SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 2080

SPONSOR: Banking and Insurance Committee and Senator Carlton

SUBJECT: Insurance

DATE: April 10, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.				
4.				
5.				
6.				

I. Summary:

The bill adopts the Risk-Based-Capital for Health Organizations Model Act, which is a solvency model act created by the National Association of Insurance Commissioners (NAIC). In order to maintain accreditation by NAIC, accredited states must adopt the model act. This act would require domestic health maintenance organizations (HMOs) to annually calculate certain risk-based levels based on a formula adopted by the NAIC. A comparison of the HMO's actual capital level and its risk-based capital levels may trigger any of several levels of regulatory action on the part of the Department of Insurance.

The bill requires HMOs to reserve for claims arising for services provided to subscribers if the services are provided through a health care risk contract, unless a financial instrument secures the obligations under such contracts. A health care risk contract would be defined to mean a contract in which a person receives compensation in an amount greater than 1 percent of the HMO's annual written premium in exchange for providing services. The HMO would also be required to report information concerning these transactions to the department. An HMO would also be required to submit a comprehensive business plan at the time of its application for licensure with the department.

Foreign or alien insurers that are commercially domiciled (writing 25 percent or more of the direct written premiums in Florida than in its state of domicile) would be required to meet the requirements of part I and II of ch. 625, F.S. (accounting and investments requirements for insurers).

The definition of covered policy is amended for the purpose of providing coverage through the Hurricane Catastrophe Fund for policies transferred from an insurer or the joint underwriting association.

The bill eliminates or revises many reporting requirements related to workers' compensation insurance and private passenger automobile insurance. The department is authorized to adopt rules for the electronic filing of reports and other information.

The service of process requirements are revised to eliminate the requirement that every notice of service of process must be forwarded by the department via registered or certified mail and allows the department to use more cost-effective methods for the delivery of the notice.

The bill adds an exception and revises a current exception to the requirement that at least 2 months' premium be paid as a down payment for a motor vehicle insurance policy.

The bill also revises the maximum interest rate that an insurer or agent may charge when it finances the premium, to specify that the interest rate or service charge may be level amounts that in the aggregate do not exceed 18 percent simple interest per year on the average unpaid balance as billed over the term of the policy.

This bill substantially amends the following sections of the Florida Statutes: 215.555, 624.307, 624.315, 624.408, 624.423, 626.742, 626.8736, 626.907, 634.161, 624.424, 624.4435, 624.4242, 625.340, 626.8805, 627.7295, 627.901, 627.914, 627.915, 641.19, 641.26, 641.263, 641.265, 641.35, 641.2018, 641.495, 817.234, 817.50. This bill repeals section 641.2342, Florida Statutes.

II. Present Situation:

Health Maintenance Organizations

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. Such organizations stress preventive care and make efforts to avoid unnecessary hospitalization and expensive tertiary care. Subscribers must surrender certain freedom of choice selections of health care providers and health care related services. Subscriber choice is typically restricted to a "gatekeeper" physician (primary care physician) or other health care professional that is either an employee of, or has contracted to provide professional services on behalf of, the subscriber's HMO. Furthermore, subscribers are restricted in their choice of hospitals and other health care delivery facilities that they may utilize.

Under present law, the department regulates HMO finances, contracting, and marketing activities under part I of ch. 641, F.S., while the Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a Certificate of Authority from the department, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate under part III of chapter 641 and that is otherwise in compliance with the licensure provisions under part I may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.

In regulating the financial operations of HMOs, the department is responsible for ensuring that these entities are financially solvent and conducts their marketing activities in accordance with guidelines contained in ch. 641, F.S. A major role the department performs in the regulation of

HMOs is to ensure that the contracts under which these entities provide services do not contain terms that are inconsistent, ambiguous, or misleading. Under the provisions of s. 641.2342, F.S., each HMO is required to file, upon request of the department, financial statements for all contract providers of comprehensive health care providers who have assumed through capitation or other means, more than 10 percent of the health care risks of the HMO. This provision does not apply to individual physicians.

Under the provisions of s. 641.234, F.S., the department may require an HMO to submit any contract for administrative services, contract with providers other than an individual physician, contract for management services, and contract with an affiliated entity to the department. After reviewing the contract, the department may order an HMO to cancel the contract in accordance with the terms of the contract and applicable law, if it determines that the fees to be paid by the HMO are so unreasonably high as compared with similar contracts entered into by other HMOs in similar circumstances that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the HMO or that the contract with an entity that is not licensed under state statutes, if such license is required, or is not in good standing with the applicable regulatory agency.

