SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Banking and Insurance Committee

BILL:	SB 2294
INTRODUCER:	Senator Atwater
SUBJECT:	Risk-Based Capital Requirements for Health Maintenance Organizations
DATE:	March 24, 2006
REVISED:	03/28/06

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Deffenbaugh	BI	**Fav/5 amendments**
2.			HE	
3.			HA	
4.				
5.				
6.				

Please see last section for Summary of Amendments

- [X] Technical amendments were recommended
- [X] Amendments were recommended
- [ ] Significant amendments were recommended

I. Summary:

Senate Bill 2294 creates risk-based capital (RBC) requirements for health maintenance organizations (HMOs) similar to those imposed on insurers, for the purpose of monitoring the solvency of HMOs. HMOs would be required to file risk-based capital reports from January 1, 2007 to January 1, 2011 as informational-only filings with the OIR. RBC reports will be used for regulatory purposes after that period.

The bill grants an HMO the ability to offer more point-of-service riders to their health maintenance contracts and permits the offer of preferred provider (PPO) contracts for up to 49 percent of the HMO's total premiums. An HMO offering point-of-service riders or (PPO) contracts in excess of the HMO's total premiums must comply with the premium to surplus provisions of s. 624.4095, F.S., as though the HMO were a health insurer. This section of the bill is effective upon becoming a law.

The bill is effective, except as otherwise provided, on January 1, 2007.

This bill creates the following sections of the Florida Statutes: 641.224.

This bill substantially amends the following sections of the Florida Statutes: 641.31.

II. Present Situation:

HMOs: Point-of-Service Riders

Traditionally, an HMO member must use the HMO's network of health care providers for the provision of health care. The use of a non-contracted provider outside the HMO's network generally will result in the HMO limiting or denying benefits to the member. However, under s. 641.31(38), F.S., an HMO may sell a point-of-service rider to a subscriber that permits the subscriber to choose a health care provider that is not under contract with the HMO. The choice of provider is left up to the subscriber, not the HMO, as the point-of-service rider does not require a referral from the HMO in order to utilize non-contracted health care providers. The point-of-service rider may require the subscriber to pay a reasonable co-payment for each visit for services provided by a non-contracted provider.

An HMO is limited on the number of point-of-service riders it may offer for sale.[1] The premiums paid for point-of-service riders cannot exceed 15 percent of the total premiums for all health plan products sold by the HMO. Because point-of-service riders subject an HMO to greater potential costs, HMOs offering such riders must meet additional solvency requirements. The HMO must have been licensed for a minimum of three years and must maintain a minimum surplus of $5 million.

State Regulation of HMO Solvency

Each HMO must at all times maintain a minimum surplus that is the greater of $1.5 million, 10 percent of total liabilities, or 2 percent of total annualized premium.[2] Alternatively, if the HMO has been in operation for 5 years or more and has a surplus of the greater of $2 million or 2 times the minimum surplus requirements listed above, it may provide a written guarantee to assure payment of covered subscriber claims and all of the HMO's liabilities if it meets certain conditions. An HMO choosing to provide a written guarantee must yearly submit audited financial statements certified by an independent certified public accountant. If an HMO does not meet these requirements, it is ineligible to receive a certificate of authority to operate as an HMO in Florida.

Each health maintenance organization must deposit with the department cash or securities with a market value of $300,000 or more, if the OIR determines that additional funds are necessary. Failure to maintain the necessary deposit of assets may subject the HMO to having its certificate of authority revoked by the office. If the office determines that the financial condition of an HMO had deteriorated to the point that the policyholders' best interests are not being preserved by the HMO's activities, it may require an additional deposit of between $100,000 and $2,000,000 for as long as the office deems necessary.

Each HMO must file quarterly and annual financial statements with the OIR.[3] The annual financial statement must include an actuarial certification[4] that the HMO is actuarially sound (taking into consideration the rates, benefits, and expenses of the HMO and other funds available to pay the HMO's obligations), that its rates are actuarially adequate, that incurred but not

[1] s. 641.31(38), F.S.
[2] s. 641.225, F.S.
[3] s. 641.26, F.S.
[4] s. 641.26(1)(f), F.S.

reported claims and claims reported but not paid have been adequately provided for, and that the HMO has adequately provided for all obligations as required by s. 641.35(3)(a), F.S. Additionally, Florida law requires that the Office of Insurance Regulation conduct a financial examination of a health maintenance organization at least once every five years.[5] The examination includes an analysis of the HMO's affairs, transactions, accounts, and business records. If the examination reveals the need for an HMO to enter rehabilitation, liquidation, reorganization, conservation or be dissolved, such an action must be conducted via a delinquency proceeding under Part I of Chapter 631, Florida Statutes, or via supervision by the OIR pursuant to ss. 624.80-624.87, F.S.

