SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 1226

SPONSOR: Banking and Insurance Committee and Senator Holzendorf

SUBJECT: Insurance

DATE: April 27, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	Favorable/CS
2.	White	Wilson	GO	Fav/1 amendment
3.				
4.				
5.				

I. Summary:

The committee substitute would restrict current provisions that require insurers to guarantee the issuance of an individual health insurance policy. In 1997, to comply with the federal Health Insurance Portability and Accountability Act, Florida enacted several provisions, including s. 627.6487, F.S., which guarantees the availability of individual health insurance coverage to individuals with 18 months of certain prior creditable coverage, the most recent of which was group coverage. In 1998, this provision was expanded to include persons whose most recent coverage was under an individual policy, under certain circumstances. The committee substitute specifies that, the most recent prior creditable coverage under an individual plan must have been provided in Florida to qualify as creditable coverage for purposes of guaranteed availability of s. 627.6487, F.S.

The committee substitute provides the following changes to the Insurance Code relating to life insurance:

- Modifying the method of calculating the deficiency reserve for renewable term life insurance policies;
- Updating the buyer's guide required to be used by insurers soliciting life insurance business; and
- Authorizing the Department of Insurance to adopt by rule the model rules for the valuation of life insurance policies adopted by the National Association of Insurance Commissioners in March 1999.

In addition, the maximum service charge a general lines agent, insurer, or subsidiary of an insurer may charge to finance insurance premiums on policies is revised to authorize a service charge not exceeding $12 per year for any balance greater than $220. Currently, an agent is authorized to charge $1 per installment for a maximum of $12 per year. If the total premium financing charge or rate of interest exceeds this amount per year, the agent, insurer, or subsidiary of the insurer would be subject to the provisions of part XV, of ch. 627, F.S. part XV of ch. 627, F.S., which

authorizes the Department of Insurance to impose penalties for excessive premium finance charges.

Finally, the bill authorizes the Division of Risk Management within the Department of Insurance to directly purchase annuities through a structured settlement consulting firm for the purpose of entering into structured settlements and exempts the purchase from the competitive sealed bidding process and proposal requirements.

This bill substantially amends the following sections of the Florida Statutes: 284.33, 625.121, 626.99, 627.6487, 627.901, and 627.902.

II. Present Situation:

Health Insurance Portability and Accountability Act (HIPAA)

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) which requires insurers issuing individual health insurance policies to guarantee the issuance of coverage to persons who previously were covered for at least 18 months and meet other eligibility criteria. The Act allowed each state to craft alternative methods of guaranteeing availability of coverage. The federal HIPAA law allows each state the option to enact and enforce the federal provisions or fall back to federal enforcement. HIPAA specifies that the federal provisions pertaining to health insurers in the individual market generally do not preempt state regulation of individual insurers. However, if the state's statutory provisions prevent the application of a federal requirement, HIPAA preempts the statutes and the federal requirements prevail. At a minimum, each state must ensure that its provisions comport with HIPAA and do not diminish the federal requirements. However, each state is permitted to adopt provisions that expand or provide more favorable treatment for the individual.

In 1997, Florida enacted legislation to conform state law to HIPAA, which included an alternative mechanism that was deemed to be acceptable by the federal Health Care Finance Administration (HCFA).[1] In order to be eligible for guaranteed-issuance of individual coverage under HIPAA and Florida's conforming legislation, an individual must have had prior creditable coverage for at least 18 months, without a break in coverage of more than 63 days, and not be eligible for any other group coverage, Medicare or Medicaid. Under federal law, the individual's most recent prior coverage must have been under a *group* plan, a governmental plan, or church plan. However, in 1998, Florida expanded the eligibility criteria under state law to also include persons whose most recent coverage was under an *individual* plan if the prior insurance coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO.[2]

[1]Chapter 97-179, Laws of Florida.

[2]Chapter 98-159, L.O.F.; amending s. 627.6487, F.S. Individuals are protected from losing their individual coverage in most other circumstances by the requirement in both state and federal law that individual policies be guaranteed-renewable, subject to certain exceptions. [s. 627.6425, F.S.]

