HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 673 Insurer Guaranty Associations
SPONSOR(S): Insurance & Banking Subcommittee, Fischer
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 626

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	8 Y, 5 N, As CS	Hinshelwood	Luczynski
2) Ways & Means Committee	13 Y, 0 N	Aldridge	Langston
3) Commerce Committee			

SUMMARY ANALYSIS

Florida operates five insurance guaranty funds and associations to ensure policyholders' paid insurance premiums are protected and outstanding claims are settled, up to limits provided by law, if their insurer is liquidated. In response to recent long-term care insurer insolvencies, the bill incorporates some recent changes made to the Life and Health Insurance Guaranty Association Model Act and additional recommendations of stakeholders. The bill makes changes to two 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, and the Florida Health Maintenance Organization Consumer Assistance Plan (HMOCAP), which provides protection for commercial health maintenance organization (HMO) members in the event of the HMO's insolvency. The bill:

- Expands the assessment base of the FLAHIGA to include HMOs, life insurers, and annuity insurers in order to fund long-term care insurer impairments and insolvencies. Currently, only health insurers are assessed. Any assessments related to a long-term care insurer would be allocated 50 percent to health insurers and HMOs and the remaining 50 percent to life and annuity member insurers.
- Caps a FLAHIGA member's or HMO's assessment relating to long-term care insurer impairments and insolvencies at 0.5 percent of the sum of its premiums written in Florida for the preceding calendar year.
- Removes the interest rate cap on the FLAHIGA's coverage for long-term care or any other health insurance benefit, as many long-term care insurance policies contain inflation protection benefits that exceed the current interest rate cap.
- Clarifies that Medicare, Medicaid, and the Children's Health Insurance Program are excluded from the FLAHIGA's coverage and assessments.
- Adds an exclusion for structured settlement annuity benefits to which a payee, or a beneficiary if the payee is deceased, has transferred his or her rights in a structured settlement factoring transaction.
- Adds two director positions to the FLAHIGA's board, one of which must be a director of the HMOCAP board of directors.
- Amends the FLAHIGA's powers and duties by allowing the FLAHIGA to reissue policies or contracts rather than simply continue policies that have proven unsustainable, removing the need for the FLAHIGA to seek approval from a receivership court to issue substitute coverage or an alternative policy, requiring such approval to be given by the Department of Financial Services (DFS), and allowing the FLAHIGA to directly file for rate or premium increases that are actuarially justified.
- Expands the HMOCAP's powers and duties in the event of a long-term care insurer impairment or insolvency.
- Makes other technical and conforming changes to ch. 631, F.S., relating to insurer insolvency and guaranty payments.

The Revenue Estimating Conference estimated SB 626, a bill substantially similar to CS/HB 673, to have no cash impact on state revenues in FY 2019-20 and 2020-21 and to have a recurring impact thereafter that is indeterminate as to magnitude and direction on state revenues. Local government revenues are unaffected.

The bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background: 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.[1] The OIR monitors the solvency of insurers, examines insurers, and takes administrative action, if necessary.

Chapter 631, F.S., relating to insurer insolvency and guaranty payments, governs the receivership process for insurance companies in Florida. Federal law specifies that insurance companies cannot file for bankruptcy. [2] Instead, they are either "rehabilitated" or "liquidated" by the state. In Florida, the Division of Rehabilitation and Liquidation of the DFS is responsible for rehabilitating or liquidating insurance companies.[3]

Florida operates five insurance guaranty funds and associations[4] 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.[5] A guaranty association generally is a not-for-profit corporation created by law and is directed to protect policyholders from financial losses and delays in claims payments and settlements due to the insolvency of an insurance company. A guaranty association accomplishes its mission by assuming responsibility for settling claims and refunding unearned premiums[6] to policyholders. Insurers are required by law to participate in guaranty associations as a condition of transacting business in Florida.

[1] S. 20.121(3), F.S.

[2] 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.

[3] 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.

[4] The FLAHIGA (ss. 631.711 – 631.737, F.S.) generally is responsible for claims settlement and premium refunds for health and life insurers who are insolvent. The HMOCAP (ss. 631.811 – 631.828, F.S.) offers assistance to members of insolvent health maintenance organizations, and the Florida Workers' Compensation Insurance Guaranty Association (ss. 631.901 – 631.932, F.S.) is directed by law to protect policyholders of insolvent workers' compensation insurers. The Florida Self-Insurers Guaranty Association (ss. 440.385 – 440.386, F.S.) protects policyholders of insolvent individual self-insured employers for workers' compensation claims. The Florida Insurance Guaranty Association (ss. 631.50 – 631.70, F.S.) 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.

