CHAPTER 636

PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS

636.002 Short title.—Sections 1-57, chapter 93-148, Laws of Florida, may be cited as the "Prepaid Limited Health Service Organization Act of Florida."

History.—s. 1, ch. 93-148.

636.003 Definitions.—As used in this act, the term:

(1) "Capitation" means the fixed amount paid by a prepaid limited health service organization to a health care provider under contract with the prepaid limited health service organization in exchange for the rendering of covered limited health services.

(2) "Commissioner" means the Commissioner of Insurance.

(3) "Department" means the Department of Insurance.

(4) "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract, or any other evidence of coverage, with an entity authorized to provide or arrange for such services under this act.

(5) "Evidence of coverage" means the certificate, agreement, membership card, or contract issued pursuant to this act setting forth the coverage to which an enrollee is entitled.

(6) "Insolvent" means that all the statutory assets of the prepaid limited health service organization, if made immediately available, would not be sufficient to discharge all of its statutory liabilities or that the prepaid limited health service organization is unable to pay its debts as they become due in the usual course of business.

(7) "Limited health service" means ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services. "Limited health service" does not include inpatient, hospital surgical services, or emergency services except as such services are provided incident to the limited health services set forth in this subsection.

(8) "Prepaid limited health service contract" means any contract entered into by a prepaid limited health service organization with a subscriber or group of subscribers to provide limited health services in exchange for a prepaid per capita or prepaid aggregate fixed sum.

(9) "Prepaid limited health service organization" means any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. Prepaid limited health service organization does not include:

(a) An entity otherwise authorized pursuant to the laws of this state to indemnify for any limited health service; or

(b) A provider or entity when providing limited health services pursuant to a contract with a prepaid limited health service organization, a health maintenance organization, a health insurer, or a self-insurance plan.

(10) "Provider" means, but is not limited to, any physician, dentist, health facility, or other person or institution which is duly licensed in this state to deliver limited health services.

(11) "Qualified independent actuary" means an actuary who is a member of the American Academy of Actuaries or the Society of Actuaries and has experience in establishing rates for limited health services and who has no financial or employment interest in the prepaid limited health service organization.

(12) "Reporting period" means the annual accounting period or fiscal year, or any part thereof, of the prepaid limited health service organization. The calendar year shall be the fiscal year for each such organization other than those holding an existing certificate of authority as of October 1, 1993.

(13) "Subscriber" means an individual who has contracted, or arranged, or on whose behalf a contract or arrangement has been entered into, with a prepaid limited health service organization for health care services or other persons who also receive health care services as a result of the contract.

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

(15) "Surplus notes" means debt which has been subordinated to all claims of subscribers and general creditors of the organization and the debt instrument shall so state.

(16) "Statutory accounting principles" means generally accepted accounting principles, except as modified by this act.

(17) "Qualified employee" means an employee of the organization:

(a) Who has a minimum of 5 years of experience in rate determinations for prepaid health services, and who demonstrates through filings with the department that the person is in fact qualified under the terms of this act; or

(b) Who is a member of the American Academy of Actuaries or the Society of Actuaries and has experience in establishing rates for limited health service.

History.—s. 2, ch. 93-148.

636.004 Applicability of other laws.—Except as provided in this act, prepaid limited health service organizations are governed by the provisions of this act and are exempt from the Florida Insurance Code unless specifically referenced.

History.—s. 3, ch. 93-148.

636.005 Incorporation required.—

(1) On or after October 1, 1993, any entity that has not yet obtained a certificate of authority to operate a prepaid limited health service organization in this state must be incorporated.

(2) A prepaid limited health service organization may be organized as a profit or nonprofit corporation.

(3) A prepaid limited health service organization may be incorporated in another state if the entity maintains a certificate of authority or license in the state in which it is domiciled to provide services which the applicant intends to provide in this state and maintains a certificate of authority in this state.

(4) Entities issued a certificate of authority pursuant to part I, part II, or part III of [1]chapter 637, or [1]chapter 638, prior to October 1, 1993, unless otherwise specified in this act, must be in compliance with the provisions of this act by April 1, 1994.

(5) This section shall not apply to providers licensed pursuant to chapter 463 or any other licensed professional if incorporation is limited or restricted by law.

History.—s. 4, ch. 93-148.

[1]**Note.**—Repealed by s. 57, ch. 93-148.

636.006 Insurance business not authorized.—Nothing in the Florida Insurance Code or this act authorizes any prepaid limited health service organization to transact any insurance business other than that specifically authorized by this act, or otherwise to engage in any other type of insurance unless it is authorized under a certificate of authority issued by the department under the provisions of the Florida Insurance Code.

History.—s. 5, ch. 93-148.

636.007 Certificate of authority required.—A person, corporation, partnership, or other entity may not operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the department pursuant to this act. A political subdivision of this state which is operating an emergency medical services system and offers a prepaid ambulance service plan as a part of its emergency medical services system shall be exempt from the provisions of this act and all other provisions of the insurance code. An insurer, while authorized to transact health insurance in this state, or a health maintenance organization possessing a valid certificate of authority in this state, may also provide services under this act without additional qualification or authority, but shall be otherwise subject to the applicable provisions of this act.

History.—s. 6, ch. 93-148.

636.008 Application for certificate of authority.—Before any entity may operate a prepaid limited health service organization, it must obtain a certificate of authority from the department. An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the department on a form prescribed by the department. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following:

(1) A copy of the applicant's basic organizational document, including the articles of incorporation, arti-

cles of association, partnership agreements, trust agreement, or other applicable documents and all amendments to such documents.

(2) A copy of all bylaws, rules, and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs.

(3) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the prepaid limited health service organization, including any possible conflicts of interest.

