The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on General Government

BILL:	CS/SB 1190
INTRODUCER:	Banking and Insurance Committee and Senator Lee
SUBJECT:	Insurer Solvency
DATE:	April 1, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Betta	DeLoach	AGG	**Pre-meeting**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1190 substantially revises the solvency requirements for health maintenance organizations (HMOs) in the areas of minimum surplus, premium-to-surplus writing ratios, risk-based capital, financial reporting, financial management, and governance. These changes will require HMOs to meet the same regulatory requirements as insurers in these areas, thereby increasing consumer protections against insolvencies. The bill also increases the cap on HMO financial examination costs for examinations conducted by the Office of Insurance Regulation (OIR).

The OIR is primarily responsible for monitoring the solvency of regulated insurers and examining insurers to determine compliance with applicable laws, and taking administrative action, if necessary. Solvency regulation includes the requirements for starting and operating an insurance company or HMO, monitoring the financial condition through examinations and audits, and procedures for the administrative supervision, rehabilitation, or liquidation of a company if it is in unsound financial condition or insolvent.

Increasing the cap that the HMOs pay for examinations from $50,000 to $100,000 will result in a reduction of expenditures of state funds from the Insurance Regulatory Trust Fund within the Department of Financial Services.

The bill is effective upon becoming law, except as specified.

II. Present Situation:

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations, and other risk-bearing entities.[1] The Florida Insurance Code contains many provisions designed to prevent insurers from becoming insolvent and to protect and provide recovery for policyholders in the event of insolvency. Section 624.401, F.S., generally requires insurers and other risk-bearing entities to obtain a certificate of authority prior to engaging in insurance transactions and to meet certain initial and ongoing solvency requirements, such as minimum capital and surplus requirements, writing ratios, and financial reporting requirements.

Minimum Surplus Requirements Initial Licensure

For purposes of obtaining a certificate of authority, s. 624.408, F.S., requires an insurer writing health benefit plans[2] or long-term plans to maintain a minimum surplus as to policyholders of not less than the greater of $2.5 million or four percent of the insurer's total liabilities plus six percent of the insurer's liabilities relative to health insurance.[3] An HMO is required to have a minimum surplus of not less than the greater of $1.5 million, 10 percent of total liabilities, or two percent of total, annualized premiums. The current minimum surplus dollar thresholds for licensure have not changed for life and health insurers since 1989 and, for HMOs, since 1988.[4]

Requirements after Licensure

To maintain a certificate of authority to transact insurance, life and health insurers are required to maintain a minimum surplus as to policyholders not less than the greater of $1.5 million, or four percent of the insurer's total liabilities, plus six percent of the insurer's liabilities relative to health insurance.[5] The HMOs are required to meet the same requirements provided for initial licensure. The current minimum surplus dollar thresholds applicable to life and health insurers and HMOs beyond licensure have not changed since 1989 for life and health insurers,[6] and since 1998 for HMOs.[7]

Risk-Based Capital

Risk-based capital (RBC) is a capital adequacy standard that represents the amount of required capital that an insurer must maintain, based on the inherent risks in the insurer's operations. The RBC standard provides a safety net for insurers and provides state insurance regulators with authority for timely corrective action. On or before March 1 of each year, insurers and multi-state HMOs and prepaid limited health services organizations (PLHSOs)[8] must file risk-based capital reports and plans with the National Association of Insurance Commissioners (NAIC), while all

[1] Section 20.121(3)(a), F.S.
[2] Section 627.6699, F.S., defines the term, "health benefit plan," to mean any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract.
[3] Section 624.407, F.S.
[4] Sections 25 and 26, ch. 89-360, Laws of Florida (insurers); s. 5, ch. 88-388, Laws of Florida (HMOs).
[5] Section 624.407, F.S.
[6] Section 26, ch. 89-360, Laws of Florida.
[7] Section 20, ch. 98-159, Laws of Florida. The change to $1.5 million enacted in 1998 was phased in over three years.
[8] A PLHSO provides limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment that is authorized under chapter 636, F.S.

domestic insurers must also file a copy with the OIR, in accordance with statutory RBC requirements.[9] As of September 30, 2014, there was one multi-state HMO and four multi-state PLHSOs in Florida. [10]

Premium-to-Surplus Writing Ratios

Insurers are subject to premium-to-surplus ratios that determine the amount of premium they can write based on the amount of surplus. Section 624.4095, F.S., sets maximum ratios of premiums written to surplus as to policyholders. The basic ratio is 10-to-1 for gross written premiums and 4-to-10 for net written premiums.[11] The HMOs are not subject to such a requirement.

