company action level risk-based
17 capital;
18 2. Notification by the department to the health
19 maintenance organization of an adjusted risk-based capital
20 report that indicates the event described in subparagraph 1.,
21 provided the health maintenance organization does not
22 challenge the adjusted risk-based capital report under
23 subsection (7); or
24 3. If, pursuant to the provisions of subsection (7), a
25 health maintenance organization challenges an adjusted
26 risk-based capital report that indicates the event described
27 in subparagraph 1., the notification by the department to the
28 health maintenance organization that the department has, after
29 a hearing, rejected the health maintenance organization's
30 challenge.
31

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1 (b) If a company action level event occurs, the health
2 maintenance organization shall prepare and submit to the
3 department a risk-based capital plan that shall:
4 1. Identify the conditions that contribute to the
5 company action level event.
6 2. Contain proposals of corrective actions that the
7 health maintenance organization intends to take and that would
8 be expected to result in the elimination of the company action
9 level event.
10 3. Provide projections of the health maintenance
11 organization's financial results in the current year and at
12 least the 2 succeeding years, both in the absence of proposed
13 corrective actions and giving effect to the proposed
14 corrective actions, including projections of statutory balance
15 sheets, operating income, net income, capital and surplus, and
16 risk-based capital levels. The projections for both new and
17 renewal business might include separate projections for each
18 major line of business and separately identify each
19 significant income, expense, and benefit component.
20 4. Identify the key assumptions impacting the health
21 maintenance organization's projections and the sensitivity of
22 the projections to the assumptions.
23 5. Identify the quality of, and problems associated
24 with, the health maintenance organization's business,
25 including, but not limited to, its assets, anticipated
26 business growth and associated surplus strain, extraordinary
27 exposure to risk, mix of business, and use of reinsurance, if
28 any, in each case.
29 (c) The risk-based capital plan shall be submitted:
30 1. Within 45 days after a company action level event;
31 or

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1 2. If the health maintenance organization challenges
2 an adjusted risk-based capital report pursuant to the
3 provisions of subsection (7), within 45 days after
4 notification to the health maintenance organization that the
5 department has, after a hearing, rejected the health
6 maintenance organization's challenge.
7 (d) Within 60 days after the submission by a health
8 maintenance organization of a risk-based capital plan to the
9 department, the department shall notify the health maintenance
10 organization whether the risk-based capital plan shall be
11 implemented or is, in the judgment of the department,
12 unsatisfactory. If the department determines the risk-based
13 capital plan is unsatisfactory, the notification to the health
14 maintenance organization shall set forth the reasons for the
15 determination and may set forth proposed revisions which will
16 render the risk-based capital plan satisfactory in the
17 judgment of the department. Upon notification from the
18 department, the health maintenance organization shall prepare
19 a revised risk-based capital plan, which may incorporate by
20 reference any revisions proposed by the department, and shall
21 submit the revised risk-based capital plan to the department:
22 1. Within 45 days after the notification from the
23 department; or
24 2. If the health maintenance organization challenges
25 the notification from the department under the provisions of
26 subsection (7), within 45 days after a notification to the
27 health maintenance organization that the department has, after
28 a hearing, rejected the health maintenance organization's
29 challenge.
30 (e) If the department notifies a health maintenance
31 organization that the health maintenance organization's

1 risk-based capital plan or revised risk-based capital plan is
2 unsatisfactory, the department may, at its discretion, subject
3 to the health maintenance organization's right to a hearing
4 under the provisions of subsection (7), specify in the
5 notification that the notification constitutes a regulatory
6 action level event.
7 (f) Each domestic health maintenance organization that
8 files a risk-based capital plan or revised risk-based capital
9 plan with the department shall file a copy of the risk-based
10 capital plan or revised risk-based capital plan with the
11 insurance department in any state in which the health
12 maintenance organization is authorized to do business if:
13 1. The state has a risk-based capital provision
14 substantially similar to the provisions of s. 641.264; and
15 2. The insurance department of that state has notified
16 the health maintenance organization of its request for the
17 filing in writing, in which case the health maintenance
18 organization shall file a copy of the risk-based capital plan
19 or revised risk-based capital plan in that state no later than
20 the later of:
21 a. Fifteen days after the receipt of notice to file a
22 copy of its risk-based capital plan or revised risk-based
23 capital plan with the state; or
24 b. The date on which the risk-based capital plan or
25 revised risk-based capital plan is filed under paragraph (c)
26 or paragraph (d).
27 (4)(a) A regulatory action level event includes, with
28 respect to a health maintenance organization:
29 1. The filing of a risk-based capital report by the
30 health maintenance organization that indicates that the health
31 maintenance organization's total adjusted capital is greater