(4) A complete biographical statement, on forms prescribed by the department, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under subsection (3).

(5) A statement generally describing the applicant, its facilities and personnel, and the limited health service or services to be offered.

(6) A copy of the form of all contracts made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees.

(7) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in subsection (3).

(8) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees.

(9) A copy of the form of any prepaid limited health service contract which is to be issued to employers, unions, trustees, individuals, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers.

(10) A copy of the applicant's most recent financial statements audited by an independent certified public accountant.

(11) A copy of the applicant's financial plan, including a 3-year projection of anticipated operating results, a statement of the sources of funding, and provisions for contingencies, for which projection all material assumptions shall be disclosed.

(12) A schedule of rates and charges for each contract to be used which contains an opinion from a qualified independent actuary or a qualified employee that the rates are not inadequate, excessive, or discriminatory.

If a prepaid limited health service organization does not employ or otherwise retain the services of an independent actuary, the chief executive officer of the prepaid limited health service organization must review and sign the certification indicating his agreement with its conclusions. If the department determines that, based upon documents filed with the department, the qualified employee is not qualified, the organization shall retain the services of a qualified independent actuary.

(13) A description of the proposed method of marketing.

(14) A description of the subscriber complaint procedures to be established and maintained as required under s. 636.038.

(15) A description of how the applicant will comply with s. 636.046.

(16) The fee for issuance of a certificate of authority as provided in s. 636.057.

(17) Such other information as the department may reasonably require to make the determinations required by this act.

The department shall issue a certificate of authority which shall expire on June 1 each year and which the department shall renew if the applicant pays the license fees provided in s. 636.057 and if the department is satisfied that the organization is in compliance with this act.

History.—s. 7, ch. 93-148.

636.009 Issuance of certificate of authority; denial.

(1) Following receipt of an application filed pursuant to s. 636.008, the department shall review such application and notify the applicant of any deficiencies contained therein. The department shall issue a certificate of authority to an applicant who has filed a completed application in conformity with s. 636.008, upon payment of the fees specified by s. 636.057 and upon the department being satisfied that the following conditions are met:

(a) The requirements of s. 636.008 have been fulfilled.

(b) The entity is actuarially sound.

(c) The entity has met the applicable minimum surplus requirements specified in s. 636.045.

(d) The procedures for offering limited health services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, handicap, health, or economic status. However, this paragraph does not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor does it prohibit prospective experience rating.

(e) The entity furnished evidence of adequate insurance coverage, including, but not limited to, general liability or professional liability coverage, or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing covered services.

(f) The ownership, control, and management of the entity are competent and trustworthy and possess managerial experience that would make the proposed operation beneficial to the subscribers. The department shall not grant or continue authority to transact the business of a prepaid limited health service 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 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.

(g) The entity has demonstrated compliance with s. 636.047 by obtaining a blanket fidelity bond in the amount of at least $50,000, issued by a licensed insurance carrier in this state, that will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with the funds. All employees handling the funds must be covered by the blanket fidelity bond. However, the fidelity bond need not cover an individual who owns 100 percent of the stock of the organization if such stockholder maintains total control of the organization's financial assets, books and records, and fidelity bond coverage is not available for such individual. An agent licensed under the provisions of the Florida Insurance Code may, either directly or indirectly, represent the prepaid limited health service organization in the solicitation, negotiation, effectuation, procurement, receipt, delivery, or forwarding of any subscriber's contract, or collect or forward any consideration paid by the subscriber to the prepaid limited health service organization. The licensed agent shall not be required to post the bond required by this subsection.

(h) The prepaid limited health service organization has a grievance procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

(i) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the department may consider:

1. The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments, and other patient charges used in connection therewith.

2. The adequacy of surplus, other sources of funding, and provisions for contingencies.

3. The manner in which the requirements of s. 636.046 have been fulfilled.

(j) The agreements with providers for the provision of limited health services contain the provisions required by s. 636.035.

(k) Any deficiencies identified by the department have been corrected.

(l) All requirements of this chapter have been met.

(2) If the certificate of authority is denied, the department shall notify the applicant and shall specify the reasons for denial in the notice.

History.—s. 8, ch. 93-148.

636.012 Continued eligibility for certificate of authority.—In order to maintain its eligibility for a certificate of authority, a prepaid limited health service organization must continue to meet all conditions required to be met under this act and the rules adopted thereunder for the initial application for and issuance of its certificate of authority under ss. 636.008 and 636.009.

History.—s. 9, ch. 93-148.

636.013 Effect on organizations operating on October 1, 1993.—On or before April 1, 1994, every prepaid limited health service organization operating in this state without a certificate of authority must submit an application for a certificate of authority to the department. Each such organization may continue to operate during the pendency of its application for a period not to exceed 6 months from the date of application submission. If an application is denied under this section, the applicant will then be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

History.—s. 10, ch. 93-148.

636.014 Effect on certificated entities.—Any entity possessing a certificate of authority issued pursuant to part I, part II, or part III of [1]chapter 637, or [1]chapter 638 shall be issued a certificate of authority as a prepaid limited health service organization at the next renewal date.

History.—s. 11, ch. 93-148.

[1]**Note.**—Repealed by s. 57, ch. 93-148.

636.015 Language used in contracts and advertisements; translations.—

(1)(a) All contracts or forms must be printed in English.

(b) If the negotiations leading up to the effectuation of a prepaid limited health service organization contract are conducted in a language other than English, the prepaid limited health service organization must supply to the member a written translation of the contract, which translation accurately reflects the substance of the contract and is in the language used to negotiate the contract. The written translation must be affixed to, and shall become a part of, the contract or form, including a certification that the written translation is identical to the English version. Any such translation must be furnished to the department as part of the filing of the prepaid limited health services contract form. No translation of a prepaid limited health services contract form may be approved by the department unless the translation accurately reflects the substance of the prepaid limited health services contract form in translation.

