A bill to be entitled

An act relating to insurer solvency; amending s. 624.4073, F.S.; prohibiting former officers and directors of insolvent insurers or health maintenance organizations from serving as an officer or director of an insurer or health maintenance organization under certain circumstances; amending s. 624.4085, F.S.; providing and revising definitions; revising requirements relating to the filing of a risk-based capital report by a property and casualty insurer or health organization; providing an exception for certain health organizations; conforming provisions; amending s. 631.271, F.S.; revising provisions relating to the order of distribution of claims from an insurer's estate to include certain claims related to a patient's health care coverage; amending s. 631.718, F.S.; providing requirements relating to certain assessments for payment of claims under long-term care insurance policies of an impaired or insolvent insurer; requiring the Florida Insurance Guaranty Association, Inc., to provide notice to the Department of Financial Services and the Office of Insurance Regulation within a specified period; amending s. 641.201, F.S.; providing that health maintenance organizations are considered insurers for

certain purposes and are subject to the risk-based capital requirements; providing a directive to the Division of Law Revision and Information; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 624.4073, Florida Statutes, is amended to read:

624.4073 Officers and directors of insolvent insurers.—Any person who was an officer or director of an insurer or a health maintenance organization doing business in this state and who served in that capacity within the 2-year period prior to the date the insurer became insolvent, for any insolvency that occurs on or after July 1, 2002, may not thereafter serve as an officer or director of an insurer or a health maintenance organization authorized in this state unless the officer or director demonstrates that his or her personal actions or omissions were not a significant contributing cause to the insolvency.

Section 2. Effective July 1, 2017, paragraphs (g) and (j) of subsection (1), of section 624.4085, Florida Statutes, are redesignated as paragraphs (h) and (k), respectively, present paragraphs (g) and (j) of subsection (1), subsection (2), paragraph (a) of subsection (3), and paragraph (b) of subsection

(6) are amended, and a new paragraph (g) is added to subsection (1), to read:

624.4085 Risk-based capital requirements for insurers.—

(1) As used in this section, the term:

(g) "Health organization" means a health maintenance organization or a prepaid limited health service organization.

(h) ~~(g)~~ "Life and health insurer" means an insurer authorized or eligible under the Florida Insurance Code to underwrite life or health insurance. The term also includes a property and casualty insurer that writes accident and health insurance only. ~~Effective January 1, 2015, the term also includes a health maintenance organization that is authorized in this state and one or more other states, jurisdictions, or countries and a prepaid limited health service organization that is authorized in this state and one or more other states, jurisdictions, or countries.~~

(k) ~~(j)~~ "Property and casualty insurer" means any insurer licensed under the Florida Insurance Code, but does not include a single-line mortgage guaranty insurer, financial guaranty insurer, ~~or~~ title insurer, or a property and casualty insurer that writes accident and health insurance only ~~life and health insurer~~.

(2)(a) Each domestic insurer that is subject to this section shall, on or before March 1 of each year, prepare and file with the National Association of Insurance Commissioners a

report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing the information required in the risk-based capital instructions. In addition, each domestic insurer shall file a printed copy of its risk-based capital report:

1. With the office on or before March 1 of each year.

2. With the insurance department in any other state in which the insurer is authorized to do business, if that department has notified the insurer of its request in writing, in which case the insurer shall file its risk-based capital report not later than the later of:

a. Fifteen days after the receipt of notice to file its risk-based capital report with that state; or

b. March 1.

(b) The comparison of an insurer's total adjusted capital to any of its risk-based capital levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer, and may not be used as a means to rank insurers generally. Therefore, except as otherwise required under this section, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or

in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; however, if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its risk-based capital levels (or any of them) or an inappropriate comparison of any other amount to the insurer's risk-based capital levels is published in any written publication and the insurer is able to demonstrate to the office with substantial proof the falsity or inappropriateness of the statement, the insurer may publish in a written publication an announcement the sole purpose of which is to rebut the materially false statement.

(c) The office shall use the risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans solely for monitoring the solvency of insurers and assessing the need for corrective action with respect to insurers. The office may not use that information for ratemaking, as evidence in any rate proceeding, or for calculating or deriving any elements of an appropriate premium level or rate of return for any line of insurance which an

insurer or an affiliate of such insurer is authorized to write.