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1 than or equal to its authorized control level risk-based
2 capital but less than its regulatory action level risk-based
3 capital;
4 2. Notification by the department to a health
5 maintenance organization of an adjusted risk-based capital
6 report that indicates the event described in subparagraph 1.,
7 provided the health maintenance organization does not
8 challenge the adjusted risk-based capital report under the
9 provisions of subsection (7);
10 3. If, pursuant to the provisions of subsection (7),
11 the health maintenance organization challenges an adjusted
12 risk-based capital report that indicates the event described
13 in subparagraph 1., the notification by the department to the
14 health maintenance organization that the department has, after
15 a hearing, rejected the health maintenance organization's
16 challenge;
17 4. The failure of the health maintenance organization
18 to file a risk-based capital report by April 1, unless the
19 health maintenance organization has provided an explanation
20 for the failure that is satisfactory to the department and has
21 cured the failure within 10 days after April 1;
22 5. The failure of the health maintenance organization
23 to submit a risk-based capital plan to the department within
24 the time period set forth in paragraph (3)(c);
25 6. Notification by the department to the health
26 maintenance organization that:
27 a. The risk-based capital plan or revised risk-based
28 capital plan submitted by the health maintenance organization
29 is, in the judgment of the department, unsatisfactory; and
30 b. Notification constitutes a regulatory action level
31 event with respect to the health maintenance organization,

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1 provided the health maintenance organization has not
2 challenged the determination under subsection (7);
3 7. If, pursuant to subsection (7), the health
4 maintenance organization challenges a determination by the
5 department under subparagraph 6., the notification by the
6 department to the health maintenance organization that the
7 department has, after a hearing, rejected the health
8 maintenance organization's challenge;
9 8. Notification by the department to the health
10 maintenance organization that the health maintenance
11 organization has failed to adhere to its risk-based capital
12 plan or revised risk-based capital plan, but only if the
13 failure has a substantial adverse effect on the ability of the
14 health maintenance organization to eliminate the company
15 action level event in accordance with its risk-based capital
16 plan or revised risk-based capital plan and the department has
17 so stated in the notification, provided the health maintenance
18 organization has not challenged the determination under
19 subsection (7); or
20 9. If, pursuant to subsection (7), the health
21 maintenance organization challenges a determination by the
22 department under subparagraph 8., the notification by the
23 department to the health maintenance organization that the
24 department has, after a hearing, rejected the health
25 maintenance organization's challenge.
26 (b) If a regulatory action level event occurs, the
27 department shall:
28 1. Require the health maintenance organization to
29 prepare and submit a risk-based capital plan or, if
30 applicable, a revised risk-based capital plan.
31

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1 2. Perform such examination or analysis as the
2 department deems necessary of the assets, liabilities, and
3 operations of the health maintenance organization, including a
4 review of its risk-based capital plan or revised risk-based
5 capital plan.
6 3. Subsequent to the examination or analysis, issue a
7 corrective order specifying such corrective actions as the
8 department shall determine are required.
9 (c) In determining corrective actions, the department
10 may take into account factors the department deems relevant
11 with respect to the health maintenance organization based upon
12 the department's examination or analysis of the assets,
13 liabilities, and operations of the health maintenance
14 organization, including, but not limited to, the results of
15 any sensitivity tests undertaken pursuant to the risk-based
16 capital instructions. The risk-based capital plan or revised
17 risk-based capital plan shall be submitted:
18 1. Within 45 days after the occurrence of the
19 regulatory action level event;
20 2. If the health maintenance organization challenges
21 an adjusted risk-based capital report pursuant to subsection
22 (7) and the challenge is not frivolous in the judgment of the
23 department, within 45 days after the notification to the
24 health maintenance organization that the department has, after
25 a hearing, rejected the health maintenance organization's
26 challenge; or
27 3. If the health maintenance organization challenges a
28 revised risk-based capital plan pursuant to subsection (7) and
29 the challenge is not frivolous in the judgment of the
30 department, within 45 days after the notification to the
31 health maintenance organization that the department has, after