(2) The text of all advertisements by a prepaid limited health service organization, if printed or broadcast in a language other than English, also must be available in English and must be furnished to the department upon request. As used in this subsection, the term "advertisement" means any advertisement, circular, pamphlet, brochure, or other printed material disclosing or disseminating advertising material or information by a prepaid limited health service organization to prospective or existing subscribers and includes any radio or television transmittal of an advertisement or information.

History.—s. 12, ch. 93-148.

636.016 Prepaid limited health service contracts. For any entity licensed prior to October 1, 1993, all subscriber contracts in force at such time shall be in compliance with this section upon renewal of such contract.

(1) Any entity issued a certificate of authority and otherwise in compliance with this act may enter into contracts in this state to provide an agreed-upon set of limited health services to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum.

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

1. Is in any respect in violation of, or does not comply with, any provision of this act 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 if the rating methodology followed by the prepaid limited health service organization is determined by the department to be inconsistent with the provisions of s. 636.017.

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

(c) All contracts shall be for a minimum period of 12 months, unless the contract holder requests, in writing, a shorter contract period.

(2) Every prepaid limited health service organization shall provide each subscriber a contract, a certificate, membership card, or member handbook which must clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity which is underwriting any of the services offered by the prepaid limited health service organization. The contract, certificate, provider listing, or member handbook must also state where and in what manner the health services may be obtained.

(3) The documents provided pursuant to subsection (2) must have a clear and understandable description of the method used by the prepaid limited health service organization for resolving subscriber grievances.

(4) The rate of payment for a prepaid limited health services contract sold on an individual basis must be a part of the contract and must be stated in individual contracts issued to subscribers.

(5) All prepaid limited health service coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, provide also that the coverage, benefits, or services applicable for children will be provided with respect to a preenrolled newborn child of the subscriber, or covered family member of the subscriber, from the moment of birth, or adoption pursuant to chapter 63.

(6) No alteration of any written application for any prepaid limited health services contract may be made by any person other than the applicant without his written consent, except that insertions may be made by the prepaid limited health service organization for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(7) No contract may contain any waiver of rights or benefits provided to or available to subscribers under the provisions of any law or rule applicable to prepaid limited health service organizations.

(8) Each document provided pursuant to subsection (2) must state that emergency services, if any, will be provided to subscribers in emergency situations not permitting treatment through the prepaid limited health service organization providers, without prior notification to and approval of the organization. The prepaid limited health services document must contain a definition of emergency services, describe procedures for determination by the prepaid limited health service organization of whether the services qualify for reimbursement as emergency services, and contain specific examples of what does constitute an emergency.

(9)(a) All prepaid limited health services contracts, certificates, and member handbooks must contain the following provision:

"Grace Period: This contract has a (insert number of days, but not less than 10 days)-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the contract will stay in force."

(b) Paragraph (a) does not apply to certificates or member handbooks delivered to individual subscribers under a group prepaid limited health services contract when the employer who will hold the contract on behalf of the subscriber group pays the entire premium for the individual subscriber. However, such required provision applies to the group prepaid limited health services contract.

(10) The contract must clearly disclose the intent of the prepaid limited health service organization as to the applicability or nonapplicability of coverage to preexisting conditions. The contract must also disclose what services are excludable.

(11) All prepaid limited health service organization contracts which provide coverage for a member of the family of the subscriber, must, as to such family member's coverage, provide that coverage, benefits, or services applicable for children will 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 in the residence of the subscriber. In the case of a newborn child, coverage begins 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. However, coverage for such child is not required if the child is not ultimately adopted by the subscriber in compliance with chapter 63.

History.—s. 13, ch. 93-148.

636.017 Rates and charges.—

(1) The rates charged by any prepaid limited health service organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory. The department may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this section.

(2) In determining whether a rate is in compliance with subsection (1), the department must take into consideration the limited services provided, the method in which the services are provided, and the method of provider payment. This section may not be construed as authorizing the department to establish by rule minimum loss ratios for prepaid limited health service organizations' rates.

History.—s. 14, ch. 93-148.

636.018 Changes in rates and benefits; material modifications; addition of limited health services.—

(1)(a) No prepaid limited health services contract, certificate of coverage, application, enrollment form, rider, endorsement, and applicable rates to be charged may be delivered in this state unless the forms and rates have been filed with the department by or on behalf of the prepaid limited health service organization and have been approved by the department. Every form filed shall be identified by a unique form number placed in the lower left corner of each form. If a prepaid limited health service 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 prepaid limited health services 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 renewal certificate, it must file such changes 30 days prior to the effective date of the proposed change. At least 30 days' written notice must be provided to the subscriber before application of any approved change in rates. In the case of a group enrollee, there may be a contractual agreement with the prepaid limited health service organization to have the contract holder provide the required notice to the individual enrollees of the group. Any proposed change must contain information as required by s. 636.017.

(b) The prepaid limited health service organization's certification must be prepared by an independent actuary or a qualified employee. The chief executive officer of the prepaid limited health service organization must review and sign the certification indicating his agreement with its conclusions. Following receipt of notice of any disapproval or withdrawal of approval, no prepaid limited health service organization may issue or use any form disapproved by the department or as to which the department has withdrawn approval.

(2) If such filings are disapproved, the department shall notify the prepaid limited health service organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization has 21 days from the date of receipt of notice to request a hearing before the department pursuant to chapter 120.

History.—s. 15, ch. 93-148.

