The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	CS/SB 626
INTRODUCER:	Banking and Insurance Committee; and Senators Brandes and Broxson
SUBJECT:	Insurer Guaranty Associations
DATE:	April 10, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Babin/Davis	Betta	AEG	**Recommend: Fav/CS**
3.	Babin/Davis	Kynoch	AP	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 626 revises provisions relating to the Florida Life and Health Insurance Guaranty Association (association or FLAHIGA)[1] and the Florida Health Maintenance Organization Consumer Assistance Plan (HMOCAP).[2] In response to recent long-term care insurer insolvencies, the bill incorporates some recent changes made to a National Association of Insurance Commissioners' (NAIC) model act and additional recommendations of stakeholders. The bill:

- Expands the assessment base of the association to fund long-term care insurer impairments and insolvencies by including health maintenance organizations (HMOs), life insurers, and annuity insurers. Any assessments related to a long-term care insurer would be allocated 50 percent to accident and health member insurers and HMOs, and the remaining 50 percent to life and annuity member insurers. Total assessments on member insurers and HMOs are capped at 0.5 percent of premiums per year. Currently, only health insurers are assessed.
- Exempts any nonprofit HMO from the long-term care insurance assessment if it operates only in Florida and has statutory capital and surplus of less than $200 million as of December 31 of the year preceding the year in which the assessment is made.

[1] The purpose of the association is to protect policyholders against failure in the performance of contractual obligations under life and health insurance policies and annuity contracts due to the impairment or insolvency of the member insurer that issued the policies or contracts.

[2] The purpose of the HMOCAP is to protect subscribers enrolled with HMOs, subject to certain limitations, against the failure of their HMO to perform its contractual obligations due to its insolvency.

- Increases the number of directors that may be on the association's board and requires that one director be a member director of the HMOCAP.

The bill has an indeterminate fiscal impact on the corporate income tax and an indeterminate fiscal impact on the insurance premium tax, both on a recurring basis. See Section V.

The bill takes effect upon becoming a law.

II. Present Situation:

People need long-term care when they are unable to take care of themselves. Long-term care services may include assistance with activities of daily living, home health care, respite care, hospice care, adult day care, or care in an assisted living facility or nursing home. Current estimates suggest the annual costs of care in a nursing home are $85,000, and home health care can cost upwards of $25,000 per year. The demand for long-term care has increased significantly, as people live longer and the U.S. population ages.[3]

Insurer Insolvency

States primarily regulate insurance companies, and the state of domicile serves as the primary regulator for insurers. In Florida, the Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers and other risk-bearing entities.[4] The OIR monitors the solvency of insurers, examines insurers, and takes administrative action, if necessary.[5]

Federal law provides that insurance companies may not file for bankruptcy.[6] The state, through the Division of Rehabilitation and Liquidation of the Department of Financial Services (DFS), is instead responsible for rehabilitating or liquidating an insurer.[7] If an 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. Generally, once an insurance company is liquidated, an insurance guaranty association becomes liable for the policy or contract obligations of the liquidated insurance company. Insurance guaranty funds are designed to protect policyholders of liquidated insurers from financial losses and delays in claim payments, up to limits provided by law. The Florida Legislature has created five guaranty funds.[8]

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[3] National Association of Insurance Commissioners, *Long Term Care Insurance Fact Sheet*, May 2018, available at https://www.naic.org/documents/consumer_alert_ltc.htm (last viewed Feb. 27, 2019). Life expectancy after age 65 is now 19.4 years. From 2015 to 2055, the number of people aged 85 and older is expected to almost triple from over six million to over 18 million.
[4] Section 20.121(3), F.S.
[5] Part VI, ch. 624, F.S.
[6] The Bankruptcy Code expressly provides that "a domestic insurance company" may not be the subject of a federal bankruptcy proceeding. 11 U.S.C. s. 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. ss. 1011- 1012.
[7] Sections 631.051 and 631.061, F.S. Chapter 631, F.S., governs the receivership process for insurance companies in Florida.
[8] See parts II-V of ch. 631, F.S. and s. 440.385, F.S. (The Florida Insurance Guaranty Association, Florida Life and Health Insurance Guaranty Association, Florida Health Maintenance Organization Consumer Assistance Plan, Florida Workers' Compensation Insurance Guaranty Association, and the Florida Self-Insurers Guaranty Association, respectively.)