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1 a hearing, rejected the health maintenance organization's
2 challenge.
3 (d) The department may retain actuaries, investment
4 experts, and other consultants as may be necessary in the
5 judgment of the department to review the health maintenance
6 organization's risk-based capital plan or revised risk-based
7 capital plan, examine or analyze the assets, liabilities, and
8 operations, including contractual relationships, of the health
9 maintenance organization, and formulate the corrective order
10 with respect to the health maintenance organization. The fees,
11 costs, and expenses relating to consultants shall be borne by
12 the affected health maintenance organization or such other
13 party as directed by the department.
14 (5)(a) An authorized control level event includes:
15 1. The filing of a risk-based capital report by the
16 health maintenance organization that indicates that the health
17 maintenance organization's total adjusted capital is greater
18 than or equal to its mandatory control level risk-based
19 capital but less than its authorized control level risk-based
20 capital;
21 2. Notification by the department to the health
22 maintenance organization of an adjusted risk-based capital
23 report that indicates the event described in subparagraph 1.,
24 provided the health maintenance organization does not
25 challenge the adjusted risk-based capital report under
26 subsection (7);
27 3. If, pursuant to subsection (7), the health
28 maintenance organization challenges an adjusted risk-based
29 capital report that indicates the event described in
30 subparagraph 1., notification by the department to the health
31 maintenance organization that the department has, after a

1 hearing, rejected the health maintenance organization's
2 challenge;
3 4. The failure of the health maintenance organization
4 to respond, in a manner satisfactory to the department, to a
5 corrective order, provided the health maintenance organization
6 has not challenged the corrective order under subsection (7);
7 or
8 5. If the health maintenance organization has
9 challenged a corrective order under subsection (7) and the
10 department has, after a hearing, rejected the challenge or
11 modified the corrective order, the failure of the health
12 maintenance organization to respond, in a manner satisfactory
13 to the department, to the corrective order subsequent to
14 rejection or modification by the department.
15 (b) If an authorized control level event occurs, with
16 respect to a health maintenance organization, the department
17 shall:
18 1. Take such actions as are required under paragraph
19 (4)(b) regarding a health maintenance organization with
20 respect to which a regulatory action level event has occurred;
21 or
22 2. If the department deems it to be in the best
23 interests of the subscribers and creditors of the health
24 maintenance organization and of the public, take such actions
25 as are necessary to cause the health maintenance organization
26 to be placed under regulatory control under chapter 631. If
27 the department takes such actions, the authorized control
28 level event shall be deemed sufficient grounds for the
29 department to take action under chapter 631 and the department
30 shall have the rights, powers, and duties with respect to the
31 health maintenance organization as are set forth in such

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1 chapter. If the department takes actions under this
2 subparagraph pursuant to an adjusted risk-based capital
3 report, the health maintenance organization shall be entitled
4 to such protections as are afforded to health maintenance
5 organizations under the summary proceedings provisions of s.
6 120.574.
7 (6)(a) A mandatory control level event includes:
8 1. The filing of a risk-based capital report by the
9 health maintenance organization that indicates that the health
10 maintenance organization's total adjusted capital is less than
11 its mandatory control level risk-based capital;
12 2. Notification by the department to the health
13 maintenance organization of an adjusted risk-based capital
14 report that indicates the event described in subparagraph 1.,
15 provided the health maintenance organization does not
16 challenge the adjusted risk-based capital report under
17 subsection (7); or
18 3. If, pursuant to subsection (7), the health
19 maintenance organization challenges an adjusted risk-based
20 capital report that indicates the event described in
21 subparagraph 1., notification by the department to the health
22 maintenance organization that the department has, after a
23 hearing, rejected the health maintenance organization's
24 challenge.
25 (b) If a mandatory control level event occurs, the
26 department shall take such actions as are necessary to place
27 the health maintenance organization under regulatory control
28 under chapter 631. If the department takes such actions, the
29 mandatory control level event shall be deemed sufficient
30 grounds for the department to take action under chapter 631
31 and the department shall have the rights, powers, and duties