636.019 Additional contract contents.—A prepaid limited health services contract may contain additional provisions not inconsistent with this act which are:

(1) Necessary because of the manner in which the organization is constituted or operated in order to state the rights and obligations of the parties to the contract; or

(2) Desired by the organization and neither prohibited by law nor in conflict with any provisions required to be included.

History.—s. 16, ch. 93-148.

636.022 Restrictions upon expulsion or refusal to issue or renew contract.—A prepaid limited health service organization may not expel or refuse to renew the coverage of or refuse to enroll any individual member of a subscriber group on the basis of the race, color, creed, handicap, marital status, sex, or national origin of the subscriber or individual. A prepaid limited health service organization may not expel or refuse to renew the coverage of any individual member of a subscriber group on the basis of the age or health status of the subscriber or individual. For group solicitations, a prepaid limited health service organization may preunderwrite to determine group acceptability. However, once a contract is issued, a prepaid limited health service organization must provide coverage to all existing enrollees and their dependents, and newly employed enrollees and their dependents who have enrolled within 30 days of eligibility or membership. Late enrollees who apply during other than an open enrollment period may be subject to evidence of insurability requirements of the prepaid limited health service organization. Nothing in this section prohibits a prepaid limited health service organization from requiring that, as a condition of continued eligibility for membership, dependents of a subscriber upon reaching a specified age convert to a converted contract. Coverage must continue to be provided to handicapped children who are incapable of self-sustaining employment by reason of mental or physical handicap, and substantially dependent upon the enrollee for support and maintenance.

History.—s. 17, ch. 93-148.

636.023 Charter; bylaw provisions.—No prepaid limited health services contract may contain any provision purporting to make any portion of the articles of incorporation, charter, bylaws, or other organizational document of the prepaid limited health service organization a part of the contract unless the provision is set forth in full in the contract. Any contract provision in violation of this section is invalid unless the provision operates to the benefit of the subscriber.

History.—s. 18, ch. 93-148.

636.024 Execution of contracts.—

(1) Every prepaid limited health services contract must be executed in the name of and on behalf of the prepaid limited health service organization by its officer, attorney in fact, employee, or representative duly authorized by the organization.

(2) A facsimile signature of any executing individual may be used in lieu of an original signature.

(3) No prepaid limited health services contract which is otherwise valid is rendered invalid by reason of

the apparent execution thereof on behalf of the prepaid limited health service organization by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the contract.

History.—s. 19, ch. 93-148.

636.025 Validity of noncomplying contracts.—

(1) Any prepaid limited health services contract rider, endorsement, attachment, or addendum otherwise valid which contains any condition or provision not in compliance with the requirements of this act is not thereby rendered invalid, but must be construed and applied in accordance with such conditions and provisions as they would have applied had such contract, rider, endorsement, attachment, or addendum been in full compliance with this act. If an organization issues or delivers any contract for an amount which exceeds any limitations otherwise provided in this act, such organization is liable to the subscriber or his beneficiary for the full amount stated in the contract in addition to any other penalties that may be imposed under this act.

(2) Any prepaid limited health services contract delivered or issued for delivery in this state covering a subscriber, which subscriber pursuant to the provisions of this act the organization may not lawfully cover under the contract, is cancelable at any time by the organization, any provision of the contract to the contrary notwithstanding, and the organization must promptly cancel the contract in accordance with the request of the department therefor. No such illegality or cancellation may be deemed to relieve the organization of any liability incurred by it under the contract while in force or to prohibit the organization from retaining the pro rata earned premium or rate thereon. This subsection does not relieve the organization from any penalty otherwise incurred by the organization under this act for any such violation.

History.—s. 20, ch. 93-148.

636.026 Construction of contracts.—Every prepaid limited health services contract must be construed according to the entirety of its terms and conditions as set forth in the contract and as amplified, extended, or modified by any application, endorsement, attachment, or addendum.

History.—s. 21, ch. 93-148.

636.027 Delivery of contract.—Unless delivered upon execution or issuance, a prepaid limited health services contract, certificate of coverage, or member handbook must be mailed or delivered to the subscriber or, in the case of a group prepaid limited health services contract, to the employer or other person who will hold the contract on behalf of the subscriber group, prior to the effective date of coverage by the prepaid limited health service organization. However, if the employer who will hold the contract on behalf of the subscriber group requires retroactive enrollment of a subscriber, the organization must deliver the contract certificate or member handbook to the subscriber within 10 days after receiving notice from the employer of the retroactive enrollment.

History.—s. 22, ch. 93-148.

636.028 Notice of cancellation of contract.—

Except for nonpayment of premium or termination of eligibility, a prepaid limited health service organization may not cancel or otherwise terminate or fail to renew a prepaid limited health services contract without giving the subscriber at least 45 days' notice in writing of the cancellation, termination, or nonrenewal of the contract. The written notice must state the reason or reasons for the cancellation, termination, or nonrenewal. The only reasons for cancellation at such time other than the renewal period shall be as follows:

(1) The subscriber's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that the subscriber's continuing participation seriously impairs the organization's ability to provide services to other subscribers.

(2) Fraud or material misrepresentation in applying for or presenting any claim for benefits under the contract.

(3) Misuse of the documents provided as evidence of benefits available pursuant to the contract.

(4) Furnishing to the organization, by the subscriber, incorrect or incomplete information for the purposes of fraudulently obtaining services.