Florida Life and Health Insurance Guaranty Association

Part III of ch. 631, F.S., governs the powers and duties of the Florida Life and Health Insurance Guaranty Association (association or FLAHIGA).[9] The association services covered policies and contracts, collects premiums, and pays valid claims.[10] All insurers authorized to write life insurance policies, health insurance policies, supplemental contracts, and annuity contracts (with exceptions) in Florida are required, as a condition of doing business in this state, to be member insurers of the association.[11] Currently, the association does not provide coverage for or assess health maintenance organizations.[12]

The association's aggregate liability with respect to one life may not exceed the following:
- Life Insurance Death Benefit: $300,000 per insured life.
- Life Insurance Cash Surrender: $100,000 per insured life.
- Health Insurance or Long-term Care Insurance Claims: $300,000 per insured life.
- Annuity Cash Surrender: $250,000 for deferred annuity contracts per contract owner.
- Annuity in Benefit: $300,000 per contract owner.[13]

The board of directors of the association must be composed of not fewer than five but not more than nine member insurers.[14] At least one member of the board must be a domestic insurer.[15] The member insurers elect the members of the board, and the members of the board are subject to the approval of the DFS. In approving or appointing members to the board, the DFS must consider whether all member insurers are represented fairly.

The association has three operating accounts: health insurance, life insurance, and annuity for purposes of administration and assessments.[16] The association may impose Class A assessments for administrative costs [17] and Class B assessments to administer its duties relating to impaired or insolvent insurers.[18] Class B assessments are calculated based on the premiums collected by each assessed member insurer on policies or contracts covered for each account in proportion to premiums collected by all assessed member insurers for the three most recent calendar years. Florida law limits assessments on a member insurer to a maximum of one percent of the sum of the insurer's written premium in Florida regarding business covered by the account received

[9] In 1979, the Florida Legislature enacted provisions of the National Association of Insurance Commissioners' *Life and Health Insurance Guaranty Association Model Act*, which created FLAHIGA. Ch. 79-189, L.O.F. The National Association of Insurance Commissioners (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.
[10] See association's website available at http://www.flahiga.org/aboutus.cfm (last viewed Feb. 18, 2019).
[11] Sections 631.713 and 631.715, F.S.
[12] Section 631.713(3)(e), F.S.
[13] Section 631.717(9), F.S. FLAHIGA, *Frequently Asked Questions*, available at https://www.flahiga.org/FAQ (last viewed Feb. 28, 2019).
[14] Section 631.716(1), F.S.
[15] Section 624.06, F.S.
[16] Section 631.715(2), F.S.
[17] Section 631.718(2) and (3), F.S.
[18] *Id.*

during the three calendar years preceding the year in which the assessment is made, divided by three.[19]

Member insurers of the association may offset the amount of an assessment against the insurance premium tax or corporate income tax.[20] The credit may be taken in an amount of five percent of the assessments for each of the 20 years following the year in which the assessment was paid.[21]

Florida Health Maintenance Organization Consumer Assistance Plan (HMOCAP)

Part IV of ch. 631, F.S., creates the HMOCAP. The purpose of the HMOCAP is to protect subscribers of commercial health maintenance organizations (HMOs) against the risk of harm resulting from an HMO's insolvency. All HMOs authorized in Florida are required to be members.[22] The board of directors of the HMOCAP must consist of at least five and not more than nine persons.[23] Member HMOs select board members, and the board members are subject to approval by the DFS. Coverage by the HMOCAP[24] ceases six months after the date of the insolvency; once the HMOCAP has provided $300,000 in covered benefits; or when a subscriber obtains coverage with another HMO or health insurer.