The department licenses and regulates various risk bearing entities like insurers and HMOs; however, the intermediary entities are not licensed or regulated by the department. The contracts entered into between HMOs and intermediary entities are essentially "risk bearing arrangements" and the intermediary entity is referred to as the "downstream risk taker." A question arises concerning which entity is ultimately responsible to pay a provider's claim when there is a dispute and since the intermediary is not licensed, what recourse does the department have against the intermediary.

The department does regulate fiscal intermediary service organizations, which manage and administer the business affairs of health care provider. These entities are regulated under the provisions of s. 641.316, F.S., to ensure the financial soundness of such organizations. These entities are required to secure and maintain a security bond in the minimum amount of 10 percent of the funds handled by the intermediary in connection with its fiscal and fiduciary services during the prior year or $1 million, whichever is less. The minimum bond amount is $50,000.

Additionally, the department is charged with ensuring that rates charged to subscribers are not excessive, inadequate, or unfairly discriminatory. Agent activities, relating to solicitation of contracts to provide HMO services, and permissive handling of HMO assets and investments, among others, are under the department's jurisdiction as well.

Risk-Based Capital Requirements

The National Association of Insurance Commissioners (NAIC) established a program for accreditation of states in 1989. Florida and New York were the first two states to be accredited; New York's accreditation was suspended in March 1993 because of its failure to adopt NAIC models relating to managing general agents and reinsurance intermediaries. In order to be accredited, a state must adopt by law or rule the substance of a number of NAIC model laws and rules relating to insurer solvency.

Accreditation of a state provides a benefit to insurers domiciled in that state. Because of accreditation, other accredited states accept Florida examination reports of Florida domestics. Other state laws may provide exemptions for insurers domiciled in accredited states; for example, Florida's insurance holding company law applies to Florida domestics and to insurers domiciled in non-accredited states. Florida relies on the accreditation process to assure itself that insurers domiciled in other accredited states are adequately regulated as to solvency.

Accreditation also provides a national system of solvency regulation, relying on each accredited state to regulate the solvency of its domestic insurers sufficiently to meet national standards. In the last several years, accreditation was seen as an alternative to the program of federal regulation of insurer solvency.

Risk-based capital is a method of financial review of insurance companies which measures the minimum amount of capital necessary to support their overall business operations, given the size and risk profile of the respective companies. The capital requirements generally are assessed against four types of risk: asset risk; credit risk, underwriting risk, and off-balance sheet risk.

Chapter 97-292, Laws of Florida, enacted the Risk-Based Capital for Insurers Act in 1997. The act essentially instituted reporting and disclosure requirements for risk-based capital levels for domestic insurers based on a formula adopted by the National Association of Insurance Commissioners (NAIC). Insurers are required to internally monitor trigger levels and respond as necessary. A comparison of the insurer's actual capital level and its risk-based capital levels may trigger any of several levels of regulatory action by the Department of Insurance or departmental supervision of corrective actions mandated on the insurer. Subsequently, the NAIC adopted the Risk-Based Capital for Managed Care Organizations. According to the Model Act, the risk-based formula was designed for use with provider-sponsored organizations, and other similar risk-bearing entities (e.g., hospitals, doctors, limited liability corporations, networks and dental practices).

Annual Reporting Requirements for Insurers and Health Maintenance Organizations

Section 624.424, F.S., requires insurers to file an annual statement for the preceding calendar year on or before March 1, and quarterly statements for the periods ending March 31, June 30, and September 30 within 45 days after each such date. Each insurer's annual statement must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist. The department may by rule require reports or filings required under the Insurance Code to be submitted on a computer-diskette compatible with the electronic data processing equipment specified by the department.

Each health maintenance organization (HMO) is required to file annually within three months after the end of its fiscal year a report with the department that includes a financial statement, an audited financial statement, and other information required under the provisions of s. 641.26, F.S.

Investments of Foreign Aliens or Alien Insurers

A foreign or alien insurer is considered to be commercially domiciled in Florida if it has written an average of 25 percent or more of its direct premiums in Florida than it has written in its state of domicile for the preceding 3 years and the direct premiums represent 55 percent of its total direct premium written countrywide during the 3 preceding years.

Domestic insurers and commercially domiciled insurers ceding directly written risks of loss are required to file a report with the department concerning that each reinsurance treaty within 30 days of receipt of a cover note or similar confirmation of coverage.

Chapter 625 prescribes the accounting procedures and investment requirements for insurers. Part I does not expressly apply to commercially domiciled insurers, rather it applies to insurers. Typically the state of domicile for an insurer establishes the accounting procedures and requirements for an insurer. Part II of ch. 625, except for s. 625.340, F.S., applies only to domestic insurers and commercially domiciled insurers. Section 625.340, F.S., provides that the investment portfolio of a foreign or alien insurer is permitted by the laws of its domicile, if it is of a quality substantially as high as that required under this chapter. for similar funds of like domestic insurers.