Prior to disenrollment, the organization must make an effort to resolve the problem through the grievance procedure and must determine that the subscriber's behavior is not due to use of the services provided or mental illness. All prepaid limited health services contracts must contain a clause which requires that this notice be given. In the case of a prepaid limited health services contract issued to an employer holding the contract on behalf of the subscriber group, the prepaid limited health service organization may make the notification through the employer, and, if the prepaid limited health service organization elects to take this action through the employer, the organization shall be deemed to have complied with the provisions of this section upon notifying the employer of the requirements of this section and requesting the employer to forward the required notice to all subscribers.

History.—s. 23, ch. 93-148.

636.029 Construction and relationship with other laws.—

(1) No other provision of the insurance code applies to a prepaid limited health service organization unless such an organization is specifically mentioned therein.

(2) Except as provided in this act, the insurance code does not apply to prepaid limited health service organizations certificated under this act. Any person, entity, or prepaid limited health service organization operating without a subsisting certificate of authority in violation of this act or rules adopted thereunder, in addition to being subject to the provisions of this act, is subject to the provisions of the insurance code.

(3) The department is vested with all powers granted to it under the insurance code with respect to the investigation of any violation of this act.

History.—s. 24, ch. 93-148.

636.032 Acceptable payments.—Each prepaid limited health service organization may accept from gov-

ernment agencies, corporations, groups, or individuals payments covering all or part of the cost of contracts entered into between the prepaid limited health service organization and its subscribers.

History.—s. 25, ch. 93-148.

636.033 Certain words prohibited in name of organization.—

(1) No entity certificated as a prepaid limited health service organization, other than a licensed insurer or health maintenance organization insofar as its name is concerned, may use in its name, contracts, or literature any of the words "insurance," "casualty," "surety," "mutual," or "HMO," or any other words descriptive of the insurance, casualty, HMO, or surety business or deceptively similar to the name or description of any insurance, HMO, or surety corporation doing business in the state.

(2) No person, entity, or health care plan not certificated under the provisions of this act may use in its name, logo, contracts, or literature the phrase "prepaid limited health services contract" or the initials "PLHSC" to imply, directly or indirectly, that it is a prepaid limited health service organization or hold itself out to be a prepaid limited health service organization.

History.—s. 26, ch. 93-148.

636.034 Extension of benefits.—Every prepaid limited health services contract must provide that termination of the contract by the prepaid limited health service organization is without prejudice to any continuous loss which commenced while the contract was in force. Extension of benefits beyond the period the contract was in force must be until the specific treatment or procedure undertaken upon any subscriber has been completed or for 90 days, whichever is the lesser period of time.

History.—s. 27, ch. 93-148.

636.035 Provider arrangements.—

(1) Whenever a contract exists between a prepaid limited health service organization and a provider, and the organization fails to meet its obligations to pay fees for services already rendered to a subscriber who is in good standing, the prepaid limited health service organization is liable for such fee or fees rather than the subscriber, and the contract must so state.

(2) No subscriber, who is in good standing, of a prepaid limited health service organization is liable to any provider of health care services for any services covered by the prepaid limited health service organization.

(3) No provider of prepaid limited health care services or any representative of such provider may collect or attempt to collect from a subscriber any money for services covered by a prepaid limited health service organization, and no provider or representative of such provider may maintain any action against a subscriber of a prepaid limited health service organization to collect money owed to such provider by a prepaid limited health service organization.

(4) Every contract between a prepaid limited health service organization and a provider of health care services must be in writing and must contain a provision that the subscriber is not liable to the provider for any services covered by the subscriber's or enrollee's contract with the prepaid limited health service organization.

(5) The provisions of this section do not apply to the amount of any deductible or copayment which is not covered by the contract, or for services not authorized by the prepaid limited health service organization.

(6) For all provider contracts executed after October 1, 1993, and within 180 days after October 1, 1993, for contracts in existence as of October 1, 1993:

(a) The contracts must provide that the provider will provide no less than 90 days' advance written notice to the prepaid limited health service organization before canceling the contract with the prepaid limited health service organization for any reason.

(b) The contract must also provide that nonpayment for goods or services rendered by the provider to the prepaid limited health service organization shall not be a valid reason for avoiding the 90-day advance notice of cancellation.

(c) For all provider contracts in force on October 1, 1993, the organization shall be responsible for notifying all providers of the provisions of this section and their responsibilities under this part.

(7) Upon receipt by the prepaid limited health service organization of a 90-day cancellation notice, the prepaid limited health service organization may, if requested by the provider, terminate the contract in less than 90 days if the prepaid limited health service organization is not financially impaired or insolvent.

History.—s. 28, ch. 93-148.

636.036 Administrative, provider, and management contracts.—

(1) The department may require a prepaid limited health service organization to submit any contract for administrative services, contract with a provider physician, contract for management services, or contract with an affiliated entity to the department if the department has information that the prepaid limited health service 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 prepaid limited health service organization to cancel the contract if it determines that the fees to be paid by the prepaid limited health service organization under the contract are so unreasonably high as compared with similar contracts entered into by the prepaid limited health service organization in similar circumstances that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the prepaid limited health service organization.

(3) All contracts for administrative services, management services, or provider services or contracts with affiliated entities, entered into or renewed by a prepaid limited health service organization on or after October 1, 1993, must contain a provision that the contract will be canceled upon issuance of an order by the department pursuant to this section.

History.—s. 29, ch. 93-148.

636.037 Contract providers.—Each prepaid limited health service organization must, upon the request of

the department, file financial statements for all contract providers of limited health care services who have assumed through capitation or other means more than 10 percent of the health care risks of the prepaid limited health service organization.

History.—s. 30, ch. 93-148.

636.038 Complaint system.—Every prepaid limited health service organization must establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. This section does not preclude an enrollee or a provider from filing a complaint with the department or limit the department's ability to investigate such complaints.

History.—s. 31, ch. 93-148.