(d) The risk-based capital level for a life and health insurer ~~insurer's risk-based capital~~ is determined in accordance with the formula set forth in the risk-based capital instructions. The formula takes into account and may adjust for the covariance between:

1. The risk with respect to the insurer's assets;

2. The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

3. The interest rate risk with respect to the insurer's business; and

4. Any other business or other relevant risk set out in the risk-based capital instructions,

determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(e) The ~~A property and casualty insurer's~~ risk-based capital of a property and casualty insurer or a health organization, is determined in accordance with the formula set forth in the risk-based capital instructions. The formula takes into account and may adjust for the covariance between:

1. The asset risk;

2. The credit risk;

3. The underwriting risk; and

4. Any other business or other relevant risk set out in

the risk-based capital instructions,

determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(f) The Legislature finds that an excess of capital over the amount produced by the risk-based capital requirements and the formulas, schedules, and instructions specified in this section is a desirable goal with respect to the business of insurance. Accordingly, insurers should seek to maintain capital above the risk-based capital levels required by this section. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this section.

(g) If a domestic insurer files a risk-based capital report that the office finds is inaccurate, the office shall adjust the risk-based capital report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must state the reason for the adjustment. A risk-based capital report that is so adjusted is referred to as the adjusted risk-based capital report. The adjusted risk-based capital report must also be filed by the insurer with the National Association of Insurance Commissioners.

Until January 1, 2020, a health organization that holds a certificate of authority in this state before the effective date of this act, but is not authorized in any other state, jurisdiction, or country, is not required to comply with this subsection. A health organization that has agreed to comply with this section by execution of an agreement with the office remains subject to the terms of that agreement.

(3)(a) A company action level event includes:

1. The filing of a risk-based capital report by an insurer which indicates that:

a. The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital;

b. If a life and health insurer reports using the life and health annual statement instructions, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital, but is less than the product of its authorized control level risk-based capital and 3.0, and has a negative trend;

c. ~~Effective January 1, 2015,~~ If a life and health insurer, ~~or~~ property and casualty insurer, or health organization reports using the health annual statement instructions, the insurer or organization has total adjusted capital that is greater than or equal to its company action level risk-based capital, but is less than the product of its

authorized control level risk-based capital and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Risk-Based Capital Forecasting and Instructions, Health, updated annually by the NAIC; or

d. If a property and casualty insurer reports using the property and casualty annual statement instructions, the insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital, but less than the product of its authorized control level risk-based capital and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Risk-Based Capital Forecasting and Instructions, Property/Casualty, updated annually by the NAIC;

2. The notification by the office to the insurer of an adjusted risk-based capital report that indicates an event in subparagraph 1., unless the insurer challenges the adjusted risk-based capital report under subsection (7); or

3. If, under subsection (7), an insurer challenges an adjusted risk-based capital report that indicates an event in subparagraph 1., the notification by the office to the insurer that the office has, after a hearing, rejected the insurer's challenge.

(6)

(b) If a mandatory control level event occurs:

1. With respect to a life and health insurer or health

organization, the office shall, after due consideration of ss. ~~s.~~ 624.408, ~~and effective January 1, 2015, ss.~~ 636.045, and 641.225, take any action necessary to place the insurer under regulatory control, including any remedy available under chapter 631. A mandatory control level event is sufficient ground for the department to be appointed as receiver as provided in chapter 631. The office may forego taking action for up to 90 days after the mandatory control level event if the office finds there is a reasonable expectation that the event may be eliminated within the 90-day period.

2. With respect to a property and casualty insurer, the office shall, after due consideration of s. 624.408, take any action necessary to place the insurer under regulatory control, including any remedy available under chapter 631, or, in the case of an insurer that is not writing new business, may allow the insurer to continue to operate under the supervision of the office. In either case, the mandatory control level event is sufficient ground for the department to be appointed as receiver as provided in chapter 631. The office may forego taking action for up to 90 days after the mandatory control level event if the office finds there is a reasonable expectation that the event may be eliminated within the 90-day period.

