HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1273 Insurer Solvency
SPONSOR(S): Insurance & Banking Subcommittee; Grant, M.
TIED BILLS: **IDEN./SIM. BILLS:** SB 1242

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	13 Y, 0 N, As CS	Peterson	Luczynski
2) Government Operations & Technology Appropriations Subcommittee			
3) Commerce Committee			

SUMMARY ANALYSIS

The Office of Insurance Regulation (OIR) is responsible for overseeing the solvency of insurers and other risk-bearing entities in order to protect policyholders against the risk that insurers will not be able to meet their financial responsibilities. Solvency regulation includes the requirements for starting and operating an insurance company, monitoring of the financial condition of insurers through examinations and audits, and procedures for administrative supervision, rehabilitation, or liquidation of an insurance company if it is in unsound financial condition or insolvent. The bill makes a series of changes to improve the OIR's solvency oversight.

Specifically, the bill:

- Extends to HMOs the premium-to-surplus ratio requirements that currently apply to health insurers. The bill phases in the requirements for HMOs that hold a certificate of authority before the effective date of the bill, from July 1, 2020 – July 1, 2028.
- Extends the risk based capital requirements in current law to single-state health maintenance organizations (HMOs) and prepaid limited health service organizations (PLHSO). HMOs and PLHSOs that held a certificate of authority prior to the effective date of the bill will have until January 1, 2020, to comply unless the HMO or PLHSO has previously agreed to comply by execution of an agreement with the OIR. HMOs and PLHSOs that obtain a new certificate of authority on or after July 1, 2017, will need to comply with the RBC requirements immediately.
- Adds claims by medical providers as Class 2 claims in an insolvency involving a health insurer or HMO.
- Requires the Florida Life and Health Guaranty Association (FLAHIGA) to provide notice to the Department of Financial Services and the OIR 60 days in advance of assessing member insurers for costs incurred related to a delinquency proceeding. Such notice must include details of the expenses by category and by date, and justification for the expenditures.
- Extends the premium base for assessments related to long term care policies by the FLAHIGA to include premiums written in the life insurance account.
- Prohibits an officer or director of an insurer or HMO that becomes insolvent within 2 years of their service to serve on the board of another insurer or HMO, unless he or she is determined not to have contributed to the insolvency.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides for an effective date upon becoming a law, except as otherwise provided.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The Office of Insurance Regulation (OIR) is responsible for overseeing the solvency of insurers and other risk-bearing entities in order to protect policyholders against the risk that insurers will not be able to meet their financial responsibilities. Solvency regulation includes the requirements for starting and operating an insurance company,[1] monitoring of the financial condition of insurers through examinations and audits, and procedures for administrative supervision, rehabilitation, or liquidation of an insurance company if it is in unsound financial condition or insolvent.

Solvency of Health Maintenance Organizations (HMO)

The OIR reports that Florida HMOs are experiencing significant financial pressure.[2] Fifteen of 37 HMOs reported losses in 2015, with net income down a combined 13.8 percent among all HMOs since 2013. Since 2011, 4 insolvent HMOs have been liquidated, resulting in $132 million in claims paid by the remaining HMOs.[3] The OIR cites impacts from the Affordable Care Act (ACA), which has led to rapid growth in plan enrollment and the uncertain future regarding whether or how it will be replaced, as two causes of the financial distress. Figure 1 shows that between 2012 and 2015, HMO enrollment rose 74 percent.