Management Services Organizations

For the purpose of determining the financial condition or solvency of an HMO and pursuant to s. 641.35, F.S., the OIR provides that specified assets can be included as admitted assets and other assets are excluded as non-admitted assets according to statutory accounting principles. Statutory accounting principles are characterized as a conservative approach since it evaluates the HMO's liquidity and the ability to pay claims in the future.

Certain entities, such as "management services organizations" (MSOs) provide services for HMOs. A MSO may provide management and administrative services to a practice, or it may acquire a practice's assets (thereby providing capital to the practice) and subsequently enter into agreements to provide the practice with space, equipment, or both.[12] Non-healthcare provider investors, a hospital, a group of physicians, a joint venture between a hospital and physicians, or a health plan may own a MSO.[13] A MSO is not regulated by the OIR; therefore, the OIR is unaware of its financial condition. If an HMO records a MSO transaction as a receivable or asset on its financial statements, the OIR is unable to determine if these transactions and amounts are accurate and that sufficient assets are available to pay losses and claims. Therefore, if a MSO receivable is recorded as an admitted asset, it could misrepresent the financial condition or solvency of an HMO. According to the OIR, very few HMOs currently book MSO receivables as admitted assets.

Financial Reporting

Section 624.424, F.S., requires insurers to submit annual and quarterly financial statements and an annual audited financial report. Insurers must file annual financial reports with the OIR on or before March 1. The HMOs and PLHSOs must file "within 3 months after the end of its fiscal year." Unlike insurers and HMOs, PLHSOs must also file a 4th quarter financial report, in

[9] Section 624.4085, F.S.
[10] Office of Insurance Regulation, Senate Bill 1190 Analysis (March 5, 2015) (on file with Banking and Insurance Committee).
[11] This ratio is modified by a factor of 0.8 for health insurance. This means that premiums may not be more than 3.2 times surplus. However, this provision does not apply to life and health insurers which have a surplus as to policyholders greater than $40 million and which have written health insurance during each of the immediately preceding five calendar years.
[12] Gregory D. Anderson and Emily B. Grey, The MSO'S Prognosis after the ACA: A Viable Integration Tool? Physicians and Physician Organizations Law Institute, February 11 and 12, 2013, Phoenix, Arizona.
[13] *Id.*

addition to the three other quarterly reports. For PLHSOs, the audited financial statements are submitted as part of the annual report.

Governance and Financial Management

Board of Directors

Florida law requires domestic insurers to be managed by a board of at least five directors.[14] A majority of the directors must be U.S. citizens. Current law does not impose similar requirements upon HMOs. Florida law also prescribes standards for insurer directors in discharging their duties, including among others, consideration of the benefits to the insurer by remaining independent. Former officers and directors of insolvent insurers serving within two years of the insolvency may not serve in that capacity for another insurer without demonstrating that his or her actions or omissions were not a significant contributing cause of the insolvency.

Dividends

Stock insurers and HMOs may only pay dividends[15] out of available and accumulated surplus funds derived from realized net operating profits on their business and net realized capital gains. The HMOs must receive approval from the OIR to pay dividends or distribute cash if, immediately before or after such distribution, their available and accumulated surplus funds are or would be less than zero. The OIR approval is not required if the HMO would have at least 115 percent of required statutory surplus after payment of the dividend (i.e., ordinary dividends). Under current law, an HMO with negative retained earnings may still pay a dividend without OIR approval.

Stock insurer dividend payments or distributions to stockholders made without the prior written approval of the OIR must not exceed the larger of:

- The lesser of ten percent of surplus or net gain from operations (life and health companies) or net income (property and casualty companies), not including realized capital gains, plus a two year carry forward for property and casualty companies;
- Ten percent of surplus, with dividends payable constrained to unassigned funds minus 25 percent of unrealized capital gains;
- The lesser of ten percent of surplus or net investment income (net gain before capital gains for life and health companies) plus a three-year carry forward (two-year carry forward for life and health companies) with dividends payable constrained to unassigned funds minus 25 percent of unrealized capital gains.