To provide funds for the administration of the plan and the payment of claims, the plan may assess members of the plan to fund claims paid by the plan.[25] Assessments against member HMOs are levied as a percentage of annual earned premium revenue for non-Medicare and non-Medicaid contracts. The assessment in any calendar year may not exceed 0.5 percent of each member HMO's annual earned premium revenue for non-Medicare and non-Medicaid contracts.[26]

Section 631.828, F.S., allows a member HMO to offset against its corporate income tax liability or other liabilities, on an individual or consolidated basis, as applicable, any assessments described in s. 631.819, F.S. The credit may be taken to the extent of 20 percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid.

Long-term Care Insurance and Insolvencies

Many individuals buy long-term care insurance policies[27] to help pay for some of their long-term care needs. Despite the growing long-term care need, the number of long-term care insurance policies have fallen from 754,000 in 2002 to 129,000 in 2014. The number of insurers offering

[19] Section 631.718(5), F.S.
[20] Section 631.72, F.S.
[21] *Id.*
[22] Section 631.815, F.S.
[23] Section 631.816, F.S.
[24] Section 631.817, F.S.
[25] Section 631.819, F.S.
[26] Section 631.819(3), F.S.
[27] In Florida, a long-term care insurance policy is any insurance policy or rider advertised, marketed, offered, or designed to provide coverage on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Section 627.9404, F.S.

the coverage has declined from about 100 in 2002 to about 12 today.[28] This may be attributable to the premium rates for newly issued policies increasing as the remaining issuers of existing policies have refined their pricing due to inaccurate pricing assumptions relating to claim costs, mortality, interest rates, and policy lapses, which lead to an underpriced product.

Funding Claims of Insolvent Insurers

In 2017, Penn Treaty,[29] which was domiciled in Pennsylvania, was liquidated. The insurer wrote approximately 75,000 (primarily long-term care insurance) policies.[30] The insolvency is expected to be the second-largest insolvency in insurance guaranty fund history (the largest for an accident and health insurer).[31] As of December 31, 2018, there were 7,468 in-force policies in Florida.[32]

According to the NAIC, all states regulate long-term care insurance as health insurance.[33] The Penn Treaty insolvency resulted in health insurers bearing the majority of the assessments because long-term care insurance is classified as health insurance. Life insurers, however, wrote the majority of long-term care insurance premiums. In Florida, health insurers have paid almost $336 million in assessments for the Penn Treaty insolvency.[34] The estimated actuarial liability on December 31, 2018, which is subject to change, was $110 million.[35]

NAIC Life and Health Insurance Guaranty Association Model Act

To address concerns with guaranty fund coverage and assessments for any future long-term care insurer insolvency, the NAIC modified the *Life and Health Insurance Guaranty Association Model Act* to expand the assessment base to include HMOs, life and annuity insurers for funding long-term care insurer insolvencies and impairments. Assessments for long-term care impairments and insolvencies are allocated equally between the life and health accounts. The NAIC clarifies the authority of the guaranty associations to adjust rates and coverage in the case of liquidation. Further, the NAIC clarifies that federal programs, such as Medicare and Medicaid, are excluded from the assessment base. Life and annuity policies with long-term care insurance riders are considered the same as the underlying product, not as a health insurance product.

[28] NAIC, *Long-term Care Challenges*, Jan. 14, 2019, available at https://www.naic.org/cipr_topics/topic_long_term_care.htm (last viewed Feb. 10, 2019).
[29] Penn Treaty collectively includes Penn Treaty Network America Insurance Company and its affiliate, American Network Insurance Company.
[30] National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), Guaranty System to Provide Safety Net for Policyholders of Penn Treaty/American Network Insurance Companies, Mar. 1, 2017) available at https://www.nolhga.com/resource/file/NOLHGAPennTreatyPressReleaseFINAL.pdf (last viewed Feb. 20, 2019).
[31] Chicago Fed Letter, *The risks of pricing new insurance products: The case of long-term care*, 2018 Number 397.
[32] Correspondence from FLAHIGA, Feb. 24, 2019, on file with Senate Banking and Insurance Committee.
[33] NAIC and NOLHGA, *State of the U.S. long-term care insurance industry*, March 30, 2017.
[34] Assessments paid from 2015 to 2019. Correspondence on file with the Senate Committee on Banking and Insurance.
[35] *Id.*