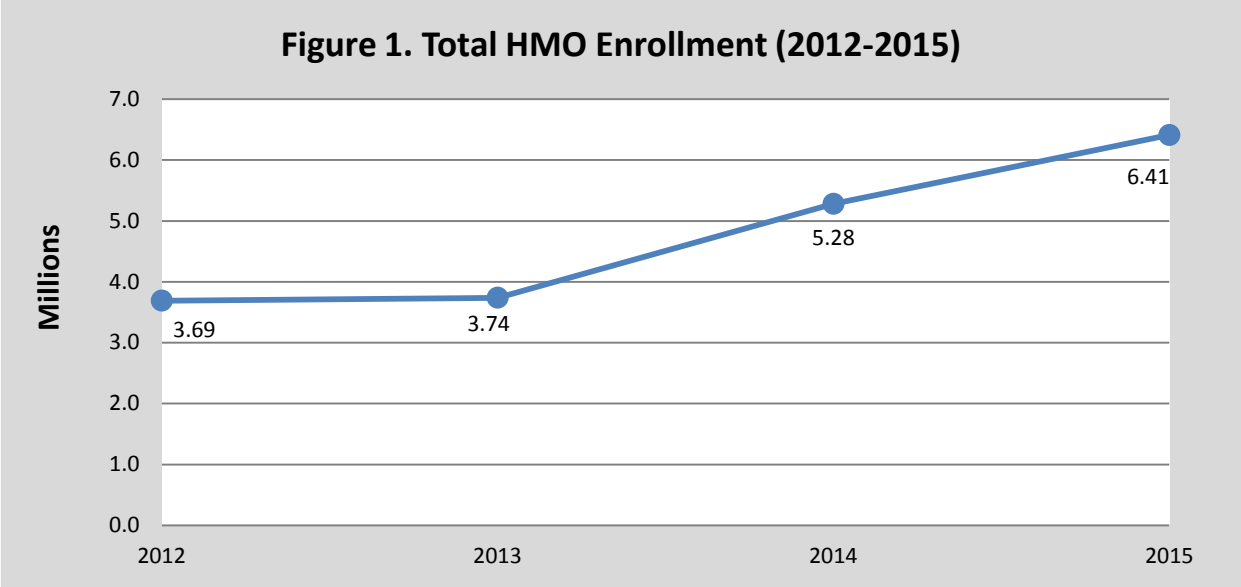
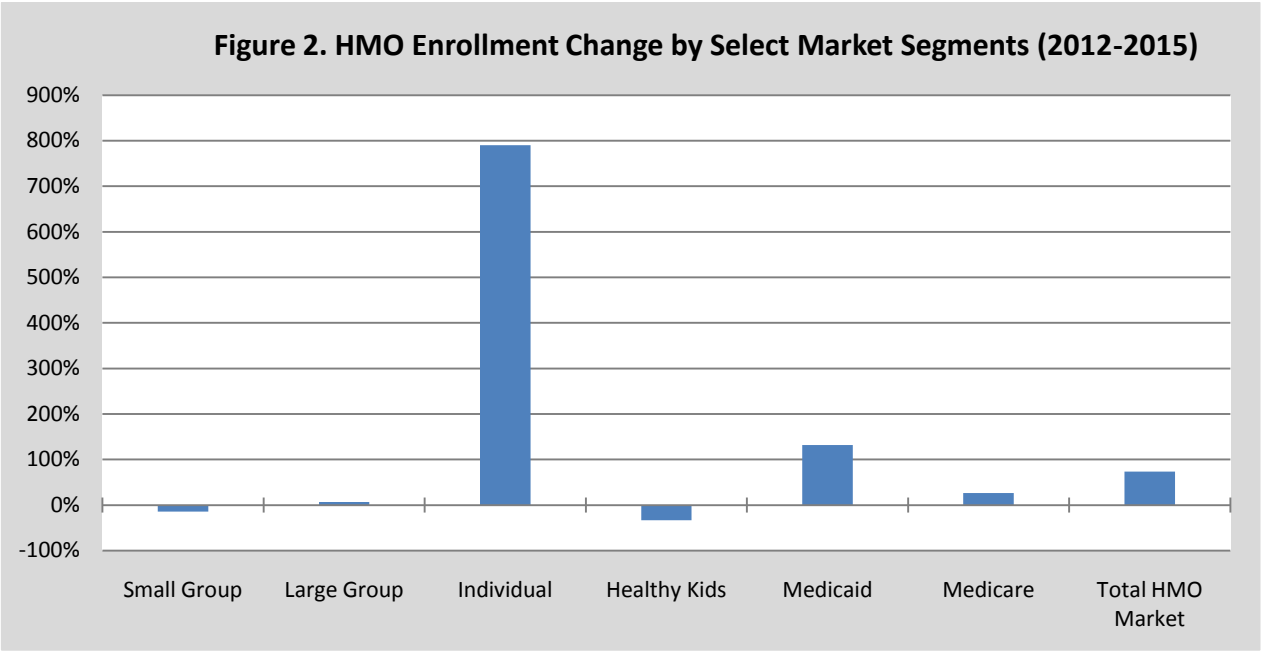


Figure 2 shows substantial growth in the individual market during this same period, which is consistent with impacts that would have occurred as a result of the ACA and availability of products on the Exchange.[4] The number of enrollees in the individual market increased from 105,952 in 2012 to 942,815 in 2015, which represents an increase of 790 percent. By contrast, the increase in the Medicaid market during that period was 131 percent.

[1] ss. 624.411 - 624.414, F.S.
[2] Office of Insurance Regulation, Agency Analysis of 2017 House Bill 1273, pp. 3 - 4 (Mar. 13, 2017).
[3] Part IV of ch. 631, F.S., creates the "Florida Health Maintenance Organization Consumer Assistance Plan." Its purpose is to protect subscribers of HMOs against the risk of harm resulting from an HMO's insolvency. All HMOs are required to be members. Claims paid by the plan may be funded by an assessment against its members.
[4] "Exchange" is another term for the Health Insurance Marketplace, a service available in every state that helps individuals, families, and small businesses shop for and enroll in medical insurance. HEALTHCARE.GOV, *Exchange*, https://www.healthcare.gov/glossary/exchange/ (last visited Mar. 19, 2017).