636.039 Examination by the department.—The department shall examine the affairs, transactions, accounts, business records, and assets of any prepaid limited health service organization, in the same manner and subject to the same terms and conditions that apply to insurers under part II of chapter 624, 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 act. 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 prepaid limited health service organization are not subject to audit, but 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 prepaid limited health service organization concerning its business and affairs. The expenses of examination of each prepaid limited health service organization by the department are subject to the same terms and conditions as apply to insurers under part II of chapter 624. Expenses of all examinations of a prepaid limited health service organization may never exceed a maximum of $20,000 for any 1-year period.

History.—s. 32, ch. 93-148.

636.042 Assets, liabilities, and investments.—Section 641.35 applies in its entirety to determine what assets, liabilities, and investments are acceptable for a prepaid limited health service organization.

History.—s. 33, ch. 93-148.

636.043 Annual, quarterly, and miscellaneous reports.—

(1) Each prepaid limited health service organization must file with the department annually, within 3 months after the end of its fiscal year, a report verified by the oath of at least two officers covering the preceding calendar year. Any organization licensed prior to October 1, 1993, shall not be required to file a financial statement, as required by paragraph (2)(a), based on statutory accounting principles until the first annual report for fiscal years ending after December 31, 1994.

(2) Such report must be on forms prescribed by the department and must include:

(a)1. A statutory financial statement of the organization prepared in accordance with statutory accounting principles, including its balance sheet, income statement, and statement of changes in cash flow for the preceding year, certified by an independent certified public accountant, or a consolidated audited financial statement of its parent company prepared on the basis of statutory accounting principles, certified by an independent certified public accountant, attached to which must be consolidating financial statements of the parent company, including the prepaid limited health service organization.

2. Any entity subject to this chapter may make written application to the department for approval to file audited financial statements prepared in accordance with generally accepted accounting principles in lieu of statutory financial statements. The department shall approve the application if it finds it to be in the best interest of the subscribers. An application for exemption is required each year and must be filed with the department at least 2 months prior to the end of the fiscal year for which the exemption is being requested.

(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 prepaid limited health service organization, including any possible conflicts of interest.

(c) The number of prepaid limited health services contracts, issued and outstanding, and the number of prepaid limited health services contracts terminated.

(d) The number and amount of damage claims for medical injury initiated against the prepaid limited health service organization, and if known, 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.

(e) An actuarial report certified by a qualified independent actuary or qualified employee that:

1. The prepaid limited health service 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.

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

(f) Such other information relating to the performance of the prepaid limited health service organization as is reasonably required by the department.

(3) Every prepaid limited health service organization which fails to file an annual report or quarterly report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 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 ceases 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 may not collect more than $50,000 for each report.

(4) Each authorized prepaid limited health service organization must file a quarterly report for each calendar quarter within 45 days after the end of the quarter. The report shall contain:

(a) A financial statement prepared in accordance with statutory accounting principles. Any entity licensed before October 1, 1993, shall not be required to file a financial statement based on statutory accounting principles until the first quarterly filing after the entity files its annual financial statement based on statutory accounting principles as required by subsection (1).

(b) A listing of providers.

(c) Such other information relating to the performance of the prepaid limited health service organization as is reasonably required by the department.

(5) The department may require monthly reports if the financial condition of the prepaid limited health service organization has deteriorated from previous periods or if the financial condition of the organization is such that it may be hazardous to subscribers if not monitored more frequently.

(6) Each authorized prepaid limited health service organization shall retain an independent certified public accountant, hereinafter referred to as "CPA," who agrees by written contract with the prepaid limited health service organization to comply with the provisions of this act. The contract must state that:

(a) The CPA will provide to the prepaid limited health service organization audited statutory financial statements consistent with this act.

(b) Any determination by the CPA that the prepaid limited health service organization does not meet minimum surplus requirements as set forth in this act will be stated by the CPA, in writing, in the audited financial statement.

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

History.—s. 34, ch. 93-148.

636.044 Agent licensing.—

(1) With respect to a prepaid limited health services contract, a person may not, unless licensed and appointed as a health insurance agent in accordance with the applicable provisions of the insurance code:

(a) Solicit contracts or procure applications; or

(b) Engage or hold himself out as engaging in the business of analyzing or abstracting prepaid limited health services contracts or of counseling or advising or giving opinions to persons relative to such contracts other than as a consulting actuary advising a prepaid limited health service organization or as a salaried bona fide full-time employee so counseling and advising his employer relative to coverage for the employer and his employees.

(2) All qualifications, disciplinary provisions, licensing and appointment procedures, fees, and related matters contained in the insurance code which apply to the appointment of health insurance agents by insurers also apply to prepaid limited health service organizations and to persons appointed by prepaid limited health service organizations as their agents.

(3) Examination, licensure, or appointment is not required of any regular salaried officer or employee of a prepaid limited health service organization who devotes substantially all of his services to activities other than the solicitation of prepaid limited health service organization contracts from the public and who receives no commission or other compensation directly dependent upon the solicitation of such contracts.

(4) As used in this section, the term "salaried" refers to basic remuneration and does not include commissions, bonuses, or any other compensatory measures.

History.—s. 35, ch. 93-148.

636.045 Minimum surplus requirements.—

(1) Except as provided in subsection (2), each prepaid limited health service organization must at all times maintain a minimum surplus in an amount which is the greater of $150,000 or 10 percent of total liabilities. Any prepaid limited health service organization which had a valid certificate of authority issued pursuant to part I, part II, or part III of [1]chapter 637, or [1]chapter 638, before October 1, 1993, must maintain the surplus required on September 30, 1993, until the following dates, and then shall increase its surplus as follows:

Date	Amount
January 1, 1994	The greater of $100,000 or 6 percent of total liabilities, whichever is greater.
January 1, 1995	The greater of $125,000 or 8 percent of total liabilities, whichever is greater.
January 1, 1996	The greater of $150,000 or 10 percent of total liabilities, whichever is greater.