The Florida law provides two mechanisms for guaranteeing access to individual coverage to persons who lose their eligibility for prior coverage. These mechanisms apply after exhaustion of the period of time that group coverage can be continued under the federal COBRA law or Florida's "mini-COBRA" law which, generally, is up to 18 months.[3] One method requires the insurance company or HMO that issued the group health plan to offer an individual *conversion policy* to persons who lose their eligibility for group coverage.[4] Florida law requires that the insurer or HMO offer at least two conversion policy options, one of which must be the standard benefit plan that Florida law requires small group carriers to offer small employers. The maximum premium that may be charged for any conversion policy is limited to 200 percent of the standard risk rate, which is a statewide average rate computed annually by the Department of Insurance, calculated separately for indemnity policies, exclusive/preferred provider policies, and HMO contracts.[5]

Florida's second method of guaranteeing access to individual coverage is by allowing eligible individuals to purchase an individual policy from any insurance company or HMO issuing individual coverage in the state. The policy must be offered on a guaranteed-issue basis, that is, regardless of the health condition of the individual. The insurer or HMO must offer each of their two most popular policy forms, based on statewide premium volume. This is referred to as the *federal fall back method*, since it is the method that applies under HIPAA if a state fails to enact an alternative mechanism.[6] Under Florida law, this method applies to persons who meet the eligibility criteria but who are *not* entitled to a conversion policy under ss. 627.6675 or 641.3921, F.S. This generally includes persons who were previously covered under a *self-insured* employer's plan or who move to Florida after terminating coverage from previous employment in another state. It also applies to persons whose previous coverage was under an *individual* plan that was terminated for specified reasons.

The requirement under Florida law that insurers and HMOs offer conversion policies does not apply to self-insured employers. States may not impose any such requirement on self-insured employers due to federal ERISA preemption. However, a self-insured employer may offer conversion coverage which, under certain conditions, will disqualify a person from obtaining coverage from an individual carrier on a guaranteed-issue basis.

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[3]The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to employers with 20 or more employees and allows individuals who lose eligibility for group coverage to continue their coverage for 18 months (or 29 months for handicapped persons or 36 months for divorced and widowed dependents) by paying up to 102 percent of the group premium. The Florida Health Insurance Coverage Continuation Act, s. 627.6692, F.S., ("mini-COBRA") applies to insurers covering employers with *fewer* than 20 employees, and allows continuation for 18 months at 115% of the group premium.

[4]Section 627.6675, F.S. (group insurance policies) and section 641.3921, F.S. (group HMO contracts). Any individual who is eligible for a conversion policy under an insured plan or a self-insured plan under either of these two statutes is excluded from the definition of "eligible individual" under s. 627.6487, F.S., and is not eligible for guaranteed-issuance of coverage from an insurer issuing individual policies.

[5]Sections 627.6675(3) and 641.3922(3), F.S.

[6]More specifically, under HIPAA's fall back approach, carriers must offer eligible individuals either: (1) all of its individual market plans, (2) only its two most popular plans, or (3) two representative plans providing a lower-level and a higher-level coverage option that are subject to a risk-spreading or financial subsidization mechanism. Under Florida law, the carrier's only option is to offer its two most popular plans to an eligible individual.

As amended in 1998, the definition of *eligible individual* in s. 627.6487, F.S., excludes any person who is eligible for "a conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured *or self-insured* employer plan." [emphasis added] Thus, a conversion coverage option under a self-insured plan serves as the sole method of guaranteeing coverage, but only if the conversion policy or contract is issued by an authorized insurer or HMO and meets the requirements specified in the respective conversion statutes, notably that the standard benefit plan be offered as one of at least two policy options and that premiums not exceed 200 percent of the standard risk rate. In fact, such protections may be required in order for the conversion policy to serve as an acceptable alternative mechanism under HIPAA. If the conversion policy does not meet these conditions, an otherwise eligible individual is entitled to obtain coverage from any insurer or HMO issuing individual coverage.

Florida Casualty Insurance Risk Management Trust Fund

The Division of Risk Management of the Department of Insurance is responsible for administering the Florida Casualty Insurance Risk Management Trust Fund, which is created under part II of chapter 284, F.S. This trust fund was established for the purpose of providing casualty insurance for the State of Florida. The trust fund covers all departments of the State of Florida and their employees, agents, and volunteers. The Florida Casualty Insurance Risk Management Trust Fund provides insurance to the State of Florida for: 1) workers' compensation, 2) general liability, 3) fleet automotive liability, 4) federal civil rights actions, and attorneys fees in certain other proceedings against the state.

