HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: **HB 1277 CS** **Risk-Based Capital Requirements for Health Maintenance Organizations**
SPONSOR(S): **Hasner**
TIED BILLS: **HB 1279** IDEN./SIM. BILLS: **SB 2294**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee	17 Y, 0 N, w/CS	Freire	Cooper
2) Health Care Regulation Committee			
3) State Administration Appropriations Committee			
4) Commerce Council			
5)			

SUMMARY ANALYSIS

This bill has two main components. The first part creates risk-based capital requirements for health maintenance organizations (HMOs) to ensure the solvency of those entities. Currently, s. 641.225, F.S., requires HMOs to maintain a surplus totaling the greater of either $1.5 million, 10 percent of total liabilities, or 2 percent of total annualized premiums in order to retain a certificate of authority. Solvency requirements are monitored by the Office of Insurance Regulation (OIR) through annual and quarterly reports filed by HMOs.

This bill is similar to the National Association of Insurance Commissioners (NAIC) Model HMO Act, which has been adopted in 28 states. It requires HMOs to file informational reports with the OIR from January 1, 2007 to April 2, 2011. Starting April 2, 2011, this bill requires HMOs to comply with the risk-based capital requirements, and it provides four action levels delineating what the OIR can do when an HMO has not met its risk-based capital requirements.

The second part of this bill allows HMOs to offer more point-of-service riders in their contracts, from 15 percent of their premiums to 49 percent of their premiums. Due to the nature of HMOs, HMOs have been regulated differently from regular health insurance companies. Currently, under s. 641.31(38), F.S., HMOs are only allowed to offer up to 15 percent of their premiums as point-of-service riders. Likewise, they are not required to comply with the health insurance premium surplus requirements.

This bill, in allowing HMOs to offer more than 15 percent, but less than 49 percent, of their premiums as point-of-service riders and preferred provider policies, also requires HMOs offering more than 15 percent of their premiums and point-of-service riders to comply with s. 624.4095, F.S., relating to health insurance premium surplus. This section is effective upon becoming law.

This bill does not have a fiscal impact on state or local government.

This bill is effective on January 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government: This bill requires insurance companies to file a risk-based capital report with the Office of Insurance Regulation (OIR). It authorizes the OIR to either take corrective, regulatory, or complete control over an insurance company if its surplus falls below designated amounts.

Promote Personal Responsibility: This bill requires HMOs to show solvency by maintaining a specified amount of risk-based capital.

B. EFFECT OF PROPOSED CHANGES:

General Health Insurance Information[1]

Today, people acquire health insurance through either the private industry, employer self-funded, government subsidized, or government funded insurers. Providers tailor different health plans to meet certain needs. Common plans include indemnity (fee-for-service) and managed care.

In the 1990's, the indemnity policy was the main type of group insurance available. Under this policy, an employer would pay an employee's monthly premium and the insured would pay out all insurance claims submitted to it by the provider of a fee-for-service basis. This kind of policy proved to be expensive, and in response, the health insurance industry made modifications to make it more cost-effective.

Another common plan is managed care. The goal of managed care is to limit the services rendered by the provider in order in order to save money for the insurer and the payor. Unlike indemnity policies which pay medical service providers on a fee-for-service basis, managed care organizations pay medical service providers a negotiated, discounted price for services. Three forms of managed care organizations include health maintenance organizations (HMOs), the preferred provider organization (PPO), and point of service plans (POS).

A PPO has a network of health care providers who have agreed to accept a discounted fee as payment for the service rendered. A POS plan provides consumers the additional option of using an indemnity type fee-for-service plan. It allows HMOs to cover employees outside of the employer's primary base and outside of the HMOS immediate coverage. While more costly to patients, a POS plan grants patients more flexibility to choose a doctor outside of the PPO network.

An HMO provides comprehensive health care to a population, in a geographical location, at a pre-determined price that is prepaid directly to the HMO. In an HMO, patients are assigned to a primary care physician (PCP) who is usually an internist. One of the reasons that HMO plans tend to cost consumers less is because prior to seeing a specialist in the HMO, patients must see the PCP.

In Florida, there are 36 HMOs, serving a total of 3,843,685 policyholders.[2]

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[1] Anne Maltz and Feinstein Herrick, *Health Insurance 101*, 723 PLI/ Lit 353 (2005). The information from this subsection came from this article, published by the Practising Law Institute Litigation and Administrative Practice Course Handbook Series, on file with the Insurance Committee.