[5] "Before the creation of guaranty associations, a typical claimant could have waited for years for payment of a claim and then still receive only a fraction of what was due under the terms of the policy or contract. Guaranty associations, subject to statutory limitations, were created to alleviate these problems and ensure the stability of the insurance market. Specifically, in the event of a life/health insurer liquidation, the guaranty mechanism provides for the continuation of eligible contracts that would otherwise terminate." National Association of Insurance Commissioners, *Guaranty Associations*, https://www.naic.org/cipr_topics/topic_guaranty_associations.htm (last visited Mar. 4, 2019).

[6] 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.

The bill makes changes to two of the five guaranty funds and associations – the FLAHIGA, which is the guaranty association for most health and life insurers, and the HMOCAP, which provides protection for commercial health maintenance organization (HMO) members[7] in the event of the HMO's insolvency.

Background: The FLAHIGA

Statutory provisions relating to the FLAHIGA, which was created in 1979, are contained in part III of chapter 631, F.S. The FLAHIGA is a nonprofit corporation and is governed by a board of directors composed of at least five but not more than nine member insurance companies.[8] All insurance companies (with limited exceptions) licensed to write life and health insurance or annuities in Florida are required, as a condition of doing business in Florida, to be a member of the FLAHIGA.[9] Currently, the FLAHIGA does not provide coverage for or assess health maintenance organizations.[10]

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.[11] 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.

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.[12]

By law, the FLAHIGA is divided into three operating accounts:

- The health insurance account;
- The life insurance account; and
- The annuity account.[13]

The FLAHIGA is authorized to levy two types of assessments to carry out its responsibilities.[14] Class A assessments may be levied for the purpose of covering the FLAHIGA's general administrative costs.[15] These assessments are capped at $250 per member per calendar year.[16] Class B assessments are authorized to fund the FLAHIGA's duties related to a specific insolvency.[17] These assessments are based on an insurer's pro rata share of all premiums collected by insurers in the state on policies

[7] Commercial HMO members are "those who have group HMO coverage, generally through their employer, or persons who purchase individual coverage directly through the HMO. Persons who are enrolled with an HMO for Medicaid or Medicare coverage are not covered by the HMOCAP." HMOCAP, *About the HMOCAP*, http://flhmocap.com/about/ (last visited Mar. 4, 2019). *See also* s. 631.813, F.S.
[8] Ss. 631.715(1) and 631.716(1), F.S.
[9] S. 631.715(1), F.S.
[10] S. 631.713(3)(e), F.S.
[11] Generally, 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.
[12] S. 631.717(9), F.S.; FLAHIGA, *Frequently Asked Questions,* https://www.flahiga.org/FAQ (last visited Mar. 4, 2019).
[13] S. 631.715(2)(a), F.S.
[14] S. 631.718(2), F.S.
[15] S. 631.718(2)(a), F.S.
[16] S. 631.718(3)(a), F.S.
[17] S. 631.718(2)(b), F.S.

covered by the account during the three years prior to the assessment.[18] An insurer's assessment for each account may not exceed, in any one calendar year, 1 percent of the insurer's average premiums during the three-year period on premiums written in the covered account.[19] An insurer may offset any assessment against either its premium tax or corporate income tax liability in 5 percent increments over the 20-year period following the year in which the assessment was paid.[20] When assessments related to insolvencies are imposed, the FLAHIGA must issue a certificate of contribution to each insurer paying such assessment for the amount of the assessment paid.[21] A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the DFS approves.[22] However, any amount of assessment offset against the insurer's premium tax or corporate income tax liability may not be shown as an asset of the insurer.[23]

Background: The HMOCAP

Statutory provisions relating to the HMOCAP, which was created in 1988, are contained in part IV of chapter 631, F.S. The purpose of the HMOCAP is to protect subscribers of commercial HMOs against the risk of harm resulting from an HMO's insolvency.[24] The HMOCAP is a nonprofit corporation and is governed by a board of directors composed of at least five but not more than nine HMOs.[25] All HMOs licensed in this state are required, as a condition of doing business in Florida, to be a member of the HMOCAP.[26]

Any person of this state who has lost their health care coverage provided by an HMO due to insolvency is eligible to obtain coverage by the HMOCAP.[27] The HMOCAP will guarantee, reinsure, assume, or provide coverage for all subscriber contracts of the insolvent HMO.[28] Coverage by the HMOCAP ceases 6 months after the date of the insolvency, unless the person is under treatment for an injury that occurred or an illness that was diagnosed while the person was covered by the insolvent HMO or the HMOCAP; once the HMOCAP has provided $300,000 in covered benefits; or when a subscriber obtains coverage with another HMO or health insurer.[29]