Risk Based Capital

Insurance companies must meet the risk-based capital requirements of s. 624.4085, F.S. HMOs currently do not have to meet such requirements. The National Association of Insurance Commissioners (NAIC) is a voluntary association of insurance regulators from all 50 states. One function of the NAIC is as a promulgator of model laws. Two of those model laws that serve similar purposes are the Risk Based Capital For Insurers Model Act and the Risk-Based Capital for Health Organizations Model Act. Twenty-eight states have adopted the Risk-Based Capital for Health Organizations Model Act. Florida has adopted the RBC for Insurers Model Act, but not the RBC for Health Organizations Model Act.

The risk-based capital (RBC) system uses a formula to assess the adequacy of an insurer's or HMO's capital. The RBC system determines a company's minimum necessary capital level by evaluating the risk level of an insurer or HMO's underwriting, investments, and other factors depending on the lines of business the company writes. If a Florida insurer's actual capital level falls below certain levels when compared with the minimum capital level, s. 624.4085, F.S., authorizes the DFS to take action to require the insurer to rectify the shortfall or begin receivership proceedings. The various action levels under the risk-based capital system are based on the company's "control level"—the level of capital at or below which the OIR is authorized to petition a court to place the insurer in receivership. There are four RBC action levels that are used by both the RBC for Insurers Model Act and the RBC for Health Organizations Model Act:

- Company Action Level[6]—If an insurer's total adjusted capital is only 150 percent to 200 percent above the company's control level, this level is triggered. The insurer must submit to the OIR a comprehensive financial plan that identifies the causes of the financial condition and contains proposals to correct the financial problems identified and restore total adjusted capital to 200 percent or above. The financial plan must contain projections[7] of the insurer's expected financial condition for the current year and the four succeeding years both if the financial plan is implemented and if it is not. Failure to file the plan as required or filing of an unsatisfactory plan can trigger a regulatory action level event at the discretion of the OIR.
- Regulatory Action Level[8]—If an insurer's total adjusted capital is 100 percent or higher but less than 150 percent above the company's control level, this level is triggered. At this level, the company must submit a comprehensive financial plan to the office.

[5] s. 641.27, F.S.
[6] s. 624.4085(3), F.S.
[7] The plan must also detail the assumptions underlying these projections.
[8] s. 624.4085(4), F.S.

Additionally, the OIR must perform either an on-site examination of the insurer pursuant to s. 624.316, F.S., or an analysis of the insurer's liabilities, assets and operations. The OIR is also mandated to issue a corrective order detailing the corrective actions the office determines are required.

- Authorized Control Level[9]—If an insurer's total adjusted capital is 70 percent or higher up to 100 percent of the authorized control level, then this action level is triggered. The authorized control level permits the OIR to petition to put the insurer into receivership pursuant to Part I, Chapter 631, F.S., the Insurers Rehabilitation and Liquidation Act. This power is in addition to all powers available in the action levels detailed above.
- Mandatory Control Level[10]—If an insurer's total adjusted capital is less than 70 percent of the authorized control level, then the OIR must place the insurer into receivership pursuant to the Insurers Rehabilitation and Liquidation Act.

If a domestic insurer is placed in receivership, often an attempt will be made to rehabilitate the company. In rehabilitation, the receiver (the Division of Rehabilitation and Liquidation) is authorized to conduct all business of the insurer, including managing its assets and controlling all employees. If the rehabilitation is successful, control of the company is turned back over to private sector ownership. If, however, the insurer is insolvent and there is no realistic chance it can be rehabilitated, then the receiver will petition the court to liquidate the company. In liquidation, the receiver takes possession of all of the insurer's assets, marshals them, and eventually uses them to pay claimants to the extent possible and then dissolves the corporate existence of the domestic insurer.