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1 with respect to the health maintenance organization as are set
2 forth in such chapter. If the department takes actions under
3 this paragraph pursuant to an adjusted risk-based capital
4 report, the health maintenance organization shall be entitled
5 to the summary proceedings protections of s. 120.574. However,
6 the department may forego action for up to 90 days after the
7 mandatory control level event if the department finds there is
8 a reasonable expectation that the mandatory control level
9 event may be eliminated within the 90-day period.
10 (7) Upon the occurrence of any of the following
11 events, the health maintenance organization shall have the
12 right to a confidential departmental hearing, on a record, at
13 which the health maintenance organization may challenge any
14 determination or action by the department. The health
15 maintenance organization shall notify the department of its
16 request for a hearing within 5 days after the notification by
17 the department under this subsection. Upon receipt of the
18 health maintenance organization's request for a hearing, the
19 department shall set a date for the hearing, which shall be no
20 less than 10 nor more than 30 days after the date of the
21 health maintenance organization's request. Such events are:
22 (a) Notification to a health maintenance organization
23 by the department of an adjusted risk-based capital report.
24 (b) Notification to a health maintenance organization
25 by the department that:
26 1. The health maintenance organization's risk-based
27 capital plan or revised risk-based capital plan is
28 unsatisfactory; and
29 2. Notification constitutes a regulatory action level
30 event with respect to the health maintenance organization.
31

1 (c) Notification to a health maintenance organization
2 by the department that the health maintenance organization has
3 failed to adhere to its risk-based capital plan or revised
4 risk-based capital plan and that the failure has a substantial
5 adverse effect on the ability of the health maintenance
6 organization to eliminate the company action level event with
7 respect to the health maintenance organization in accordance
8 with its risk-based capital plan or revised risk-based capital
9 plan.
10 (d) Notification to a health maintenance organization
11 by the department of a corrective order with respect to the
12 health maintenance organization.
13 (8)(a) This section is supplemental to any other
14 provisions of this part and shall not preclude or limit any
15 other powers or duties of the department as provided in the
16 insurance code.
17 (b) The department may adopt reasonable rules
18 necessary to implement this section.
19 (c) The department may exempt from the application of
20 this section a health maintenance organization that:
21 1. Writes direct business only in this state;
22 2.a. Assumes no reinsurance in excess of 5 percent of
23 direct premium written; and
24 b. Writes direct annual premiums for comprehensive
25 medical business of $2,000,000 or less; or
26 3. Is a limited health service organization that
27 covers less than 2,000 lives.
28 (9) There shall be no liability on the part of, and no
29 cause of action shall arise against, the commissioner or the
30 department or its employees or agents for any action taken by
31

1 them in the performance of their powers and duties under this
2 section.
3 (10) All notices by the department to a health
4 maintenance organization that may result in regulatory action
5 under this section shall be effective upon dispatch if
6 transmitted by registered or certified mail, or in the case of
7 any other transmission shall be effective upon the health
8 maintenance organization's receipt of notice.
9 (11) For risk-based capital reports required to be
10 filed in 2002, 2003, and 2004 by health maintenance
11 organizations with respect to their 2001, 2002, and 2003
12 annual statement data, the following requirements shall apply
13 in lieu of the provisions of subsections (3), (4), (5), and
14 (6):
15 (a) If a company action level event occurs with
16 respect to a health maintenance organization, the department
17 shall take no regulatory action under this section.
18 (b) If a regulatory action level event as provided in
19 subparagraphs (4)(a)1., 2., or 3. occurs, the department shall
20 take the actions required under subsection (3).
21 (c) If a regulatory action level event as provided in
22 subparagraphs (4)(a)4., 5., 6., 7., 8., or 9. occurs or an
23 authorized control level event occurs, the department shall
24 take the actions required under subsection (4) with respect to
25 the health maintenance organization.
26 (d) If a mandatory control level event occurs with
27 respect to a health maintenance organization, the department
28 shall take the actions required under subsection (5) with
29 respect to the health maintenance organization.
30
31

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1 Nothing in this subsection restricts or otherwise limits the
2 department's authority under other provisions of the insurance
3 code.
4 (12) It is the intent of the Legislature that the
5 risk-based capital instructions, risk-based capital reports,
6 adjusted risk-based capital reports, risk-based capital plans
7 and revised risk-based capital plans, and related documents,
8 materials, or information are intended solely for use by the
9 department in monitoring the solvency of health maintenance
10 organizations and the need for possible corrective action with
11 respect to health maintenance organizations and shall not be
12 used by the department for ratemaking nor considered or
13 introduced as evidence in any rate proceeding nor used by the
14 department to calculate or derive any elements of an
15 appropriate premium level or rate of return for any line of
16 insurance that a health maintenance organization or any
17 affiliate is authorized to write.
18 Section 22. Paragraph (a) of subsection (3) of section
19 641.35, Florida Statutes, is amended to read:
20 641.35 Assets, liabilities, and investments.--
21 (3) LIABILITIES.--In any determination of the
22 financial condition of a health maintenance organization,
23 liabilities to be charged against its assets shall include:
24 (a) The amount, estimated consistently with the
25 provisions of this part, necessary to pay all of its unpaid
26 losses and claims incurred for or on behalf of a subscriber,
27 on or prior to the end of the reporting period, whether
28 reported or unreported, including claims arising for services
29 provided to subscribers where these services are provided
30 under health care risk contracts unless the obligations under
31 such contracts are secured by a financial instrument