To provide these various coverages, the Department of Insurance is authorized to purchase insurance and reinsurance through the Department of Management Services, pursuant to state procurement requirements under ch. 287, F.S. The law also allows the Department of Insurance to purchase risk management services, including claims control, investigation, claims adjustment, and legal services.[7]

Chapter 287, F.S., sets forth the requirements the state must follow in purchasing commodities and contractual services. Under Florida law, insurance is not considered a commodity, but it is required to be purchased in the same manner as a commodity.[8] When purchasing insurance for the state risk management program, the Department of Management Services must follow the invitation to bid or request for proposal process.[9] According to the Division of Risk Management, this process can take several months to complete.

An arrangement to satisfy a legal liability which involves the periodic payment of money through an annuity (or other financial product) is generally referred to as a structured settlement. Under a structured settlement involving an annuity arrangement, one party pays a lump sum premium to an

[7]Id.

[8]See s. 287.022(1), F.S.

[9]See s. 287.057(1) & (2), F.S.

insurance company to purchase an annuity in the name of the claimant. The premium varies depending on the number and length of payments. The insurance company then makes periodic payments to the claimant for the negotiated period of time.

Structured settlements are commonly used as an alternative to simple lump sum settlements. Structured settlements can offer some advantages to both parties involved in the settlement. For claimants, a structured settlement can provide assurance of future income, which may be necessary for claimants with long term medical needs. Also, money paid to a claimant through a structured settlement receives more favorable federal tax treatment. Unlike investment earnings on a lump sum payment, which are taxable, payments made under a structured settlement are not taxable. However, claimants must weigh these advantages against the disadvantage of not having access at any one time to the entire amount of money received in the settlement.

For the paying party, structured settlements can provide a more cost effective means of extinguishing the legal liability. For example, a $2 million lump sum payment would cost $2 million. However, $2 million paid over time through a structured settlement might be accomplished through purchasing an annuity that costs only $500,000 -- a savings of $1.5 million.

Life Insurance

Life insurance contracts are written on a level-annual-premium basis, that is, the same amount of premium is paid throughout the term of the policy. Premiums collected near the beginning of the policy are higher than necessary to pay claims in those years, while premiums paid in the later years of the policy are insufficient to pay claims in those years. As a result, the premiums collected in the early years of the policy, which exceed current-year requirements, must be accounted for and held for payment of future benefits. This money is called the basic policy reserve. Therefore, if an insurer has reserved correctly, the policy reserve plus the future premiums should provide adequate funding to pay future benefits. Florida law establishes a formula which determines how much of the gross premiums collected by the insurer must be held as the basic policy reserve.

Occasionally, insurers will charge premiums which are lower than the premiums that standard mortality tables recommend. If this occurs, the basic policy reserve held by the insurer may be inadequate. To ensure that there is sufficient money to pay claims, insurers are required to reserve additional premiums, known as a deficiency reserve. The deficiency reserve equals the difference between the premiums insurers actually charge and the premium the applicable mortality tables recommended amount.

Current law directs the insurer to calculate deficiency reserves for renewable term life insurance policies by using the current term period only -- excluding the subsequent terms which could occur after renewal.

The National Association of Insurance Commissioner’s (NAIC) has adopted a model act, entitled the Standard Valuation Law, for the valuation of life insurance policies and the calculation of basic policy reserves and deficiency reserves. The most recent revision of the NAIC model act occurred in January 1997. Almost every state in the country, including Florida, has adopted a variation of the NAIC model act.

Section 625.121, F.S., is Florida's "Standard Valuation Law." Section 625.121(7), F.S., provides the method for calculating the basic policy reserve. Section 625.121(11), F.S., provides the method for calculating the deficiency reserve.

To implement the NAIC model act, the NAIC has adopted a set of model rules, which include tables of select mortality factors. The most recent version of these model rules was adopted by the NAIC in March 1999. The NAIC model rules take into account the subsequent terms of a renewable term life insurance policy when calculating the deficiency reserve. This is different from the approach required under Florida law, which only takes into account the current term period.