The OIR may approve a stock insurer dividend or distribution in excess of the maximum amount if it determines that the distribution or dividend does not jeopardize the financial condition of the insurer.

Any director of an HMO or domestic stock or mutual insurer who knowingly votes for or concurs in declaration or payment of a dividend to stockholders or members in violation of these provisions is guilty of a misdemeanor of the second degree, and is jointly and severally liable for

[14] Section 628.231, F.S.
[15] Sections 628.371 and 641.365, F.S.

any loss sustained by creditors of the insurer. Any stockholder receiving such an illegal dividend is liable in the amount thereof to the insurer. The OIR may revoke or suspend the Certificate of Authority of an insurer, which has declared or paid such an illegal dividend.[16]

OIR Examination Costs

The OIR is required to examine the "affairs, transactions, accounts, business records and assets" of each authorized HMO as often as it deems expedient for the protection of the public, but no less frequently than once every five years.[17] Insurers subject to financial examination must reimburse the OIR for 100 percent of the examination costs incurred. These funds are deposited into the Insurance Regulatory Trust Fund (Trust Fund).[18] By contrast, an HMO examination cost reimbursement is capped at $50,000, with any excess amounts paid out of the Trust Fund. Generally, this results in a subsidy of HMO examination costs exceeding $50,000.

III. Effect of Proposed Changes:

Minimum Surplus Requirements

Sections 1, 2, 6, and 7 provide the identical minimum surplus requirements for initial licensure and the maintenance of a license for an HMO or a life and health insurer writing health benefit plans or long-term care plans (ss. 624.407 and 624.408, F.S.). The bill increases the minimum dollar threshold for a certificate of authority to $10 million, up from the current $1.5 million required of HMOs and the $2.5 million required of life and health insurers.[19] It also extends the two percent of total annualized premium surplus threshold currently applied to HMOs to life and health insurers issuing health benefit plans. Current law requires life and health insurers and HMOs applying for an original certificate of authority to have minimum surplus in an amount that is the greater of a set dollar amount, or percentage of total liabilities or, in the case of HMOs, a percentage of total annualized premium.

The bill makes the minimum surplus required to be maintained by an HMO and a life and health insurer writing health benefit plans or long-term care plans after licensure, identical. The minimum surplus dollar thresholds required to be maintained after licensure is increased to $10 million, from the current $1.5 million for both HMOs and life and health insurers.

For newly licensed companies, the increased minimum surplus required to be maintained takes effect upon the bill becoming a law. For currently licensed companies (i.e., those holding a COA before the effective date of the act), the change in the minimum surplus dollar threshold required to be maintained is phased in over ten years, as follows:

- As of July 1, 2017: $3 million
- As of July 1, 2021: $6 million
- As of July 1, 2025: $10 million

[16] Section 628.391, F.S.
[17] Section 641.27, F.S.
[18] Section 624.320, F.S.
[19] Section 624.407, F.S.

As of the end of the 3rd quarter in 2014, Florida had 33 active HMOs and 454 active life and health insurers. Based on a preliminary analysis, the OIR found that 11 of these 487 existing companies could be impacted by the proposed revisions to surplus maintenance requirements—this includes six domestic HMOs, three domestic insurers and two foreign insurers. However, the bill authorizes the OIR to reduce the required level of surplus for health insurers and HMOs on a case-by-case basis if it finds it to be "in the public interest." In making this determination, the OIR may consider factors including, a company having fewer than 6,000 policies in force, less than $1 million in premium, or a limited geographic service area. This provision is similar to existing statutory authority provided to the OIR when similar surplus changes affecting residential property insurers were enacted in 2011. Although the OIR determination is discretionary and not tied to any one factor, all 11 companies appear to meet at least one of these criteria.