III. Effect of Proposed Changes:

Florida Life and Health Insurance Guaranty Association (association or FLAHIGA) (Sections 1-7)

Section 1 amends s. 631.713, F.S., to revise application of this part and subject HMOs to Class B assessments for long-term care insurer impairments or insolvencies. Currently, HMOs are exempt from assessments by the association. The section removes the interest rate cap for FLAHIGA coverage for long-term care or any other health insurance benefit as many long-term care policies contain inflation protection benefits that exceed the current interest rate cap.[36] The section clarifies that the association does not provide coverage for federal programs (Medicare, Medicaid, or Children's Health Insurance program)[37] and certain structured settlement annuity benefits.

Section 2 amends s. 631.714, F.S., to provide that the term, "long-term care assessment obligations," means long-term care impairment and insolvency assessment obligations of the association, which are subject to assessment pursuant to ss. 631.715(2)(a)1., and 631.718(3)(b), F.S., in coordination with the HMOCAP. The section clarifies that all other obligations other than long-term care assessments are obligations of the association without contribution or involvement of the HMOCAP.

Section 3 amends 631.716, F.S., to revise the board of directors for the association by increasing the maximum number of members from nine to 11. One member of the HMOCAP board of directors, or alternate, must serve on the association's board of directors as a non-member insurer board representative, and has the right to attend all board meetings and has full voting rights on all issues. The association board of directors must confirm, subject to approval by the DFS, the HMOCAP member.

Section 4 amends s. 631.717, F.S., to revise the powers and duties of the association. The section provides that, in the event of a long-term care insurer impairment or insolvency, the association is required to coordinate its activities with the HMOCAP, including the development of any plan for administering the impairment or insolvency. Further, the association is required to share information, including data, with and assist, if applicable, the HMOCAP with the administration and collection of member HMO assessments for long-term care insurer impairments or insolvencies.

The section clarifies that the association's maximum coverage for long-term care policies is $300,000, and that any portion of a long-term care rider to a life insurance policy or annuity contract is considered the same type of benefit as the base life insurance policy or annuity contract to which the rider relates. The section also provides technical changes.

[36] Office of Insurance Regulation, *2019 Agency Legislative Bill Analysis of Senate Bill 626* (Feb. 6, 2019) (on file with the Appropriations Subcommittee on Agriculture, Environment, and General Government).
[37] The program, established pursuant to Title XXI of the U.S. Social Security Act, is a program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children.

The association is authorized to file with the OIR for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under part III of ch. 631, F.S., if certain conditions are met. The approval authority for the association to issue certain alternative policies or contracts is changed from the receivership court to the DFS. The association is authorized to reissue policies or contracts.

Section 5 amends s. 631.718, F.S., to establish an assessment methodology for long-term care insurer insolvencies and impairments that is subject to approval by the DFS. The methodology must provide for 50 percent of the assessment to be allocated to accident and health member insurers and 50 percent to be allocated to life and annuity member insurers. The accident and health members' share of the assessment is calculated by including the assessable premiums of member HMOs of the HMOCAP.

The total assessment for long-term care impairments or insolvencies upon a member insurer or member HMO may not exceed 0.5 percent in any one calendar year of the sum of the member insurer or member HMO premiums written in Florida covered by the account received during the calendar year preceding the year in which the assessment is made. If this information is unavailable, the member insurers of the association or the member HMOs of the HMOCAP may use other premium information.

Section 6 amends s. 631.721, F.S., to require the association to revise its plan of operation to provide for the coordination of efforts between the association and the HMOCAP in regards to assessments for long-term care insurer impairments or insolvencies.