To provide funds for the administration of the HMOCAP and the payment of claims, the HMOCAP may assess its members.[30] Assessments against member HMOs are levied as a percentage of annual earned premium revenue for non-Medicare and non-Medicaid contracts.[31] 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.[32]

An HMO may offset against its corporate income tax liability or other liabilities, on an individual or consolidated basis, as applicable, any assessments levied by the HMOCAP. The credit may be taken to the extent of 20 percent of the amount of such assessment for each of the five calendar years

[18] S. 631.718(3)(c), F.S.
[19] S. 631.718(5)(a), F.S.
[20] S. 631.72(1), F.S.
[21] S. 631.718(8), F.S.
[22] *Id.* Under current law, "department" refers to the DFS. s. 624.05(1), F.S. However, the statute's use of the term "department" relates back to a time when the term referred to the OIR's predecessor, the Department of Insurance. The bill amends the approval authority relating to an insurer showing a certificate of contribution as an asset by changing the term "department" to "office" such that the statute correctly refers to the OIR.
[23] *Id.*
[24] S. 631.812, F.S.
[25] Ss. 631.815 and 631.816(1), F.S.
[26] S. 631.815, F.S.
[27] S. 631.817(1), F.S.
[28] S. 631.818(1)(a), F.S.
[29] Ss. 631.817(2) and 631.818(1)(b), F.S.; HMOCAP, *About the HMOCAP*, http://flhmocap.com/about/ (last visited Mar. 4, 2019).
[30] S. 631.819, F.S.
[31] S. 631.819(3), F.S.
[32] *Id.*

following the year in which such assessment was paid. The HMOCAP statutes do not currently provide for the HMOCAP to issue a certificate of contribution for the amount of assessment paid and for a member HMO to reflect such certificate as an asset in its financial statement, as is provided for in the FLAHIGA statutes.

Background: Long-term Care Insurance[33] Insolvencies

In 2017, Penn Treaty,[34] which was domiciled in Pennsylvania, was liquidated. The insurer wrote approximately 75,000 (primarily long-term care insurance) policies.[35] The insolvency is expected to be the second-largest insolvency in insurance guaranty fund history (the largest for an accident and health insurer).[36] As of December 31, 2018, there were 7,468 in-force long-term care insurance policies in Florida that were underwritten by Penn Treaty and its affiliate.[37]

According to the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA),[38] all states regulate long-term care insurance as health insurance.[39] 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 long-term care assessments related to the Penn Treaty insolvency.[40] As of December 31, 2018, the estimated future liability for long-term care assessments related to the Penn Treaty insolvency, which is subject to change, was $110 million.[41]

To address concerns with guaranty fund coverage and assessments for any future long-term care insurer insolvency, the National Association of Insurance Commissioners (NAIC)[42] modified the *Life*

[33] Statutory provisions relating to long-term care insurance are contained in part XVIII of chapter 627, F.S. "Long-term care insurance policy" is defined as "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. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited health insurance coverage not otherwise defined as long-term care insurance." s. 627.9404(1), F.S.

[34] Penn Treaty collectively includes Penn Treaty Network America Insurance Company and its affiliate, American Network Insurance Company.

[35] 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 visited Mar. 4, 2019).

[36] Chicago Fed Letter, *The Risks of Pricing New Insurance Products: The Case of Long-Term Care,* 2018 No. 397, *available at* https://www.chicagofed.org/publications/chicago-fed-letter/2018/397 (last visited Mar. 4, 2019).

[37] Emails from Paul Sanford, representative of the FLAHIGA, Re: HB 673 (Mar. 5, 2019).

[38] NOLHGA is a voluntary association made up of the life and health insurance guaranty associations of all 50 states. The NOLHGA assists its members by coordinating the administration of claims for an insolvent insurer that is licensed in more than one state. In general, the financial, legal, and administrative services required for a multi-state insolvency are provided through the NOLHGA, rather than separately by each state, thereby decreasing the need for each state association to individually provide and fund these services. NOLHGA, *What is NOLHGA*, https://www.nolhga.com/aboutnolhga/main.cfm/location/whatisnolhga (last visited Mar. 4, 2019).

[39] NOLHGA, *State of the U.S. Long-term Care Insurance Industry*, March 30, 2017, *available at* https://www.naic.org/documents/cmte_e_mlwg_related_state_of_ltc_industry.pdf (last visited Mar. 4, 2019).