[2] Managed Care Summary Report, Third Quarter 2005, available at http://www.floir.com/pdf/HMO_3Q2005.pdf, viewed on March 29, 2006.

Section 1: HMO Solvency

Currently, Florida does not have risk-based capital requirements for health maintenance organizations (HMOs). Instead, s. 641.225, F.S., requires an HMO to either maintain a surplus totaling the greater of either $1.5 million, 10 percent of total liabilities, or 2 percent of total annualized premiums in order to retain a certificate of authority. If an HMO has been in operation for 5 years and has a surplus totaling the greater of either $2 million or 2 times the minimum surplus requirement, it may provide a written guarantee assuring payment of claims and all HMO liabilities.[3]

Section 641.26, F.S., also requires HMOs to show solvency by filing quarterly and annual reports. The annual report must include: the HMO's financial statement, an audited financial statement, the number of health maintenance contracts, number and amount of damage claims against HMO, an actuarial certification, a report prepared by the certified public accountant describing the HMO's weaknesses and providing remedial actions to correct the material weaknesses, and other information relating to HMOs.[4]

Risk-Based Capital

This bill, closely resembling the National Association of Insurance Commissioners (NAIC) Model HMO Act, creates s. 641.224, F.S., entitled "Risk-based capital requirements for health maintenance organizations." Risk-based capital is a nationally recognized solvency tool used to regulate insurers and HMOs. Risk-based capital is a minimum level of capital that an insurance company should have, based on its size and the kinds of risks to which it is exposed.[5] The capital of an insurance company is calculated by summing admitted assets and then subtracting its liabilities.[6] Twenty-eight states have adopted the NAIC model HMO Act.[7]

This bill requires HMOs to annually calculate and file a report of its risk-based capital levels with the NAIC, the OIR, and with the insurance departments in states where the insurer is allowed to do business. The OIR is allowed to adjust the risk-based capital report if it finds any inaccuracy.

The statute provides that the comparison of an HMO's total adjusted capital to any of its risk-based capital levels is intended to be a regulatory tool indicating the need for possible corrective action with respect to the solvency of HMOs. It provides that the risk-based capital level may not be used to rank the HMOs, and provides that this information may only be published if an HMO is rebutting a materially false statement.

The bill provides that risk-based capital will be determined by the:

- Asset risk
- Credit risk
- Underwriting risk
- All other business risks and such other relevant risks as are set forth in the risk-based capital report.

Action Levels:

There are four action levels. To determine at which action level an HMO currently falls, an HMO's Total Adjusted Capital is compared to its Authorized Control Level Risk-Based Capital as computed by the risk-based capital formula. The Total Adjusted Capital is compared to the Authorized Control Level

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[3] Section 641.225(6)(a-b), F.S. (2005).
[4] Section 641.26(1)(a-h), F.S. (2005).
[5] Edward B. Hirshfeld, *Provider Sponsored Organizations and Provider Service Networks—Rationale and Regulation*, 22 Am Jour. L.Rev. 263, 291 (1996).
[6] Edward B. Hirshfeld, *Provider Sponsored Organizations and Provider Service Networks—Rationale and Regulation*, 22 Am Jour. L.Rev. 263, 291 (1996).
[7] *See* Information provided to Insurance Committee on February 22, 2006, on file with Insurance Committee.

because the Authorized Control Level is the earliest level at which the office can petition the court to file for receivership of an HMO. If an HMO's surplus is 200% or more of the authorized control level, no action is required. However, when an HMO's surplus is less than 200%, the bill requires HMOs and the OIR to take the following action:

- *Company Action Level Event*: The HMO's total adjusted capital is greater than or equal to its regulatory action level risk-based capital (150%) but less than its company action level risk-based capital (200%).
  - If a company action level event occurs, the bill requires the HMO to prepare and submit to the office a risk-based capital plan identifying conditions contributing to the company's action level event, to propose corrective action for the HMO to take, to project the HMO's financial results in the current year and at least 2 succeeding years, to identify key assumptions affecting the HMO's projections, and to identify problems associated with the HMO's business.
- *Regulatory Action Level Event*: The HMO's total adjusted capital is greater than or equal to its authorized control level risk-based capital (100%) but is less than its regulatory action level risk-based capital (150%).
  - If a regulatory action level event occurs, the bill provides that the office will require the HMO to prepare and submit a risk-based capital plan. The bill requires the office to evaluate the analysis and issue a corrective order for the HMO.
- *Authorized Action Level Event*: The HMO's total adjusted capital is greater than or equal to its mandatory control level risk-based capital (70%) but is less that its authorized control level risk-based capital (100%).
  - If an authorized action level event occurs, the office may choose to either 1) require the HMO to prepare and submit a risk-based capital plan and after evaluating its plan, issue a corrective order for the HMO, or 2) the office may take any action as necessary to place the HMO under regulatory control under Chapter 631. This level is sufficient ground for the department to be appointed as receiver as provided in chapter 631.
- *Mandatory Control Level Event*: The HMO's total adjusted capital is less than its mandatory control level risk-based capital (70%).
  - If a mandatory control level event occurs, the office, after due consideration to s. 641.225, F.S., shall take any action necessary to place the HMO under regulatory control, including any remedy available under Chapter 631.