Section 3. Paragraph (b) of subsection (1) of section 631.271, Florida Statutes, is amended to read:

631.271 Priority of claims.—

(1) The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this subsection. Every claim in each class shall be paid in full or adequate funds shall be retained for such payment before the members of the next class may receive any payment. No subclasses may be established within any class. The order of distribution of claims shall be:

(b) Class 2.—All claims under policies for losses incurred, including third-party claims, all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which claims are not under policies, ~~and~~ all claims of a guaranty association or foreign guaranty association, and all claims related to a patient's health care coverage by physicians, hospitals, and other providers of a health insurer or health maintenance organization. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to her or

his employee may be treated as a gratuity.

Section 4. Subsection (3) of section 631.718, Florida Statutes, is amended to read:

631.718 Assessments.—

(3)(a) The amount of any Class A assessment shall be determined by the board and may be made on a non-pro rata basis. The assessment may not be credited against future insolvency assessments and may not exceed $250 per member insurer in any one calendar year.

(b) The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the impaired or insolvent insurer.

(c) Class B assessments against member insurers for each account, except assessments made pursuant to paragraph (d), must be based upon the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the 3 most recent calendar years for which information is available preceding the year of the assessment in proportion to premiums received on business in this state for those calendar years by all assessed member insurers. If the most recent 3 years of premium information is not available for each member insurer, the board of directors may use the premium information that is reasonably available. Notice of an assessment for expenses of the association in handling claims

must be given to the department and the office at least 60 days prior to the assessment, along with details of expenses by category and date and a justification for the expenditure.

(d) Class B assessments made by the board of directors pursuant to paragraph (2)(b) for the payment of obligations under long-term care insurance policies or long-term care insurance contracts of an impaired or insolvent insurer must be made against all health insurers and life insurers in an amount sufficient to pay all long-term care obligations as they come due. Such assessment must be based upon the combined total of life and health insurance premiums written in this state for the 3 calendar years preceding the assessment and may not be considered borrowing between accounts. The assessment for each member insurer must be based on the ratio of the combined total of life and health insurance premiums written in this state by the insurer for the 3 most recent calendar years to the combined total of life and health insurance premiums written by all member insurers for the 3 most recent calendar years. For purposes of calculating the limit set forth in paragraph (5)(a), an insurer's assessment must be allocated to each account in proportion to the amount of premium received by the insurer for business covered by the account.

(e) ~~(d)~~ Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be made until necessary to implement the purposes of

this part.

(f) ~~(e)~~ Classification of assessments under subsection (2) and computation of assessments under this subsection must be made with a reasonable degree of accuracy, recognizing that exact determinations are not always possible.

This subsection applies to all assessments issued on or after the effective date of this act, regardless of the date of liquidation.

Section 5. Section 641.201, Florida Statutes, is amended to read:

641.201 Applicability of other laws.—

(1) Except as provided in this part, health maintenance organizations are ~~shall be~~ governed by ~~the provisions of~~ this part and part III of this chapter and are ~~shall be~~ exempt from all other provisions of the Florida Insurance Code except those provisions ~~of the Florida Insurance Code~~ that are explicitly made applicable to health maintenance organizations.

(2) Health maintenance organizations are considered insurers for purposes of:

(a) Sections 624.4073 and 628.231.

(b) Section 624.4095, except that:

1. The ratio of actual or projected annual gross written premiums to current or projected surplus as to policyholders for a health maintenance organization holding a certificate of

authority before the effective date of this act may not exceed 30 to 1 beginning July 1, 2020, until June 30, 2024; 20 to 1 beginning July 1, 2024, until June 30, 2028; and 10 to 1 beginning July 1, 2028.

2. In calculating the premium-to-surplus ratio of a health maintenance organization pursuant to s. 624.4095(1), actual or projected risk revenue must be added to actual or projected written premiums.

(3) Health maintenance organizations are subject to the applicable provisions of s. 624.4085.

Section 6. The Division of Law Revision and Information is directed to replace the phrase "the effective date of this act" wherever it occurs in this act with the date this act becomes a law.

Section 7. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.