(2) The department may not issue a certificate of authority on or after October 1, 1993, unless the prepaid limited health service organization has a minimum surplus in an amount of $150,000 or 10 percent of liabilities, whichever is the greater amount.

History.—s. 36, ch. 93-148.

[1]**Note.**—Repealed by s. 57, ch. 93-148.

636.046 Insolvency protection.—

(1) Except as required in subsection (2), each prepaid limited health service organization must deposit

with the department cash or securities of the type eligible under s. 641.35 which must have at all times a market value in the amount set forth in this subsection. The amount of the deposit shall be reviewed annually or more often as the department deems necessary. The market value of the deposit must be $50,000.

(2)(a) If securities or assets deposited by a prepaid limited health service organization under this act are subject to material fluctuations in market value, the department may in its discretion require the organization to deposit and maintain on deposit additional securities or assets in an amount as may be reasonably necessary to assure that the deposit will at all times have a market value of not less than the amount specified under this section.

(b) If for any reason the market value of assets and securities of a prepaid limited health service organization held on deposit under this act falls below the amount required, the organization must promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency. If the prepaid limited health service organization has failed to cure the deficiency within 30 days after receipt of notice by certified mail from the department, the department may revoke the certificate of authority of the prepaid limited health service organization.

(c) A prepaid limited health service organization may, at its option, deposit assets or securities in an amount exceeding its deposit required or otherwise permitted under this act for the purpose of absorbing fluctuations in the value of securities and assets deposited and to facilitate the exchange and substitution of securities and assets. During the solvency of the prepaid limited health service organization any excess must be released to the organization upon its request. During the insolvency of the prepaid limited health service organization, any excess deposit may be released only as provided in s. 625.62.

(3) All income from deposits belongs to the depositing prepaid limited health service organization and must be paid to it as it becomes available.

History.—s. 37, ch. 93-148.

636.047 Officers' and employees' fidelity bond.—

(1) A prepaid limited health service organization must maintain in force a fidelity bond in its own name on its officers and employees, in an amount not less than $50,000 or in any other amount prescribed by the department. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that is licensed to do business in this state.

(2) In lieu of the bond specified in subsection (1), a prepaid limited health service organization may deposit with the department cash or securities or other investments of the types set forth in s. 636.042. Such a deposit must be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a bond under this subsection.

History.—s. 38, ch. 93-148.

636.048 Suspension or revocation of certificate of authority; suspension of enrollment of new subscribers; terms of suspension.—

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

(a) The organization is not operating in compliance with this act.

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

(c) 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.

(d) The organization is insolvent.

(e) The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to ss. 636.008 and 636.009, unless amendments to such submissions have been filed with and approved by the department.

(f) The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services.

(g) The prepaid limited health service organization has no subscribers 12 months after the issuance of the certificate of authority.

(h) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees.

(2) If the department has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, it shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and shall pursue a hearing on the matter in accordance with the provisions of chapter 120.

(3) When the certificate of authority of a prepaid limited health service organization is surrendered or revoked, such organization must proceed, immediately following the effective date of the order of revocation, to wind up its affairs transacted under the certificate of authority. It may not engage in any further advertising, solicitation, or renewal of contracts. The department may, by written order, permit such further operation of the organization as it finds to be in the best interest of enrollees, so that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

(4) The department shall, in its order suspending the authority of a prepaid limited health service 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 prepaid limited health service 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 may not be made unless requested by the prepaid limited health service organi-

zation; however, the department may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.
History.—s. 39, ch. 93-148.

636.049 Administrative penalty in lieu of suspension or revocation.—In lieu of suspending or revoking a certificate of authority, or when no penalty is specifically provided, whenever any prepaid limited health service organization or other person, corporation, partnership, or entity subject to this act has been found to have violated any provision of this act, the department may:

(1) Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of such findings and an order requiring such organization, person, or entity to cease and desist from engaging in the act or practice which constitutes the violation.

(2) Impose a monetary penalty of not less than $100 for each violation, but not to exceed an aggregate penalty of $100,000.
History.—s. 40, ch. 93-148.

636.052 Civil remedy.—In any civil action brought to enforce the terms and conditions of a prepaid limited health service organization contract, the prevailing party is entitled to recover reasonable attorney's fees and court costs. This section does not authorize a civil action against the department, its employees, or the commissioner or against the Department of Health and Rehabilitative Services, its employees, or the secretary of that department.
History.—s. 41, ch. 93-148.

636.053 Injunction.—In addition to the penalties and other enforcement provisions of this act, the department is vested with the power to seek both temporary and permanent injunctive relief when:

(1) A prepaid limited health service organization is being operated by any person or entity without a subsisting certificate of authority.

(2) Any person, entity, or prepaid limited health [1]service organization has engaged in any activity prohibited by this act or any rule adopted pursuant thereto.

(3) Any prepaid limited health service organization, person, or entity is renewing, issuing, or delivering a prepaid limited health services contract without a subsisting certificate of authority.

The department's authority to seek injunctive relief is not conditioned on having conducted any proceeding pursuant to chapter 120.
History.—s. 42, ch. 93-148.
[1]Note.—The word "service" was inserted by the editors to conform to usage elsewhere in the section.