An additional impact is payment reductions to the Medicare program enacted by Congress. In 2010, the ACA reduced payments to HMOs participating in the Medicare Advantage[5] program. In 2011, the caps were frozen at 2010 levels, followed by a phased-in reduction of the caps between 2012 and 2017. Because of Florida's senior population, enrollment in these plans has doubled for some insurers during the last decade. Forty percent of Florida Medicare enrollees are in the Medicare Advantage program.

HMO Solvency Requirements

Surplus Requirements

In order to transact business in Florida, health insurers, HMOs, and prepaid limited health service organizations (PLHSO) [6] must satisfy a combination of capital and surplus requirements. All must meet minimum surplus requirements; all health insurers and certain HMOs and PLHSOs must meet capital requirements; and all health insurers, but not HMOs or PLHSOs, are subject to premium-to-surplus requirements.

A health insurer must have a minimum surplus of $2.5 million, or 4 percent of total liabilities plus 6 percent of health insurance liabilities in order to receive a certificate of authority.[7] Thereafter, a health insurer must maintain a minimum surplus of $1.5 million, or 4 percent of total liabilities plus 6 percent of health insurance liabilities in order to maintain its certificate of authority.[8] In order to obtain and maintain a certificate of authority, an HMO must maintain a minimum surplus in an amount that is the greater of $1.5 million, 10 percent of total liabilities, or 2 percent of total annualized premium. The calculation for obtaining a new certificate of authority is based on startup projections.[9]

[5] Medicare Advantage is a type of Medicare health plan offered by a private company that contracts with Medicare to provide a senior with all of the Part A and Part B benefits. Medicare Advantage Plans include health maintenance organizations, preferred provider organizations, private fee-for-service plans, special needs plans, and Medicare medical savings account plans. MEDICARE.GOV, *Medicare Advantage Plans* https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html (last visited Mar. 19, 2017).
[6] "Prepaid limited health service organizations" provide limited health services (such as dental or vision care) through an exclusive panel of providers in return for a prepayment. "Health maintenance organizations" generally provide a range of health coverage with providers under contract.
[7] s. 624.407(1)(a) & (c), F.S.
[8] s. 624.408(1)(a) & (c), F.S.
[9] s. 641.225, F.S.

Premium-to-Surplus Ratio

The premium-to-surplus ratio is used to measure the capacity of an insurance company to underwrite new policies. There are two formats of premium-to-surplus ratio: gross and net. For example, a company with gross written premiums of $2.1 billion, net written premiums of $1.5 billion and a policyholders' surplus of $900 million will have a gross premium-to-surplus ratio of 233% ($2.1 billion / $900 million) and a net premium-to-surplus ratio of 167% ($1.5 billion / $900 million). Policyholder surplus is the difference between an insurance company's assets and its liabilities.[10] The greater the policyholder surplus, the greater assets are compared to liabilities. As long as the insurer has more assets than liabilities it will be able to underwrite new policies. While each new policy increases the insurer's overall liabilities, it also increases the amount of premiums the insurer will receive from policyholders.[11]

Florida law subjects a health insurer to premium-to-surplus ratios.[12] A health insurer must maintain a ratio of premium-to-surplus of 10 to 1 on gross written premium[13] and 4 to 1 on net written premium. A health insurer that has more than $40 million in surplus and has written premium in each of the preceding 5 years is exempt from the requirement.[14] The OIR may suspend the certificate of authority of a health insurer that falls below required premium-to-surplus levels. Alternatively, the OIR can order the maximum annual gross premium that a health insurer may write in order to maintain the ratio, unless the health insurer demonstrates to the OIR that exceeding the limits does not endanger the financial condition of the health insurer or its policyholders.[15] Currently, HMOs are not subject to premium-to-surplus ratios. The OIR indicates that the premium-to-surplus ratio requirement is a critical early warning tool that prevents HMOs from growing too quickly.[16]

Effect of the Bill on HMO Surplus Requirements

The bill extends to HMOs the premium-to-surplus ratio requirements that currently apply to health insurers. The bill phases in the requirements for HMOs that hold a certificate of authority before the effective date of the bill. The surplus to premium ratios for these HMOs will be:

- 30-to-1: Beginning July 1, 2020 – June 30, 2024
- 20-to-1: Beginning July 1, 2024 – June 30, 2028
- 10-to-1: Beginning July 1, 2028

The bill specifies the methodology for calculating the premium-to-surplus ratio of an HMO. It directs that actual or projected risk revenue be added to actual or projected written premiums.