[40] Email from Paul Sanford, *supra* note 37.

[41] *Id.*

[42] The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC, *About the NAIC*, https://www.naic.org/index_about.htm (last visited Mar. 4, 2019).

and Health Insurance Guaranty Association Model Act[43] to expand the assessment base to include HMOs and life and annuity insurers for funding long-term care insurer impairments and insolvencies. Assessments for long-term care impairments and insolvencies are allocated equally between the life and health accounts. The NAIC clarified the authority of the guaranty associations to adjust rates and coverage in the case of liquidation. Further, the NAIC clarified 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.

Effect of the Bill

Assessments for long-term care insurer impairments or insolvencies

In order to fund long-term care insurer impairments and insolvencies, the bill expands the assessment base of the FLAHIGA to include HMOs, life insurers, and annuity insurers. Any assessments related to a long-term care insurer would be allocated 50 percent to health insurers and HMOs and the remaining 50 percent to life and annuity member insurers. The bill clarifies that, where a life insurance policy or annuity contract has a rider providing for long-term care benefits, the rider will follow the type of base policy and not be deemed a health policy. For purposes of long-term care insurer impairment and insolvency assessments, HMOs must be assessed in the same manner as the FLAHIGA's member insurers.

The cap on the FLAHIGA's liability for long-term care insurance benefits is $300,000 per insured life. Each FLAHIGA member's and HMOCAP member's assessment relating to long-term care insurer impairments and insolvencies may not exceed 0.5 percent of the sum of the member's premiums written in Florida regarding business covered by the account received during the calendar year preceding the year in which the assessment is made. If premium information is not reasonably available, then any reasonably available premium information may be used. Long-term care insurer impairment and insolvency assessments must be deposited into the FLAHIGA's health insurance account and used solely for long-term care insurer impairment or insolvency obligations.

Consistent with existing law for the FLAHIGA, the bill provides that the HMOCAP must issue to each HMO paying a long-term care insurer impairment or insolvency assessment a certificate of contribution for the amount of the assessment paid. A certificate of contribution may be shown by the HMO in its financial statement as an asset in such form and for such amount and period of time as the OIR approves, except that any amount of assessment offset against the HMO's corporate income tax liability or other liabilities may not be shown as an asset of the HMO.

The portions of the bill relating to long-term care assessment obligations apply only to long-term care assessment obligations assessed as a result of an insurer being adjudged insolvent by a court of competent jurisdiction or being determined by the office to be impaired on or after the effective date of the bill.

The bill requires coordination and sharing of information between the FLAHIGA and the HMOCAP in the event of long-term care insurer impairments or insolvencies and assessments resulting therefrom.

Exclusions from the FLAHIGA's coverage and assessments

The bill removes the interest rate cap on the FLAHIGA's coverage for long-term care or any other health insurance benefit, as many long-term care insurance policies contain inflation protection benefits that exceed the current interest rate cap.[44] The bill clarifies that Medicare, Medicaid, and the Children's Health Insurance Program are excluded from the FLAHIGA's coverage and assessments. The bill adds

[43] NAIC, *Life and Health Insurance Guaranty Association Model Act*, https://www.naic.org/store/free/MDL-520.pdf (last visited Mar. 4, 2019).
[44] Office of Insurance Regulation, Agency Analysis of 2019 House Bill 673 (Feb. 13, 2019).

an exclusion for structured settlement annuity benefits to which a payee, or a beneficiary if the payee is deceased, has transferred his or her rights in a structured settlement factoring transaction. This exclusion "recognize[s] that the protections afforded by guaranty associations are intended for insurance consumers, such as the original payees of structured settlement annuities. Guaranty association protection does not extend to sophisticated investors who acquire rights to receive structured settlement annuity benefits in the secondary market."[45]

The FLAHIGA's board of directors

The bill adds two director positions to the FLAHIGA's board, one of which must be a director of the HMOCAP board of directors. Such HMOCAP director must be designated by the HMOCAP board, is subject to approval by the DFS, must represent the interests of the HMOCAP and its board of directors, has the right to be present at all meetings of the FLAHIGA board, and has full voting rights on all issues coming before the FLAHIGA board.

The FLAHIGA's powers and duties

The bill amends the FLAHIGA's powers and duties to allow the FLAHIGA to reissue policies or contracts rather than simply continue policies that have proven unsustainable. The bill removes the need for the FLAHIGA to seek approval from a receivership court to issue substitute coverage or an alternative policy. Instead, the bill requires such approval to be given by the DFS. Additionally, the bill allows the FLAHIGA to directly file for rate or premium increases and requires that such increases be actuarially justified.