III. Effect of Proposed Changes:

Section 1. Creates s. 641.224, F.S., detailing the risk based capital requirements for health maintenance organizations. The section is modeled on the National Association of Insurance Commissioners Risk-Based Capital for Health Organizations Model Act, and is similar to s. 624.4085, F.S., which contains the RBC requirements for insurers. The section begins with definitions that are provided for use throughout the section.[11]

HMOs are required to file an RBC report for informational purposes only from January 1, 2007 until April 2, 2011 (the date the informational report for 2010 calendar year is due). Beginning January 1, 2011, an HMO that writes direct annual premiums of more than $2 million[12] shall be required to prepare and file with the NAIC a report for regulatory purposes detailing its risk-based capital levels for the previous calendar year.[13] A copy of the report must be filed with the OIR before April 1 of each calendar year and must also supply insurance departments in other states with a copy of the report within 15 days of the request or by April 1, whichever is later.

Risk-based capital information may only be used for limited purposes by the regulatory authorities (OIR) and HMOs.[14] HMOs are prohibited from publishing or making known in any

[9] s. 624.4085(5), F.S.
[10] s. 624.4085(6), F.S.
[11] Subsection (1).
[12] Subsection (11).
[13] Paragraph (2)(a).
[14] Paragraph (2)(b).

way information regarding the risk-based capital level of an HMO. The comparison of an HMO's total adjusted capital to its risk-based capital levels is designed to indicate the need for corrective action regarding an HMO's finances. It is a regulatory tool designed to ensure solvency. Such information may not be used to provide rankings of HMOs. An exception exists if a materially false statement regarding such information is published in writing. If an HMO can substantially prove that the statement made is false or inappropriate, that HMO may publish a written announcement that has the sole purpose of rebutting the false statement. The OIR is also constricted in its use of risk-based capital information. Such information may only be used for monitoring the solvency of an HMO, and cannot be used for ratemaking purposes or as a means to calculate premiums.[15]

A health maintenance organization's risk-based capital level is to be determined in accordance with the formula set forth in the risk-based capital instructions promulgated by the NAIC.[16] The formula takes into account the various risks that the capital of an HMO faces, including asset risk, credit risk, underwriting risk, other business risks, and other relevant risks that are set forth in the RBC report. Additionally, the statute indicates a Legislative recommendation that HMOs maintain excess capital over the amount required pursuant to the risk-based capital of the section.[17]

If the office finds an RBC report submitted by an HMO to be inaccurate, the OIR must adjust the report to correct the inaccuracy and must notify the HMO of the adjustment.[18] Notice to the HMO must state the reason for the adjustment. The adjusted risk-based capital report must be filed with the NAIC by the health maintenance organization.

Beginning with the risk-based capital report for calendar year 2011, when an HMO's risk based capital level falls to certain levels, the Office of Insurance Regulation is authorized to take certain actions to ensure the ongoing solvency of the HMO. There are four actions levels, with each successive action level indicating a decreasing level of total adjusted capital—the sum of an HMO's statutory capital, surplus and other items required by the risk-based capital instructions. The lower the level of total adjusted capital in comparison with the authorized control level RBC level of an HMO (which is the amount of capital that authorizes the OIR to petition a court to take control of the HMO) the higher degree of action the OIR is authorized to take to remedy the lack of capital in the HMO. There are four action levels:

- Company Action Level[19]—If an HMO's total adjusted capital is only 150 percent to 200 percent above the company's control level, this level is triggered. The HMO must submit to the OIR a comprehensive financial plan that identifies the causes of the financial condition and contains proposals to correct the financial problems identified and restore total adjusted capital to 200 percent or above.[20] The financial plan must contain projections of the HMO's expected financial condition for the current year and the four succeeding years both if the financial plan is implemented and if it is not. Failure to file

[15] Paragraph (2)(c).
[16] Paragraph (2)(d).
[17] Paragraph (2)(e).
[18] Paragraph (2)(f).
[19] Paragraph (3)(a).
[20] Paragraph (3)(b).

the plan as required or filing of an unsatisfactory plan can trigger a regulatory action level event at the discretion of the OIR.[21]

- Regulatory Action Level[22]—If an HMO's total adjusted capital is 100 percent or higher but less than 150 percent above the company's control level, this level is triggered. At this level, the company must submit a comprehensive financial plan to the office. Additionally, the OIR must perform either an on-site examination of the HMO pursuant to s. 624.316, F.S., or an analysis of the HMO's liabilities, assets and operations.[23] The OIR is also mandated to issue a corrective order detailing the corrective actions the office determines are required.
- Authorized Control Level[24]—If an HMO's total adjusted capital is 70 percent or higher up to 100 percent of the authorized control level, then this action level is triggered. The authorized control level permits the OIR to petition to put the HMO into receivership pursuant to Part I, Chapter 631, F.S., the Insurers Rehabilitation and Liquidation Act.[25] This power is in addition to all powers available in the action levels detailed above.
- Mandatory Control Level[26]—If an HMO's total adjusted capital is less than 70 percent of the authorized control level, then the OIR must place the HMO into receivership pursuant to the Insurers Rehabilitation and Liquidation Act.