Risk-Based Capital Requirements

Section 3. The risk-based capital requirements for insurers are applied to newly licensed single-state HMOs and prepaid limited health services organizations (PLHSOs) (i.e., those initially authorized on or after July 1, 2015). As of September 30, 2014, there were 32 single-state HMO's and 18 single-state PLHSOs. Single-state HMOs and PLHSOs in existence prior to July 1, 2015, will be grandfathered in under the bill and not subject to these new risk-based capital requirements.

Premium-to-Surplus Writing Ratios

Section 6 subjects HMOs to the same (gross) premium-to-surplus writing ratio applicable to life and health insurers, which is a writing ratio of 10-to-1 on a gross premium basis (s. 624.4095, F.S.). Premium-to-surplus ratios on a net premium basis are not relevant to HMOs. In calculating the ratios for HMOs, the bill requires that risk revenue be included in addition to premium. For new HMOs (i.e., those not holding a certificate of authority before the effective date of the act), the 10-to-1 premium to surplus writing ratio is imposed effective upon the bill becoming a law; for existing HMOs (i.e., those licensed before the effective date of the act), the change is phased in over ten years, as follows:

- As of July 1, 2017: 30-to-1
- As of July 1, 2021: 20-to-1
- As of July 1, 2025: 10-to-1

Management Services Organizations

Sections 5 and 10 define "receivables from a management services organization" (MSO) under contract with health maintenance organizations and requires such receivables to be classified as non-admitted assets. "Management services organization" is defined in the bill as "an entity providing one or more medical practice management services to health care providers, including, but not limited to, administrative, financial, operational, personnel, records management, educational, compliance, and managed care services."

Financial Reporting

Sections 4 and 8 align PLHSO and HMO annual and quarterly reporting requirements with that of life and health insurers. For example, the bill changes the due date for submitting the annual financial report from "within 3 months after the end of its fiscal year" (i.e., April 1) to March 1. The section also eliminates the PLHSO 4th quarter report—a report insurers and HMOs are not currently required to file. The financial information in the 4th quarter report is reviewed in the context of the annual report. The bill also provides that the PLHSO and HMO annual audited financial statements are standalone filings due June 1, instead of "3 months after the end of its fiscal year."

The bill also requires PLHSOs and HMOs to adhere to insurer audit rules adopted by the Financial Services Commission (e.g., Rule 69O-137.002, F.A.C.), beginning with financial statements filed for calendar year 2015.

Governance and Financial Management

Section 6 applies stock insurer board of director provisions (s. 628.231, F.S.) to HMOs. It also extends current restrictions applicable to former officers and directors of insolvent insurers to former officers and directors of HMOs. (s. 624.4073, F.S.)

Sections 6 and 11 extend the provisions (ss. 628.371 and 628.391, F.S.) applicable to insurers for the payment of dividends to HMOs. While the standards applicable to HMOs for paying dividends will change, sanctions for payment of illegal dividends remains the same since they are treated the same for both insurers and HMOs under current law. Dividends paid when unassigned surplus is negative will require approval. Section 641.365, F.S., relating to the payment of dividends by an HMO, is repealed.

OIR Examination Costs

Section 9 increases the OIR financial examination cost cap from $50,000 to $100,000 for an HMO.

Miscellaneous

Sections 12 and 13 provide a technical, conforming cross reference.

Section 14. The Division of Law Revision and Information is directed to replace the phrase "the effective date of this act" where it occurs in this act with the date the act becomes law.

Section 15. Except as otherwise provided, the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The impact of CS/SB 1190 on the private sector is indeterminate. According to HMO representatives, sometimes the HMOs are asked by the OIR to waive the current fee cap and pay the additional costs. The increase in the cap for examination costs will increase examination costs for HMOs.

C. Government Sector Impact:

The bill has an indeterminate positive fiscal impact to the Insurance Regulatory Trust fund from increasing the cap HMOs must pay for examinations from $50,000 to $100,000.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 624.407, 624.408, 624.4085, 636.043, 641.19, 641.201, 641.225, 641.26, 641.27, 641.35, 817.234 and 817.50.

This bill repeals section 641.365 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on March 17, 2015:
The bill increases the cap on the costs of an OIR financial examination an HMO must

incur from $50,000 to $100,000, rather than requiring the HMO to reimburse the actual costs.

The bill clarifies the formula for calculating the minimum surplus requirements applicable for insurers and HMOs.

B. Amendments:

None.