Risk-Based Capital for Insurers & Health Organizations

Risk-based capital (RBC) is a capital adequacy standard that represents the amount of required capital an insurer must maintain, based on the inherent risks in the insurer's operations. It is determined by a formula that considers certain material risks depending on the type of insurer, and generates the regulatory minimum amount of capital that a company is required to maintain to avoid regulatory action. RBC raises a safety net for insurers, is uniform among states, and operates as a tripwire system to give state insurance regulators authority for timely corrective action.

[10] Liabilities are the benefits that the insurer owes its policyholders.
[11] INVESTOPEDIA, *Premium to Surplus*, http://www.investopedia.com/terms/p/premium-surplus-ratio.asp (last visited Mar. 19, 2017).
[12] *See generally*, s. 624.4095, F.S., (providing specific methodologies for calculating premiums written for all lines of insurers).
[13] "Gross written premium" is defined as direct premiums written and reinsurance assumed. s. 624.4095(3), F.S.
[14] s. 624.4095(5)(b), F.S.
[15] s. 624.4095(1), F.S.
[16] Office of Insurance Regulation, Agency Analysis of 2017 House Bill 1273, p.8 (Mar. 13, 2017).

In March 2006, the National Association of Insurance Commissioners (NAIC)[17] adopted revisions to the Risk-Based Capital for Insurers Model Act (#312), which provides that states must require both life and health and property and casualty insurers to submit RBC filings with their regulators. In 2010, the NAIC adopted a recommendation to make the Risk-Based Capital for Health Organizations (#315) Model Act an accreditation standard. This model act defines "health organization" to include HMOs and PLHSOs. However, the model act permits insurance commissioners to exempt single-state HMOs and PLHSOs who meet specified criteria from the RBC requirements. Accordingly, effective January 1, 2015, it was mandatory for member states to require multi-state and non-exempt single-state HMOs and PLHSOs to submit risk-based capital filings in order to maintain accreditation.

In 2014, Florida adopted the RBC standard for multi-state[18] HMOs and PLHSOs.[19] However, Florida has neither extended the RBC requirements to single-state HMOs and PLHSO, nor adopted the exemption criteria permitted by the model act. Thus, life and health insurers, property and casualty insurers, including property and casualty insurers that write accident and health insurance, only, and multi-state HMOs and PLHSOs are subject to the RBC requirements. Single-state HMOs and PLHSOs are not. As of September 30, 2016, Florida had 36 active HMOs (34 single-state and 2 multi-state) and 23 PLHSOs (20 single-state and 3 multistate).[20]

Effect of the Bill on Risk Based Capital for Insurers & Health Organizations

The bill extends the RBC requirements to single-state HMOs and PLHSOs. Single-state HMOs and PLHSOs that held a certificate of authority prior to the effective date of the bill will have until January 1, 2020, to comply unless the HMO or PLHSO has previously agreed to comply by execution of an agreement with the OIR. HMOs and PLHSOs that obtain a new certificate of authority on or after July 1, 2017, will need to comply with the RBC requirements immediately. The bill creates a definition of "health organization" that includes all HMOs and PLHSOs—multi-state and single-state—and removes single-state HMOs and PLHSOs from the definition of "life and health insurer." This simplifies drafting, clarifies the application of the law, and is consistent with the substantive change in the bill of requiring all HMOs and PLHSOs to comply with the RBC requirements. The bill also revises the definition of "property and casualty insurer" to expressly exclude a property and casualty insurer that writes accident and health insurance. These insurers are considered "life and health insurers" in application of the RBC requirements and are included in the definition of "life and health insurer." Thus, the change to the definition of "property and casualty insurer" is not substantive.

Part I of ch. 641, F.S., is the "Health Maintenance Act."[21] By its terms, the act states that HMOs are governed by it and part III of ch. 641, F.S., but exempt from all other provisions of the Florida Insurance Code[22] not made specifically applicable.[23] The bill amends part I of ch. 641, F.S., relating to HMOs, to add an express reference requiring compliance with the RBC standards.