Florida law regulates insurers' sale of life insurance to purchasers in the state. The purpose of this law is to provide information to purchasers which will improve the buyers ability to select the most appropriate plan of life insurance, improve the buyers' understanding of the basic features of the policy, and improve the buyer's ability to evaluate the relative costs of similar plans of life insurance.[10] To achieve this purpose, the law requires insurers to adopt and use a buyer's guide. Current law provides that the adoption and use of the buyer's guide adopted May 4, 1976, by the NAIC constitutes compliance with the law. Currently, the Department of Insurance has not adopted any administrative rules relating to the valuation of life insurance policies.

Premium Financing

Under the provisions s. 627.901, F.S., an insurance agent or insurer may make reasonable service charges for financing insurance premiums on policies issued. The service charge may not exceed $1 per installment, or a $6 total per year for nay premium balance of $120 or less. If the premium balance is greater than $120 and less than $220, an agent may charge up to $9 per year. If the premium balance is greater than $220, an agent is authorized to charge a maximum service charge of $1 per installment or up to $12 per year. In the event an insurer or agent service charge is greater than the amount authorized in s. 627.901, F.S., the insurer or agent would be subject to Part XV of ch. 627, F.S., which provides for the regulation of premium finance transactions by the Department of Insurance.

III. Effect of Proposed Changes:

Section 1. Amends s. 284.33, F.S., to authorize the Division of Risk Management to contract with a "structured settlement insurance consultant" to act as an agent of record of the state and to assist in the direct purchasing of annuities for structured settlements. This section exempts from the state procurement requirements the purchase of annuities through the structured settlement insurance consultant. The consultant would act as the agent of record for the Division of Risk Management to facilitate the structured settlement and would be authorized to pay a premium to an insurance company to purchase an annuity. Then, the insurance company would make periodic payments to the claimant.

The insurance consultant would be selected in accordance with the state's procurement requirements. This section sets forth the criteria the consultant must consider in procuring

[10]Section 626.99(1), F.S.

annuities, including price, financial strength of the insurer, and the best interest of the state risk management program.

Section 2. Amends s. 625.121, F.S., to require deficiency reserves for renewable term life insurance policies to be calculated in accordance with the deficiency reserve provisions of the NAIC model rules, which take into account subsequent renewable terms. The section also authorizes the Department of Insurance to adopt by rule the model regulations for the valuation of life insurance policies, including tables of select mortality factors, as approved by the NAIC in March 1999. This section would also authorize the Department of Insurance to adopt rules effective January 1, 2000.

Section 3. Amends s. 626.99, F.S., to revise the version of the NAIC-approved buyer's guide that insurers may use when soliciting life insurance business. This section replaces the version approved by the NAIC May 4, 1976, with the version approved by the NAIC October 1, 1996.

Section 4. Amends s. 627.6487, F.S., to limit the right to guaranteed availability of individual health insurance to individuals whose most recent creditable coverage under an *individual* plan was provided in Florida. If such prior coverage was provided outside the state of Florida, it would no longer count for purposes of Florida's guaranteed availability of individual health insurance coverage.

HIPAA specifies that the federal provisions pertaining to health insurers in the individual market generally do not preempt state regulation of individual insurers. However, if the state's statutory provisions prevent the application of a federal requirement, HIPAA preempts the statutes and the federal requirements prevail. At a minimum, each state must ensure that its provisions comport with HIPAA and do not diminish the federal requirements. Section 4 of the bill requires an individual's most recent creditable coverage under an individual plan to be provided in Florida. The HIPAA law does not apply if the most recent prior coverage was an individual policy, so the requirement that an individual policy be issued in Florida would not conflict with HIPAA. (But, see the "Constitutional Issues" section of the analysis.)

Section 5. Amends s. 627.901, F.S., to authorize a general lines agent to charge a maximum service charge, not exceeding $12 per year for financing insurance premiums on policies. Currently, an agent is authorized to charge $1 per installment for a maximum of $12 per year. If the total premium financing charge or rate of interest exceeds this amount per year, the agent would be subject to the provisions of part XV, of ch. 627, F.S. Part XV of ch. 627, F.S., which authorizes the Department of Insurance to impose penalties for excessive premium finance charges.