Regardless of the control level indicated in a risk-based capital report, the HMO has the right to a hearing before the OIR for any of the following reasons[27]:

- If the OIR changes the HMO's RBC report, converting it into an adjusted RBC report;
- If the OIR determines that the HMO's risk-based capital plan or revised RBC plan is unsatisfactory and that the result will be a regulatory action level event;
- If the OIR determines that the HMO has failed to adhere to its risk-based capital plan or revised RBC plan, and that the failure has a substantial adverse effect on the ability of the HMO to eliminate the company action level event; or
- Notification by the OIR to a HMO of a corrective order (which requires certain corrective actions to be taken).

The bill also provides notice requirements for the hearing, that the hearing be conducted within 10 to 30 days after the OIR receives the HMO's request for hearing, and that the hearing be conducted in accordance with s. 624.324, F.S. (within the scope of the Insurance Code) with appellate review as provided in s. 120.68, F.S.

The Financial Services Commission is provided with rulemaking authority to administer this section.[28] The authority includes, but is not limited to, rules regarding RBC reports, adjusted RBC reports, risk-based capital plans, corrective order and procedures to be followed in the event of the triggering of a company action level event, a regulatory action level event, an authorized control level event, or mandatory control level event.

[21] Paragraph (3)(e).
[22] Paragraph (4)(a).
[23] Paragraph (4)(b).
[24] Paragraph (5)(a).
[25] Paragraph (5)(b).
[26] Subsection (6).
[27] Subsection (7).
[28] Subsection (12).

Other provisions of this section include:

- The provision of an exemption from liability, and a prohibition against bringing a cause of action against the Financial Services Commission, the Department of Financial Services, the Office of Insurance Regulation, or their employees or agents for actions taken in the performance of their duties and powers under the section.[29]
- A requirement that the OIR transmit any notice that may result in regulatory action by registered mail, certified mail, or any other method of transmission.[30] Notice is effective when the HMO receives the notice.
- An indication that this section is supplemental to the other laws of the state and does not preclude or limit any power or duty of the DFS or OIR under those laws or rules adopted under those laws.[31]

Section 2. Amends subsection (38) of section 641.31, F.S., to enhance the ability of a health maintenance organization to offer point-of-service riders and to authorize an HMO to sell preferred provider policies pursuant to s. 627.6471, F.S. The same requirements that apply to offering a point-of-service rider to an HMO contract under amended subsection (38) also apply to offering preferred provider policies sold by an HMO.

The section increases the number of point-of-service riders and PPO policies an HMO may potentially sell.[32] Currently, the premiums paid in for point-of-service riders cannot exceed 15 percent of total premiums for all health plan products sold by the HMO. The bill (mistakenly) increases that amount to 49 percent. However, the bill contains drafting errors and was intended to provide that premiums paid for point-of-service riders and preferred provider policies cannot exceed 15 percent of total premiums for all health plan products sold by the HMO, unless the HMO complies with the premium to surplus requirements of s. 624.4095, F.S., as if it were a health insurer. If this condition is met, the total gross premiums for point-of-service riders and preferred provider policies could not exceed 49 percent of the gross premiums written on an actual or projected basis for the HMO.

Once the bill is corrected, it will provide that point-of-service riders and PPO policies cannot exceed 15 percent of total premiums for all health plan products sold by the HMO, unless the HMO complies with the premium to surplus requirements of s. 624.4095. F.S. To calculate the available surplus an HMO has to provide point-of-service riders or PPO policies, the HMO's surplus is to be calculated by subtracting from the actual or projected surplus, the surplus required to be maintained under s. 641.225, F.S. (the greater of $1.5 million, 10 percent of total liabilities, or 2 percent of total annualized premium). If the premiums written for point-of-service riders and PPO policies exceed 15 percent, the HMO must file with its annual and quarterly financial reports required by s. 641.26, F.S., a report on a form provided by the commission that details the direct total premiums written, direct premiums earned, direct losses paid, and direct losses incurred for point-of-service riders and preferred provider policies.