Insurer Insolvency - Claim Priority

Part I of ch. 631, F.S., relates to insurer insolvency and governs the receivership process for insurance companies in Florida. Federal law specifies that insurance companies cannot file for bankruptcy.[24] Instead, they are either "rehabilitated" or "liquidated" by the state. In Florida, the Division of

[17] The NAIC is a voluntary association of insurance regulators from all 50 states. The NAIC coordinates regulation and examination of multistate insurers, provides a forum for addressing major insurance issues, and promotes uniform model laws among the states. The NAIC accreditation is a certification that legal, financial and organizational standards are being fulfilled by the OIR.
[18] Defined to include those authorized in Florida and one or more other states or countries. s. 636.4085(1)(g), F.S.
[19] Ch. 2014-101, Laws of Fla.
[20] Office of Insurance Regulation, Agency Analysis of 2017 House Bill 1273, p.2 (Mar. 13, 2017).
[21] s. 641.222, F.S.
[22] The Florida Insurance Code consists of chs. 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S. s. 624.01, F.S.
[23] s. 641.201, F.S.
[24] The Bankruptcy Code expressly provides that "a domestic insurance company" may not be the subject of a federal bankruptcy proceeding. 11 U.S.C. § 109(b)(2). The exclusion of insurers from the federal bankruptcy court process is consistent with federal policy generally allowing states to regulate the business of insurance. *See* 15 U.S.C. § 1012 (McCarran-Ferguson Act).

Rehabilitation and Liquidation of the Department of Financial Services (DFS) is responsible for rehabilitating or liquidating insurance companies.[25] The OIR is required to notify the DFS upon a determination that one or more grounds for the initiation of delinquency proceedings exist.[26] The DFS may then initiate a delinquency proceeding and place the insurer under the control of the DFS as the receiver.

Current law establishes the priority of distribution of claims from an insurer's estate.[27] Claims are categorized into classes and every claim in each class must be paid in full or adequate funds must be retained for such payment before the members of the next class can receive any payment. The priority schedule is comprised of eleven classes of claims. In essence, claims are paid in the following order for: 1) administrative expenses; 2) policyholder losses; 3) unearned premiums; 4) claims of the Federal government; 5) debts due to employees; 6) claims of general creditors; 7) claims of state or local governments; 8) late filed claims; 9) surplus or similar obligations and premium refunds on assessable policies; 10) interest on allowed claims of Classes 1 through 9; and 11) claims of shareholders or other owners.

Effect of the Bill on Claim Priority

The bill adds claims related to a patient's healthcare coverage by medical providers of a health insurer or health maintenance organization to Class 2. By creating express authority to pay claims for medical providers, the bill resolves a disparity attributable to past litigation that has resulted in the DFS paying claims related to insolvent health insurers as Class 2 claims and claims of insolvent health maintenance organizations as Class 6 claims.[28]

Florida Life and Health Insurance Guaranty Association and Long-Term Care Insolvencies

FLAHIGA Administrative Operations

Florida operates five insurance guaranty funds and associations to ensure policyholders of liquidated insurers are protected with respect to insurance premiums paid and settlement of outstanding claims, up to limits provided by law.[29] A guaranty association generally is a not-for-profit corporation created by law directed to protect policyholders from financial losses and delays in claim payment and settlement due to the insolvency of an insurance company. A guaranty association accomplishes its mission by assuming responsibility for settling claims and refunding unearned premiums[30] to policyholders. Insurers are required by law to participate in guaranty associations as a condition of transacting business in Florida.

The bill makes changes to one of the five guaranty funds and associations – the Florida Life and Health Insurance Guaranty Association (FLAHIGA), which is the guaranty association for most health and life insurers.

[25] Typically, insurers are put into liquidation when the company is insolvent whereas insurers are put into rehabilitation for numerous reasons, one of which is an unsound financial condition. The goal of rehabilitation is to return the insurer to a sound financial condition. The goal of liquidation, however, is to dissolve the insurer. *See* s. 631.051, F.S., for the grounds for rehabilitation and s. 631.061, F.S., for the grounds for liquidation.
[26] s. 631.031, F.S.
[27] s. 631.271, F.S.
[28] Department of Financial Services, Agency Analysis of 2017 House Bill 837, pp.3-4 (Feb. 20, 2017).
[29] The Florida Life and Health Insurance Guaranty Association generally is responsible for claims settlement and premium refunds for health and life insurers who are insolvent. The Florida Health Maintenance Organization Consumer Assistance Plan offers assistance to members of insolvent health maintenance organizations, and the Florida Workers' Compensation Insurance Guaranty Association is directed by law to protect policyholders of insolvent workers' compensation insurers. The Florida Self-Insurers Guaranty Association protects policyholders of insolvent individual self-insured employers for workers' compensation claims. The Florida Insurance Guaranty Association is responsible for paying claims for insolvent insurers for most remaining lines of insurance, including residential and commercial property, automobile insurance, and liability insurance, among others.
[30] The term "unearned premium" refers to that portion of a premium that is paid in advance, typically for six months or one year, and which is still owed on the unexpired portion of the policy.