Section 6. Amends s. 627.902, F.S., to provide that an insurer or a subsidiary of an insurer is subject to the provisions of part XV, of ch. 627, F.S., if the total service charge or rate of interest charged per year is greater than the amount authorized under the provisions of s. 627.901, F.S. Part XV of ch. 627, F.S., authorizes the Department of Insurance to impose penalties for excessive premium finance charges. Section 5 of the bill would authorize an agent to charge a maximum of $12 per year, regardless of the number of installment payments. Currently, an agent is authorized to charge $1 per installment for a maximum of $12 per year.

Section 7. Provides that this act shall 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. Other Constitutional Issues:

The bill may raise an issue relating to the constitutionally protected right to travel among the states. The bill requires a person to have the most recent prior creditable coverage under an individual plan to be issued under a plan "in this state" before having the right to guaranteed availability of individual health insurance coverage in Florida. This provision may be an impermissible durational residency requirement, similar to the ones struck down by the United States Supreme Court relating to welfare benefits and medical care.[11]

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Individuals whose most recent individual coverage was issued in another state and who lose such coverage, would no longer be entitled to access to an *individual* health insurance under Florida law if such persons move to Florida. Insurers issuing individual health insurance policies in Florida would no longer be required to issue individual coverage to such persons and those insurers may experience lower losses and greater profits as a result.

[11]See Shapiro v. Thompson, 394 U.S. 618, 89 S.Ct. 1322, 22 L.Ed.2d 600 (1969); Memorial Hospital v. Maricopa County, 415 U.S. 250, 94 S.Ct. 1076, 39 L.Ed.2d 306 (1974); Attorney General of New York v. Soto-Lopez, 476 U.S. 898, 903, 106 S.Ct. 2317, 2321, 90 L.Ed.2d 899 (1986) (state law implicates the fundamental right to travel and therefore triggers strict scrutiny: (1) when impeding interstate travel is its primary purpose; (2) when its uses a classification which serves to penalize the right to travel; or (3) where it actually deters such travel); see also Maldonado v. Houstoun, 177 F.R.D. 311, (E.D.Pa. 1997) ("[T]he purpose of preventing the Commonwealth from becoming a welfare magnet is constitutionally impermissible.").

The bill changes the method the deficiency reserve is calculated for renewable term life insurance policies for domestic insurers in Florida, thereby requiring these insurers to reserve more money than they are required to under current Florida law. These additional reserve requirements will increase the premiums for new term life insurance policies issued by such insurers or decrease the period during which rates are guaranteed for some term life policies. However, the benefit of reserving more funds on renewable term life insurance policies is to ensure the financial solvency of the insurer and to adopt a uniform method of valuation of life insurance policies nationwide. Many other states have already adopted the more stringent reserve requirements and this places these foreign insurers operating in Florida at a competitive disadvantage with domestic insurers who do not presently have to meet this requirement.

Insurers providing for the financing of premiums would be authorized to charge up to $12 per year as a service charge, regardless of the number of installment payments made by the policyholder. Presently, insurers are allowed to charge a fee of $1 per installment for a maximum of $12 per year. Policyholders financing the payment of the insurance premium could experience a slightly higher service charge due to this change.

C. Government Sector Impact:

By authorizing the Division of Risk Management to purchase annuities directly through a structured settlement consulting firm, the division may possibly be able to settle major civil rights claims and other claims for lower costs than if structured settlements were not available. The estimated savings are indeterminate at this time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

#1 by Governmental Oversight and Productivity Committee:
Creates the Commission for Health Care for the Employee Leasing Industry. The purpose of the Commission is to study the availability and affordability of health care and the delivery methods for providing health care. The amendment requires a report to be submitted to the Legislature by January 1, 2001, and specifies how the commission's ten members should be appointed, that the members will meet in the Capitol, and that Senate and House committees will serve as staff.

The amendment's use of the term "commission," may not be warranted. A "commission," is statutorily defined as a body created by specific statutory enactment within a department, the

office of the Governor, or the Executive Office of the Governor.[12] A "committee" or "task force," on the other hand, is statutorily defined as an advisory body appointed to study a specific problem and to recommend a solution with respect to that problem. A committee's or task force's existence terminates upon the completion of its assignment.[13] If the amendment's intent is to have the commission be independent of the executive branch and for it to terminate upon the completion of its duties, it may be appropriate to amend the bill so that it creates a committee or task force, rather than a commission.

[12]Section 20.03(10), F.S.

[13]Section 20.03(8), F.S.