69O-203
Rulemaking Authority

624.424 Annual statement and other information.—
(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing an annual or quarterly statement. The statements must contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally used by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form and instructions for financial statements approved by the NAIC in 2014, and subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office, or such organization as the office may designate, all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.
(b) Each insurer's annual statement must contain:
1. A statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, pursuant to criteria established by rule of the commission. In adopting the rule, the commission shall consider any criteria established by the NAIC. The office may require semiannual updates of the annual statement of opinion for a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance, health insurance, or title insurance.
2. An actuarial opinion summary written by the insurer's appointed actuary. The summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions. Proprietary business information contained in the summary is confidential and exempt under s. 624.4212, and the summary and related information are not subject to subpoena or discovery directly from the office. Neither the office nor any person who received documents, materials, or other information while acting under the authority of the office, or with whom such information is shared pursuant to s. 624.4212, may testify in a private civil action concerning such confidential information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. No waiver of any other applicable claim of confidentiality or privilege may occur as a result of a disclosure to the office under this section or any other section of the insurance code. This paragraph does not apply to life and health insurers subject to s. 625.121(3) before the operative date of the valuation manual as defined in s. 625.1212(2), and does not apply to life and health insurers subject to s. 625.1212(4) on or after such operative date.
(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.
(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.
(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.
(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.
(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.
(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.
(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office 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.
(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.
(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 5 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 5 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer

and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to administer this subsection which must be in substantial conformity with the 2006 Annual Financial Reporting Model Regulation adopted by the NAIC or subsequent amendments, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. An insurer may not raise an exception to, waiver of, or interpretation of accounting requirements as a defense in an action, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

(11) Each insurer doing business in this state which reinsures through a captive insurance company as defined in s. 628.901, but without regard to domiciliary status, shall, in conjunction with the annual financial statement required under paragraph (1)(a), file a report with the office containing financial information specific to reinsurance assumed by each captive.

(a) The report shall be filed as a separate schedule designed to avoid duplication of disclosures required by the NAIC's annual statement and instructions.

(b) Insurers must:

1. Identify the products ceded to the captive and whether the products are subject to rule 69O-164.020, Florida Administrative Code, the NAIC Valuation of Life Insurance Policies Regulation (Model #830), or the NAIC Actuarial Guideline XXXVIII (AG 38).

2. Disclose the assets of the captive in the format prescribed in the NAIC annual statement schedules.
3. Include a stand-alone actuarial opinion or certification identifying the differences between the assets the ceding company would be required to hold and the assets held by the captive.

636.232 Rules.—The commission may adopt rules to administer this part, including rules for the licensing of discount plan organizations, providing for the collection of data, relating to disclosures to plan members, and defining terms used in this part.

636.202 Definitions.—As used in this part, the term:
(1) "Discount plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term does not include any product regulated under chapter 627, chapter 641, or part I of this chapter; any medical services provided through a telecommunications medium that does not offer a discount to the plan member for those medical services; or any plan that does not charge a fee to plan members. Until June 30, 2018, a discount plan may also be referred to as a discount medical plan.
(2) "Discount plan organization" means an entity that, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. Until June 30, 2018, a discount plan organization may also be referred to as a discount medical plan organization.
(3) "Marketer" means a person or entity that markets, promotes, sells, or distributes a discount plan, including a private label entity that places its name on and markets or distributes a discount plan but does not operate a discount plan.
(4) "Medical services" means any care, service, or treatment of illness or dysfunction of, or injury to, the human body, including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, and medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions.
(5) "Member" means any person who pays fees, dues, charges, or other consideration for the right to receive the purported benefits of a discount plan.
(6) "Provider" means any person or institution that is contracted, directly or indirectly, with a discount plan organization to provide medical services to members.
(7) "Provider network" means an entity that negotiates on behalf of more than one provider with a discount plan organization to provide medical services to members.

636.204 License required.—
(1) Before doing business in this state as a discount plan organization, an entity must be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of this state or authorized to transact business in this state in accordance with chapter 605, part I of chapter 607, chapter 617, chapter 620, or chapter 865, and must be licensed by the office as a discount plan organization or be licensed by the office pursuant to chapter 624, part I of this chapter, or chapter 641.
(2) An application for a license to operate as a discount plan organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:

(a) A copy of the applicant's articles of incorporation or other organizing documents, including all amendments.
(b) A copy of the applicant's bylaws.
(c) 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 discount plan organization, including any possible conflicts of interest.
(d) A complete biographical statement on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under paragraph (c).
(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.
(f) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members.
(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in paragraph (c).
(h) 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 health services to members.
(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may petition the office to accept, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.
(j) A description of the proposed method of marketing.
(k) A description of the subscriber complaint procedures to be established and maintained.
(l) The fee for issuance of a license.
(m) Such other information as the commission or office may reasonably require to make the determinations required by this part.
(3) The office shall issue a license which shall expire 1 year later, and each year on that date thereafter, and which the office shall renew if the licensee pays the annual license fee of $50 and if the office is satisfied that the licensee is in compliance with this part.
(4) Before licensure by the office, each discount plan organization must establish an Internet website so as to conform to the requirements of s. 636.226.
(5) The license fee under subsection (2) is $50 per year per licensee. All amounts collected shall be deposited into the General Revenue Fund.
(6) This part does not require a provider who provides discounts to his or her own patients to obtain and maintain a license as a discount plan organization.

636.208 Fees; charges; reimbursement.—
(1) A discount plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount plan.
(2)(a) If the member cancels his or her membership in the discount plan organization within the first 30 days after the effective date of enrollment in the plan, the member shall

receive a reimbursement of all periodic charges upon return of the discount card to the discount plan organization.
(b) If the member cancels his or her membership in the discount plan organization after the first 30 days, the discount plan organization:
1. Must cancel the membership on or before 30 days after receipt of the member's cancellation request.
2. May not charge the member any fees after the effective date of the cancellation of the membership.
3. Must provide a pro rata reimbursement of periodic charges made for months after the cancellation date.
(c) If the member cancels his or her membership in the discount plan organization consistent with the open enrollment rules established by an employer or association for a plan having an open enrollment period, the member shall receive a pro rata reimbursement of all periodic charges upon return of the discount card to the discount plan organization.
(3) If the discount plan organization cancels a membership for any reason other than nonpayment of fees by the member, the discount plan organization must make a pro rata reimbursement of all periodic charges to the member.
(4) In addition to the reimbursement of periodic charges for the reasons stated in subsections (2) and (3), a discount plan organization shall also reimburse the member for any portion of a one-time processing fee that exceeds $30 per year.

636.216 Written agreement.—There must be a written agreement between the discount plan organization and the member specifying the benefits under the discount plan and complying with the disclosure requirements of this part.

636.218 Annual reports.—
(1) Each discount plan organization shall file with the office, within 3 months after the end of each fiscal year, an annual report.
(2) Such reports must be on forms prescribed by the commission and must include:
(a) Audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding year. An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the audited financial statement of the organization, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity.
(b) If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount plan organization, including any possible conflicts of interest.
(c) The number of discount plan members in the state.
(d) Such other information relating to the performance of the discount plan organization as is reasonably required by the commission or office.
(3) Every discount plan organization that fails to file an annual 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 office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office

under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

636.220 Minimum capital requirements.—
(1) Each discount plan organization shall at all times maintain a net worth of at least $150,000.
(2) The office may not issue a license unless the discount plan organization has a net worth of at least $150,000.

636.226 Provider name listing.—Each discount plan organization must maintain on an Internet website an up-to-date list of the names and addresses of the providers with which it has contracted, the address of which must be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount plan organization has contracted directly, as well as those who are members of a provider network with which the discount plan organization has contracted.

636.228 Marketing of discount plans.—
(1) All advertisements, marketing materials, brochures, and discount cards used by marketers must be approved in writing by the discount plan organization.
(2) The discount plan organization must have an executed written agreement with a marketer before the marketer's marketing, promoting, selling, or distributing the discount plan. Such agreement must prohibit the marketer from using marketing materials, brochures, and discount cards without the approval in writing by the discount plan organization. The discount plan organization may delegate functions to its marketers but shall be bound by any acts of its marketers, within the scope of the delegation, which do not comply with this part.

636.230 Bundling discount plans with other products.—A marketer or discount plan organization selling a discount plan with medical services and other services may commingle those products on a single page of forms, advertisements, marketing materials, or brochures.

636.234 Service of process on a discount plan organization.—Sections 624.422 and 624.423 apply to a discount plan organization as if the discount plan organization were an insurer.

636.236 Surety bond or security deposit.—
(1) Each discount plan organization licensed pursuant to this part shall maintain in force a surety bond in its own name in an amount not less than $35,000 to be used at the discretion of the office to protect the financial interests of members who may be adversely affected by the insolvency of a discount plan organization. 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 licensed discount plan organization may deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52 having at all times a value of not less than $35,000. If a licensed discount plan organization substitutes its deposited securities under this subsection with a surety bond authorized in subsection (1), such deposited securities must be returned to the discount plan organization no later than 45 days following the effective date of the surety bond.

(3) A judgment creditor or other claimant of a discount plan organization, other than the office or department, does not have the right to levy upon any of the assets or securities held in this state as a deposit under subsections (1) and (2).