Statutory provisions relating to the FLAHIGA, which was created in 1979, are contained in part III of ch. 631, F.S. The FLAHIGA is governed by a board of directors composed of nine insurance companies and is a nonprofit corporation. By law, the FLAHIGA is divided into three accounts: [31]

- The health insurance account;
- The life insurance account; and
- The annuity account.

In the event a member insurer is found to be insolvent and is ordered to be liquidated by a court, a receiver takes over the insurer under court supervision and processes the assets and liabilities through liquidation. Upon liquidation, the FLAHIGA automatically becomes liable for the policy obligations that the liquidated insurer owed to its Florida policyholders.[32] The FLAHIGA services the policies, collects premiums, and pays valid claims under the policies. The FLAHIGA's rights under the policies are those that applied to the insurer prior to liquidation. The FLAHIGA may cancel the policy if the insurer could have done so, but normally the FLAHIGA continues the policies until the association can transfer to, or substitute the policies with, a new, stable insurer with approval of the OIR. All of the FLAHIGA's expenses in handling claims related to an insolvency are paid from the insurer's estate as a Class 1 claim.

The FLAHIGA is authorized to levy two types of assessments to carry out its responsibilities. Class A assessments may be levied for the purpose of covering the FLAHIGA's general administrative costs. These assessments are capped at $250 per member per calendar year. Class B assessments are authorized to fund the FLAHIGA's duties related to a specific insolvency in the event that assets of the insurer are inadequate to fund the obligations assumed by the FLAHIGA. These assessments are based on an insurer's pro rata share of all premiums collected by insurers in the state on policies covered by the account during the three years prior to the assessment.[33] An insurer's assessment for each account may not exceed, in any one calendar year, one percent of the insurer's average premiums during the three-year period on premiums written in the covered account.[34] An insurer may offset any assessment against either its premium tax or corporate income tax liability in five percent increments recovered over a 20-year period.[35] In addition, the board may refund insurers the proportionate amount of their contribution, if the board determines the assessment generated more revenue than was needed for the account.[36]

Effect of the Bill on FLAHIGA Administrative Operations

The bill requires the FLAHIGA to provide notice to the DFS and the OIR 60 days in advance of assessing member insurers for costs incurred related to a delinquency proceeding. Such notice must include details of the expenses by category and by date, and justification for the expenditures.

Long Term Care Insurance

Long-term care refers to a wide range of medical, personal and social services. Long-term care insurance (LTCI) products were first developed in the 1960s to supplement payment for the primary form of long-term care at that time which was nursing homes. LTCI policies now incorporate a myriad of long-term care service alternatives including home health care, respite care, hospice care, personal care in the home, services provided in assisted living facilities, adult day care centers and other

[31] s. 631.715(2)(a), F.S.
[32] Generally, the FLAHIGA covers only policyholders and certificate holders that were valid Florida residents on the date that a member insurer is declared insolvent and liquidated. However, non-residents of Florida and beneficiaries of covered persons are covered by FLAHIGA under limited circumstances. s. 631.713(2), F.S.
[33] s. 631.718(3)(c), F.S.
[34] s. 631.718(5)(a), F.S.
[35] s. 631.72(1), F.S.
[36] s. 631.718(6), F.S.

community facilities. Public programs, such as Medicare and Medicaid, also cover certain long-term care services.

According to the U.S. Department of Health and Human Services, about 12 million of America's senior citizens will require long-term care by 2020. Since its inception, the LTCI market has undergone significant contraction, both in terms of sales as well as insurers participating in the market following more than two decades of rapid growth. As of 2014, the total number of individuals with long-term care insurance coverage was 7.2 million. This does not represent all people who have ever had policies—only those who still have them.[37]

Long-term care insurance is a guaranteed renewable product, which means as long as an individual pays the premium, the insurance company must continue to honor the coverage. Premiums are not guaranteed, although they are designed to be level-funded over the life of the policy. This means if the actual experience of any of a number of underlying pricing assumptions (claims, interest rate, mortality, voluntary lapse rates, etc.) varies from what was anticipated, the financial viability of the product can be threatened, unless there is an adjustment to rates. [38]

In 2016, then-Commissioner, Florida Office of Insurance Regulation, Kevin McCarty opined:[39]

> Long-term care insurance products are really difficult to price appropriately, because unlike traditional health policies where an insurer's loss ratio can be considered on an annual basis in determining rate increase needs, an LTCI insurer needs to try to correctly anticipate lapses and scrutinize mortality assumptions decades into the future. What we have found over time is LTCI policies lapse at a much lower rate than life insurance policies. Like life insurers, LTCI insurers count on premiums paid for policies lapsing to create the necessary insurance leverage. The lower lapse rate of LTCI has often resulted in prices being inadequate.
>
> Also, as life expectancy has increased beyond expectations and health conditions have improved with more people living longer, we have seen an increasing utilization of LTCI benefits. Clearly, a lot of the assumptions for LTCI were miscalculated.
>
> In a way, perhaps the classification of LTCI as health insurance may have resulted in a bad fit. While the benefits are triggered by a health event, LTCI benefits do not cover medical costs or services to restore health. The purpose of LTCI is essentially for asset protection. LTCI seems to be more in line with life insurance risk; so if it were reclassified, LTCI policies could potentially be allowed to build cash value, which is prohibited under Florida state law, for health policies.