The HMOCAP's powers and duties

The bill requires that, in the event of a long-term care insurer impairment or insolvency, the HMOCAP:

- Collect and transmit all information requested by the FLAHIGA for it to determine the appropriate assessment base of the health insurance account.
- Levy and collect assessments from HMOs.
- Coordinate the administration and collection of HMO assessments for long-term care insurer impairments and insolvencies with the FLAHIGA.

Additionally, in the event of a long-term care insurer impairment or insolvency, the HMOCAP may coordinate with the FLAHIGA and may develop a plan for handling the administration of the impairment or insolvency.

The bill makes other technical and conforming changes to ch. 631, F.S.

The bill takes effect upon becoming law.

B. SECTION DIRECTORY:

Section 1. Amends s. 631.713, F.S., relating to application of part.

Section 2. Amends s. 631.714, F.S., relating to definitions.

Section 3. Amends s. 631.716, F.S., relating to board of directors.

Section 4. Amends s. 631.717, F.S., relating to powers and duties of the association.

Section 5. Amends s. 631.718, F.S., relating to assessments.

[45] NAIC, *supra* note 43.

Section 6. Amends s. 631.721, F.S., relating to plan of operation.

Section 7. Amends s. 631.816, F.S., relating to board of directors.

Section 8. Amends s. 631.818, F.S., relating to powers and duties of the plan.

Section 9. Amends s. 631.819, F.S., relating to assessments.

Section 10. Amends s. 631.820, F.S., relating to plan of operation.

Section 11. Amends s. 631.821, F.S., relating to powers and duties of the department.

Section 12. Provides applicability of specified statutes to certain long-term care assessment obligations.

Section 13. Directs the Division of Law Revision to replace the phrase "the effective date of this act" with the date the act becomes a law.

Section 14. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The Revenue Estimating Conference estimated SB 626, a bill substantially similar to CS/HB 673, to have no cash impact on state revenues in FY 2019-20 and 2020-21 and to have a recurring impact thereafter that is indeterminate as to magnitude and direction on state revenues.[46]

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Only health insurers are currently subject to assessment for impairments or insolvencies of long-term care insurers. The bill would cause life and annuity insurers as well as HMOs to be subject to such assessments in the future. This would expand the assessment base for long-term care insurer impairments and insolvencies and would potentially reduce such assessments for health insurers. The expansion of the assessment base will provide access to more funds for the payment of policyholder claims and may result in claims being paid in a more expedient manner.

[46] Revenue Estimating Conference, *Insurance Premium Tax/Corporate Income tax, SB 626,* Feb. 15, 2019, http://edr.state.fl.us/Content/conferences/revenueimpact/archives/2019/_pdf/Impact0215.pdf (last visited Mar. 4, 2019).

Subject to certain limits, assessments may offset insurance premium tax liabilities or corporate income tax liabilities. Additionally, subject to certain conditions, a certificate of contribution that is issued by the FLAHIGA to its member insurers reflecting the amount of an assessment paid can be shown by the insurer in its financial statement as an asset. The bill would similarly allow the HMOCAP to issue certificates of contribution to member HMOs for long-term care insurer impairments and insolvency assessments paid such that member HMOs can show the certificate of contribution as an asset in their financial statements.

The impact on the private sector is dependent upon future insolvencies and the size and timing of future assessments. Therefore, the impact is indeterminate.

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:

Article VII, s. 19 of the Florida Constitution requires the imposition, authorization, or raising of a state tax or fee be contained in a separate bill that contains no other subject and be approved by two-thirds of the membership of each house of the Legislature. As such, Art, VII, s. 19 of the Florida Constitution may apply if the assessment provisions in the bill are interpreted to be a new state tax or fee.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The remaining references to “department” in ss. 631.718(8) and 631.819(6), F.S., should be changed to “office,” as recommended by the DFS.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 7, 2019, the Insurance and Banking Subcommittee considered four amendments, which were adopted, and reported the bill favorably as a committee substitute. The committee substitute:

- Conforms the House bill to the Senate bill in order to clarify that Florida’s guaranty association for health insurance will not cover federal health insurance entitlement programs.
- Ensures that the HMOCAP director who is being added to the board of the FLAHIGA cannot be a FLAHIGA member that is already serving on the FLAHIGA’s board.
- Changes two occurrences of “accident and health” to simply “health” in order to align terminology with existing statutory language.
- Changes two occurrences of “department” to “office”, as recommended by the Department of Financial Services.
- Clarifies the non-retroactive effect of the bill.
- Makes other technical changes.

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