Section 7 creates s. 631.738, F.S., relating to applicability as to certain member insurers and HMOs, to exempt any member insurer from long-term care assessment obligations if the member insurer has been adjudged insolvent by a court of competent jurisdiction, or has been determined insolvent by the DFS on or before the effective date of this act. The section also exempts any nonprofit HMO from the assessment if it operates only in Florida and has statutory capital and surplus of less than $200 million as of December 31 of the year preceding the year in which the assessment is made.

Florida Health Maintenance Organization Consumer Assistance Plan (Sections 8 through 12)

Sections 8 through 11 amend ss. 631.816, 631.818, 631.819, and 631.820, F.S. The HMOCAP is required to designate one representative to serve on the association's board of directors, subject to approval by the DFS. In the event of a long-term care insurer impairment or insolvency, the HMOCAP must:

- Collect and transmit all information requested by the association to determine the appropriate assessment base;
- Levy and collect assessments from member HMOs;
- Coordinate the administration and collection of member assessments with the association insolvency;
- Issue a certificate of contribution to each member HMO paying a long-term care insurer assessment; and

- Revise the plan of operations by including procedures for coordinating the administration and collection of member HMO assessments with the association.

Section 12 amends s. 631.821, to provide a technical conforming change.

Section 13 directs the Division of Law Revision to replace the phrase, "effective date of this act" wherever it occurs in this act with the date this act becomes law.

Section 14 provides this bill will take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The expansion of the assessment base will provide access to more funds for the payment of policyholder claims in a more expedient manner.

For future impairments or insolvencies of long-term care insurers, life and annuity insurers and HMOs would be subject to assessments; however the fiscal impact is indeterminate. The bill exempts any nonprofit HMO operating only in Florida that has statutory capital and surplus of less than $200 million, as of December 31 of the year preceding the year the assessment is made, from the assessment obligation.

Subject to certain conditions, assessments may offset insurance premium tax liabilities or corporate income tax liabilities. Currently only health insurers are subject to assessments. This would expand the assessment base, and potentially reduce future assessments for health insurers.

C. Government Sector Impact:

According to the Revenue Estimating Conference, any impact of the bill is dependent upon future insolvencies and the size and timing of future assessments. The bill is expected to have an indeterminate fiscal impact on the corporate income tax and an offsetting indeterminate fiscal impact on the insurance premium tax, both on a recurring basis.[38]

VI. Technical Deficiencies:

Section 7 of the bill provides that the DFS or the OIR may determine whether an insurer is impaired. The OIR makes the initial determination on whether an insurer is impaired.

Section 7 exempts "any nonprofit health maintenance organization that operates only in this state" and meets certain capital and surplus requirements. The section could be clarified by amending it to exempt "any member nonprofit member health maintenance organization of the Florida Health Maintenance Organization Consumer Assistance Plan transacting business only in this state…"

VII. Related Issues:

The NAIC's *Life and Health Insurance Guaranty Association Model Act* does not provide an assessment exemption for nonprofit entities that meet certain capital or surplus requirements.

However, ss. 631.718 and 631.819, F.S., authorize the association and the HMOCAP, respectively, to defer temporarily, in whole or in part, the assessment of a member if, in the opinion of the board, payment of an assessment would endanger the ability of the insurer or HMO to fulfill its contractual obligations.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 631.713, 631.714, 631.716, 631.717, 631.718, 631.721, 631.816, 631.818, 631.819, 631.820, and 631.821.

This bill creates section 631.738 of the Florida Statutes.

[38] Revenue Estimating Conference, *Insurance Premium Tax/Corporate Income Tax, SB 626,* Feb. 15, 2019, available at http://edr.state.fl.us/Content/ (last viewed Mar. 11, 2019).

IX. Additional Information:

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

CS by Banking and Insurance on March 4, 2019:
The CS:

- Exempts any nonprofit HMO from the assessment if it operates only in Florida and has statutory capital and surplus of less than $200 million as of December 31 of the year preceding the year in which the assessment is made; and
- Provides technical, clarifying changes.

B. Amendments:

None.