Long-Term Care Insolvencies

On March 1, 2017, the Pennsylvania Insurance Commissioner announced court approval of the liquidation of Penn Treaty and American Network Insurance Companies (hereinafter, Penn Treaty). The Pennsylvania Insurance Department "determined that the magnitude of additional premium rate increases needed to remedy the companies' financial difficulties (exceeding 300% on average) would severely harm policyholders and would not be permitted by state regulators, leaving no alternative other

[37] NAIC & THE CENTER FOR INSURANCE POLICY AND RESEARCH, *Long-Term Care*, http://www.naic.org/cipr_topics/topic_long_term_care.htm (last visited Mar. 24, 2017).
[38] NAIC, *The State of Long-Term Care Insurance, The Market, Its Challenges and Future Innovations*, May 2016, at 26, *available at* http://www.naic.org/documents/cipr_current_study_160519_ltc_insurance.pdf.
[39] *Id.* at 155.

than to place the companies into liquidation."[40] According to the OIR, the companies have $3.8 billion in net liabilities, approximately $350 million of which are located in Florida.[41]

FLAHIGA Assessments for LTCI Insolvencies

Long-term care insurance is considered a health line of business. As such, assessments to fund obligations related to long-term care policies of an insolvent insurer currently would be made against health insurers and other insurers that write LTCI, and paid for from the FLAHIGA's health account. The maximum amount paid by the FLAHIGA for any one person for health insurance claims is $300,000 per insured life.[42]

In 2015, major medical premiums were $18.18 billion. Five companies wrote 62 percent of all premiums.[43] The total health market with supplemental lines, but excluding government programs, was $25.5 billion.[44] In the LTCI market, 63 percent of premiums are accounted for by the top 5 companies. Total long-term care premiums in 2015 were $600 million.[45] During this same period, total life insurance premiums were $8.97 billion.[46] The OIR estimates that 98 percent of the LTCI premium written in this state since 2004 was written by insurers who primarily write life insurance or similar products.

Effect of the Bill on FLAHIGA Assessments for LTCI Insolvencies

The bill establishes a new procedure for assessments made to fund obligations of the FLAHIGA relating to long-term care policies of an impaired or insolvent insurer. Both health and life insurers will be assessed based on their pro rata share of the average combined premiums for all policies in both the life and health accounts during the three years prior to the assessment. The bill does not change the annual cap on assessments. It remains at one percent of the insurer's average premiums written in the covered account during the 3-year period.

Thus, all life insurers will now contribute for an assessment based on LTCI in proportion to their share of the total life insurance market. In addition, life insurers who have written LTCI will be additionally assessed for the proportionate share of the health insurance market represented by their LTCI (and other health) policies. Thus, they could be assessed up to one percent of premium in each of two accounts. Health insurers will see a reduction in their assessments because the total will now be spread over a larger premium pool.

The bill applies the new assessment structure to assessments made on or after the effective date of the bill, regardless of the date of liquidation. Thus, the new structure will apply to assessments that are expected to be made in the future for the Penn Treaty liquidation.

Officers and Directors

The insurance code prohibits an officer or director of an insurance company that becomes insolvent within 2 years after his or her term from serving as an officer or director of another insurer, absent proof that he or she was not a "significant contributing cause" to the insolvency.[47] This requirement does not apply to officers and directors of HMOs. The requirement also does not apply if the person served on

[40] PA.GOV, *Insurance Commissioner Announces Court Approval of Liquidation of Penn Treaty and American Network Insurance Companies; Assures Policyholders Claims Will Be Paid by State Guaranty Funds Pursuant to State*, LAW PENNSYLVANIA PRESSROOM, Mar. 1, 2017, *available at* http://www.media.pa.gov/Pages/Insurance-Details.aspx?newsid=228.
[41] Office of Insurance Regulation, Agency Analysis of 2017 House Bill 1273, p.7 (Mar. 13, 2017).
[42] s. 631.717(9), F.S.; *see also* FLAHIGA, *Frequently Asked Questions*, http://www.flahiga.org/faq.cfm (last visited Feb. 8, 2017).
[43] FLORIDA OFFICE OF INSURANCE REGULATION, *Life & Health Market Overview Reports*, Oct. 13, 2016 (revised), at 3, *available at* http://www.floir.com/siteDocuments/LHMarketOverviewReport2015.pdf.
[44] Email from Eric Johnson, Deputy Commissioner – Life & Health, Florida Office of Insurance Regulation, Re: HB 1273 (Mar. 21, 2017).
[45] *Id.*at 4.
[46] *Id.* at 7.
[47] s. 624.4073, F.S.

the board of an HMO that became insolvent and was seeking now to serve on the board of an insurance company.