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1 acceptable to the department. This requirement shall not
2 apply to a contract with a provider where the contract is
3 limited to services provided by such provider under the scope
4 of that provider's license.
5
6 The department, upon determining that a health maintenance
7 organization has failed to report liabilities that should have
8 been reported, shall require a corrected report which reflects
9 the proper liabilities to be submitted by the organization to
10 the department within 10 working days of receipt of written
11 notification.
12 Section 23. Subsection (4) of section 641.495, Florida
13 Statutes, is amended to read:
14 641.495 Requirements for issuance and maintenance of
15 certificate.--
16 (4) The organization shall ensure that the health care
17 services it provides to subscribers, including physician
18 services as required by s. 641.19(14)~~(13)~~(d) and (e), are
19 accessible to the subscribers, with reasonable promptness,
20 with respect to geographic location, hours of operation,
21 provision of after-hours service, and staffing patterns within
22 generally accepted industry norms for meeting the projected
23 subscriber needs. The health maintenance organization must
24 provide treatment authorization 24 hours a day, 7 days a week.
25 Requests for treatment authorization may not be held pending
26 unless the requesting provider contractually agrees to take a
27 pending or tracking number.
28 Section 24. Paragraph (b) of subsection (2) of section
29 817.234, Florida Statutes, is amended to read:
30 817.234 False and fraudulent insurance claims.--
31 (2)

(b) In addition to any other provision of law, systematic upcoding by a provider, as defined in s. 641.19(16)~~(15)~~, with the intent to obtain reimbursement otherwise not due from an insurer is punishable as provided in s. 641.52(5).

Section 25. Subsection (1) of section 817.50, Florida Statutes, is amended to read:

817.50 Fraudulently obtaining goods, services, etc., from a health care provider.--

(1) Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise, or services from any health care provider in this state, as defined in s. 641.19(16)~~(15)~~, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 26. Section 641.2342, Florida Statutes, is repealed.

Section 27. Except as otherwise provided in this act, this act shall take effect July 1, 2001.

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1 STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
2 COMMITTEE SUBSTITUTE FOR
SB 2080
3
4 Deletes provisions of the bill that would have eliminated the
5 requirement that notices of civil remedy actions be filed with
the Department of Insurance.
6 Revises the section authorizing the department to establish by
7 rule for the filing of required information, to require that
the department utilize generally accepted data systems and
8 implement this statute in a manner that minimizes the costs
and administrative burden on insurers.
9 Deletes the provisions of the bill relating to cease and
desist orders and removal of affiliated parties.
10
11 Reinserts the current requirement that the department include
information concerning the department's receipts and
12 expenditures in its annual report.
13 Revises the service of process provisions to specify that the
alternative method of delivery approved by the department,
14 other than registered or certified mail, must accomplish
admission of service.
15 Adds exceptions to the current requirement that at least a
16 2-month minimum down payment be paid for an auto insurance
policy.
17 Specifies that an insurer or agent who is financing premiums
18 may charge service or interest charges, in level monthly
installments, provided that the total of the charges do not
19 exceed the amounts charged under the current limit of an
annual rate of 18 percent simple interest.
20 Deletes the provisions of the bill which would have increased
21 the minimum interest rate payable on payment on death
policies, cash surrender policies, and overdue payments of
22 medical claims.
23 Deletes the bill's requirement that health maintenance
organizations (HMOs) must report annually a summary of each
24 health risk contract.
25 Provides legislative intent concerning the use of risk-based
capital data and information to provide that the information
26 is to be used solely for monitoring the solvency of HMOs and
not for ratemaking.
27 Deletes the bill's requirement that an HMO must submit a
28 comprehensive business plan at the time of its application for
licensure.
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