636.054 Payment of judgment by prepaid limited health service organization.—Except as otherwise ordered by the court or as mutually agreed upon by the parties, every judgment or decree entered in any court against any prepaid limited health service organization for the recovery of money must be fully satisfied within 60 days after the entry thereof, or, in the case of an appeal from such judgment or decree, within 60 days after the affirmance of the judgment or decree by the appellate court.
History.—s. 43, ch. 93-148.

636.055 Levy upon deposit limited.—No judgment creditor or other claimant, other than the department, of a prepaid limited health service organization shall have the right to levy upon any of the assets or securities held in this state as a deposit under s. 636.046.
History.—s. 44, ch. 93-148.

636.056 Rehabilitation, conservation, liquidation, or reorganization; exclusive methods of remedy.—

(1) A delinquency proceeding under part I of chapter 631 or supervision by the department pursuant to ss. 624.80-624.87 constitute the sole and exclusive means of liquidating, reorganizing, rehabilitating, or conserving a prepaid limited health service organization.

(2) No prepaid limited health service organization is subject to the laws and regulations governing insurance or health maintenance organization insolvency guaranty funds. No insurance insolvency guaranty fund may provide protection to any individuals entitled to receive limited health services from a prepaid limited health service organization for services related to a prepaid limited health service contract.
History.—s. 45, ch. 93-148.

636.057 Fees.—Every prepaid limited health service organization subject to this act must pay to the department the following fees:

(1) For filing an application for a certificate of authority or amendment thereto: $500.

(2) For filing each annual report: $200.

(3) For each renewal of certificate of authority: $500.
History.—s. 46, ch. 93-148.

636.058 Investigative power of department.—The department has the power to examine and investigate the affairs of every person, entity, or prepaid limited health service organization in order to determine whether the person, entity, or prepaid limited health service organization is operating in accordance with the provisions of this act or has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by s. 641.3903. The department also has the powers enumerated in ss. 641.3907, 641.3909, and 641.3913.
History.—s. 47, ch. 93-148.

636.059 Unfair methods of competition, unfair or deceptive acts or practices defined.—For the purposes of defining unfair methods of competition, unfair or deceptive acts or practices, the provisions of s. 641.3903 apply to a prepaid limited health service organization.
History.—s. 48, ch. 93-148.

636.062 Appeals from the department.—Any person, entity, or prepaid limited health service organization subject to an order of the department under s. 641.3909 or s. 641.3913 may obtain a review of the order by filing an appeal therefrom in accordance with the provisions and procedures for appeal under s. 120.68.
History.—s. 49, ch. 93-148.

636.063 Civil liability.—The provisions of this act are cumulative to rights under the general civil and common law, and no action of the department abrogates such rights to damage or other relief in any court.
History.—s. 50, ch. 93-148.

636.064 Confidentiality.—

(1) Any information pertaining to the diagnosis, treatment, or health of any enrollee of a prepaid limited health service organization is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution and shall only be available pursuant to specific written consent of the enrollee, or as otherwise provided by law. With respect to any information pertaining to the diagnosis, treatment, or health of any enrollee or applicant, a prepaid limited health service organization is entitled to claim any statutory privileges against disclosure which the provider who furnished such information to the prepaid limited health service organization is entitled to claim.

(2) Any proprietary financial information contained in contracts entered into with providers by prepaid limited health service organizations is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) Any information obtained or produced by the department pursuant to an examination or investigation is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution until the examination report has been filed pursuant to s. 624.319 or until such investigation is completed or ceases to be active. For purposes of this subsection, an investigation is considered "active" while such investigation is being conducted by the department with a reasonable, good faith belief that it may lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the department is proceeding with reasonable dispatch and there is a good faith belief that action may be initiated by the department or other administrative or law enforcement agency. Except for active criminal intelligence or criminal investigative information, as defined in s. 119.011; personal financial and medical information; information that would defame or cause unwarranted damage to the good name or reputation of an individual; information that would impair the safety and financial soundness of the licensee or affiliated party; proprietary financial information; or information that would reveal the identity of a confidential source, all information obtained by the department pursuant to an examination or investigation shall be available after the examination report has been filed or the investigation is completed or ceases to be active.

(4) The exemptions contained in this section are subject to the Open Government Sunset Review Act in accordance with [1]s. 119.14.

History.—s. 51, ch. 93-148; s. 1, ch. 95-134.

[1]Note.—

A. Repealed by s. 1, ch. 95-217.

B. Section 4, ch. 95-217, provides that "[n]otwithstanding any provision of law to the contrary, exemptions from chapter 119, Florida Statutes, or chapter 286, Florida Statutes, which are prescribed by law and are specifically made subject to the Open Government Sunset Review Act in accordance with section 119.14, Florida Statutes, are not subject to review under that act, and are not abrogated by the operation of that act, after October 1, 1995."

636.065 Acquisitions.—Each prepaid limited health service organization is subject to the provisions of s. 628.4615.

History.—s. 52, ch. 93-148.

636.066 Taxes imposed.—

(1) The premiums, contributions, and assessments received by prepaid limited health service organizations are subject to the tax imposed by s. 624.509. The Department of Revenue shall administer this section pursuant to s. 624.5092 and may adopt rules to implement this section.

(2) For 1993, the tax shall be imposed on the premiums, contributions, and assessments for dental care services and ambulance services received by prepaid limited health service organizations and any entity issued a certificate of authority pursuant to part III of [1]chapter 637 or [1]chapter 638.

(3) Beginning January 1, 1994, the tax shall be imposed on all premiums, contributions, and assessments for limited health services.

History.—s. 53, ch. 93-148.

[1]Note.—Repealed by s. 57, ch. 93-148.

636.067 Rules.—The department may, after notice and hearing, adopt rules to administer this act. A violation of any such rule subjects the violator to the provisions of s. 636.048.

History.—s. 54, ch. 93-148.