The insurance code specifies the requirements applicable to directors of a domestic insurer.[48] Generally, it requires a board that includes a minimum of 5 directors; limits the duration of terms to not more than 3 years; provides for staggered terms; requires a majority be U.S. citizens; requires directors to be stockholders, if required by the bylaws; and specifies the factors a director may consider in discharging his or her duties.

Effect of the Bill on Officers and Directors

The bill amends current law to disallow an officer or director of an insurer or HMO that becomes insolvent within 2 years of their service to serve on the board of another insurer or HMO, unless he or she is determined not to have contributed to the insolvency. This change closes a loophole with respect to boards of insurers. In addition, the bill extends this requirement to officers and directors of HMOs. The bill also amends part I of ch. 641, F.S., to make both laws expressly applicable to HMOs.

B. SECTION DIRECTORY:

Section 1: Amends s. 624.4073, F.S., relating to officers and directors of insolvent insurers.
Section 2: Amends s. 624.4085, F.S., relating to risk-based capital requirements for insurers.
Section 3: Amends s. 631.271, F.S., relating to priority of claims.
Section 4: Amends s. 631.718, F.S., relating to assessments.
Section 5: Amends s. 641.201, F.S., relating to applicability of other laws.
Section 6: Provides direction to the Division of Law Revision and Information.
Section 7: Provides an effective date of upon becoming law, except as otherwise provided.

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:

HMOs will be required to maintain the premium-to-surplus requirements required by the bill. The OIR estimates that the provision will have no impact on 91 percent of the current market based on premium volume. These HMOs either comply with the 10-to-1 ratio or qualify for the exemption. The 5 HMOs

[48] A "domestic" insurer is one formed under the laws of this state. s. 624.06(1), F.S.

that may be affected account for 9 percent of total HMO premium volume and have an aggregate surplus deficit of $87.9 million, or 2.1 percent of total HMO surplus.[49]

Health care providers and health care facilities that have treated subscribers of an HMO that becomes insolvent will benefit from the provision of the bill that raises their claims from Class 6 (claims of a general creditor) to Class 2 (claims of a policyholder).

It is difficult to estimate the impact on health and life insurers because it is not possible to estimate how many insolvencies based on long-term care insurance in addition to the Penn Treaty insolvency will occur in the future. At a minimum, the bill will have the effect of subjecting companies that write life insurance to future assessments for insolvencies involving long-term care policies that they are not subject to today. According to one estimate, life insurers' share of the health market resulting from their LTCI policies is approximately 20 percent.[50] The estimated added liability resulting from the bill—including life insurance in the assessment base—is 25 percent. This represents a 45 percent total share of the risk for future assessments to pay obligations for LTCI policies. Thus, the potential additional cost of the bill to life insurers is estimated at 25 percent of the anticipated Penn Treaty liability, or up to $87.5 million.[51] At the same time, the risk to health insurers based on their health insurance business is reduced commensurately. Both the cost to life insurers and the savings to health insurers are decreased if an assessment is made in the Penn Treaty insolvency before the bill becomes effective.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 27, 2017, the Insurance & Banking Subcommittee considered a proposed committee substitute and reported the bill favorably as a committee substitute. The committee substitute reflects multiple changes, as follows:

- Amends s. 624.4073, F.S., relating to officers and directors of insolvent insurers;

[49] Office of Insurance Regulation, Agency Analysis of 2017 House Bill 1273, p.8 (Mar. 13, 2017).
[50] Conversation with Paul S. Graham, Senior Vice President, Insurance Regulation & Chief Actuary, ACLI (Mar. 20, 2017).
[51] As previously noted, total life insurance premiums for 2015 was $8.97 billion.

- Amends s. 624.4085, F.S., relating to risk-based capital requirements for insurers by creating a definition of “health organization,” revising the definitions of “life and health insurer” and “property and casualty insurer,” and making conforming changes reflecting the definitions.
- Revises and moves language related to required notice by the FLAHIGA; and
- Removes the tier one assessment against insurers who wrote LTCI for insolvencies involving payments for LTCI.

The staff analysis has been updated to reflect the committee substitute.