[29] s. 641.224(8) F.S.
[30] s. 641.224(9) F.S.
[31] s. 641.224(10) F.S.
[32] s. 641.31(38)(c), F.S.

In no event may the total gross premiums for point-of-service riders and preferred provider policies exceed 49 percent of the gross premiums written on an actual or projected basis for HMO contracts. If such total gross premiums do exceed the 49 premium cap, the HMO must notify the OIR and stop writing such riders and PPO policies until it is in compliance with the 49 percent level.

Other new provisions added to subsection (38) by this bill include:

- A requirement that the premium for PPO policies earned by HMOs shall not be included in the health maintenance organizations assessment base provided in s. 631.819, F.S, but rather that the PPO policies are subject to the requirements of Part III of chapter 631, F.S., (the Florida Life and Health Insurance Guaranty Association Act).
- Requiring that PPO policies written by an HMO are subject to premium tax on the same basis as if the premiums were written by an authorized health insurer pursuant to chapter 624, F.S.

Section 2 of the bill is effective upon becoming a law.

Section 3. Requires an HMO subject to s. 641.224, F.S., to file with the OIR the risk-based capital report identified in s. 641.554(2), F.S. The first report must be filed by April 1, 2007, and annually thereafter. The report is for informational purposes only. This requirement shall expire upon the filing of the informational report due April 2, 2011. The provisions of s. 641.224, F.S. apply to reports filed pursuant to this section. (Note: the statutory citation should be to s. 641.2241, F.S., the public records exemption that would be created for RBC reports and hearings if SB 2306 is enacted into law).

Section 4. Provides that except as expressly provided, the effective date of the act is January 1, 2007. (The RBC reports for HMOs cannot be used for regulatory purposes until 2012.)

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Senate Bill 2294 has a linked public records exemption bill, SB 2306, which provides an exemption from public disclosure of documents, information, and certain meetings relating to risk-based capital information of a HMO.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The legislation will allow HMOs to sell a greater volume of point-of-service riders to their contracts as well as preferred provider policies. The provision should increase competition in the health insurance market.

The legislation requires HMOs to comply with risk based capital requirements similar to those placed on insurers. This will result in additional costs and duties on HMOs, but should further the office's ability to monitor the solvency of HMOs.

C. Government Sector Impact:

The OIR will assume additional duties in reviewing risk-based capital reports and monitoring the solvency of HMOs.

VI. Technical Deficiencies:

On page 10, line 27 there is a reference to "insurer" that should be changed to "health maintenance organization."

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On page 18, lines 9-12 the bill states that a notice that may result in regulatory action must be "made by registered mail, certified mail, or any other method of transmission." Registered and certified mail are both designed to show proof of receipt, and many other means of transmission will not provide such proof.

On page 20, lines 12 and 27, the bill states that an HMO cannot sell point-of-service riders or preferred provider policies that exceed "49" percent of the premium to surplus requirements of s. 624.4095, F.S. The bill should state "15" percent in both instances.

On page 22, line 30, the bill references s. 641.224, F.S. The reference should be to s. 641.2241, F.S.

VII. Related Issues:

The OIR has concerns whether the statements of intent contained in new sub-paragraphs (i) and (j) of s. 641.31(38), F.S.:

- Are sufficient to apply to Florida Life and Health Insurance Guaranty Association membership pursuant to Part III of Chapter 631, F.S.
- Provide sufficient information for the Department of Revenue to administer the applicable insurance premium tax provisions pursuant to Part IV, of Chapter 624, F.S.
- Are improperly placed within the Florida Statutes.

The bill is linked to a linked public records exemption bill, SB 2306, which provides an exemption from public disclosure of documents, information, and certain meetings relating to risk-based capital information of a HMO.

VIII. Summary of Amendments:

Barcode 364438 by Banking and Insurance:
Technical correction to strike “insurer” and insert “health maintenance organization.”

Barcode 301906 by Banking and Insurance:
Requires that any regulatory notice sent by the Office of Insurance Regulation to an HMO related to a risk based capital report must provide proof of receipt.

Barcode 104014 by Banking and Insurance:
Corrects an error in the bill to specify that HMO premiums for point-of-service riders and preferred provider policies cannot exceed 15 percent of its total premiums, unless the HMO complies with the premium to surplus requirements that apply to a health insurer.

Barcode 614296 by Banking and Insurance:
Conforming amendment to the amendment 104014.

Barcode 525122 by Banking and Insurance:
Technical amendment to correct a cross-reference.