Section 2. Point-of-Service Riders

Florida HMO Laws

Currently, chapter 641, Florida Statutes, governs HMOs. Health insurance is governed by chapters 624, F.S., *et seq*. Under s. 641.31(38), F.S., an HMO may offer point-of-service riders to some insurers. However, under no circumstance may point-of-service riders exceed 15 percent of an HMO's total premium.[8] Likewise, HMOs may not offer coverage through a preferred provider contract.

This bill allows HMOs to provide comprehensive health care services through a point-of-service rider or coverage for benefits through a preferred provider network for up to 49 percent of the gross premiums. The bill requires HMOs to comply with s. 624.4095, F.S., relating to surplus requirements for health insurers, for all point-of-service riders and preferred provider policies exceeding 15 percent of total premiums.

The bill also provides that an HMO may require subscribers of a point-of-service rider or of a preferred provider policy to pay a reasonable co-payment for each visit for services. It requires the point-of-service rider or preferred provider policy to contain provisions that comply with s. 627.6044, F.S., s.

[8] *See s. 641.31(38), F.S.*

627.410, F.S., and s. 627.411, F.S. Section 627.6044, F.S., relates to the use of a specific methodology for payment of claims. Section 627.410, F.S., relates to the filing of insurance policies and approval of forms. Section 627.411, F.S., relates to grounds in which the OIR may disapprove an insurance policy form.

Furthermore, the bill requires HMO preferred provider policies to be subject to part III of chapter 631 which regulates provider policies. It also requires preferred provider policies written by HMOs to be subject to premium tax as if the premiums were written by an authorized health insurer pursuant to chapter 624.

This part of the act is effective upon the act becoming a law.

Time to Comply

This bill provides that beginning January 1, 2007, an HMO must file annual risk-based capital reports with the OIR identified under s. 641.224(2), F.S., for informational purposes only. It provides that beginning April 2, 2011, s. 641.224, F.S., applies to any risk-based capital report filed as required.

This act shall take effect on January 1, 2007, unless expressly otherwise provided.

C. SECTION DIRECTORY:

Section 1. Creates s. 641.224, F.S., entitled "Risk-based capital requirements for health maintenance organizations."

Section 2. Amends s. 641.38(38), F.S., by giving HMOs the ability to offer more point-of-service riders and preferred provider contracts for up to 49% of their total premiums, as long as they comply with existing surplus laws.

Section 3. Provides dates by which an HMO must file with OIR and provides that the information report is effective April 2, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. **Revenues:**

   None.

2. **Expenditures:**

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. **Revenues:**

   None.

2. **Expenditures:**

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill requires HMOs to meet delineated risk based requirements and allows HMOs to sell more point-of-service riders to their policyholders. As the effective date of this bill is not until 2011, an HMO has ample time to meet the surplus requirements under this bill.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

This bill is linked to a public records and public exemptions bill, HB 1279. House Bill 1279 provides that an HMO's risk-based capital information is exempt from public disclosure.

B. RULE-MAKING AUTHORITY:

None provided.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The OIR noted that the newly created sub-paragraphs (i) and (j) under s. 641.224, F.S., may be inappropriate for the statute governing contract benefits. The OIR stated that as filed, it is unclear if these statements of intent are sufficient to apply FLHIGA membership (governed under Chapter 631, Part III) or provide sufficient information for the Department of Revenue to administer applicable insurance premium tax provisions pursuant to Part IV, of Chapter 624.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 30, 2006, the Insurance Committee approved HB 1277 with five technical amendments.

This analysis has been updated to reflect the changes made by the Insurance Committee at its March 30, 2006 meeting.