Florida Hurricane Catastrophe Fund

In 1993, the Legislature created the Florida Hurricane Catastrophe Fund to provide mandatory form of reinsurance for residential property insurers in the state (s. 215.555, F.S.). The fund is established within the State Board of Administration and is a tax-exempt source of reimbursement to property insurers for excess losses due to hurricanes. The fund reimburses insurers for 45, 75, or 90 percent of their hurricane losses, as selected by an insurer, above a certain retention, which is $3.1 billion for all insurers combined.

The definition of covered policy, for the purposes of the fund, includes a policy covering the peril of wind removed from the Florida Residential Property and Casualty Joint Underwriting Association or from the Florida Windstorm Underwriting Association, by an authorized insurer under the terms and conditions of an executed assumption agreement between the authorized insurer and either such association. Covered policy does not include any reinsurance agreement.

The Florida Residential Property and Casualty Joint Underwriting Association (RPCJUA) acts as an insurer of last resort in providing residential property insurance statewide, insuring all perils covered under a standard residential policy (except in areas eligible for coverage through the Florida Windstorm Underwriting Association, where a RPCJUA policy excludes windstorm coverage). The RPCJUA must charge the same rates charged by the insurer with the highest rates in the county, among the top twenty insurers in the state by premium volume. In recent years, legislation has been enacted which has authorized the RPCJUA to reduce the number of policies in the RPCJUA by providing a variety of financial incentives for admitted insurers to take-out the policies. Since the inception of the depopulation program in 1995, the RPCJUA has approved 33 insurance companies to remove more than 1.2 million policies through its take-out programs.

Annual Report

The department is required to submit an annual report, for the preceding calendar year, to the Legislature and the Governor. The report includes an analysis and summary of the state of the insurance industry in Florida, trends, and other data reported by insurers, as provided in s. 624.315, F.S. In addition, the department is required to provide the receipts and estimated expenses of the department for the year.

Surplus Requirements for Property and Casualty Insurers

Section 624.408(1)(b), F.S., provides alternative surplus requirements for insurers holding a certificate of authority on December 1, 1993. Rather than requiring $4 million, as provided by subparagraph (a) 5, an insurer may phase in the $4 million requirement over a period of years, beginning on December 31, 1999, and ending on December 31, 2004.

Serving Process

Under ss. 624.422, 624.423, and 48.151, F.S., the Insurance Commissioner is the process agent for service of process on an insurer. Presently, service process upon the Insurance Commissioner, as the process agent of the insurer is made by serving copies in triplicate of the process upon the Insurance Commissioner or other person in charge of his or her office. Upon receipt, the Commissioner is required to file one copy in his or her office, return one copy with his or her admission of service, and promptly file one copy of the process by registered or certified mail to the person last designated by the insurer to receive it.

Upon receipt of such service for nonresident agents and nonresident independent or public adjusters, the Insurance Commissioner is required to send one of the copies of the process by registered mail to the defendant agent at his or her last address of record with the department. Service of process upon the Insurance Commissioner as process agent of warranty associations is also provided in s. 634.161, F.S.

Recently, there has been a large increase in service of process requests which appear to be the result of the Florida Supreme Court decision in Nationwide v. Pinnacle Medical (753 So. 2d 55, Feb. 2000) which invalidated the requirements of s. 627.736 (5), F.S., regarding binding arbitration of claims by medical providers who have treated motor vehicle crash victims under the no-fault law. Following this decision, a large number of providers are filing suits in small claims court. Because of the problems using the Small Claims Court Rules and the time constraints involved in the statutorily required use of certified mail by the Insurance Commissioner, insurers are occasionally receiving default judgments due to failure to attend a pre-trial hearing, of which the insurer was unaware.

Pursuant to Small Claims Court Rule 7.09, the pre-trial hearing must be set no later than 35 days following the filing of the action. However, unlike the Rules of Civil Procedure (such as Rule 1.200(b)) which requires 20 days actual notice of a pre-trial conference) the Small Claims Court Rules do not appear to establish a specific minimum notice requirement or timeframe for the service of the initial Summons and Notice to Appear. As a result, in many instances, judges

require plaintiffs to demonstrate only that reasonable notice has been provided (for example 5 days from service) prior to entry of a default against a defendant.

Presently, the Department of Insurance is seeking a revision to the Small Claims Court rules and also requesting that the Legislature build greater flexibility into the service of process statutes so that the department can find alternatives to provide notice of service to insurers by using electronic or other means. In the past year, the department's service of process workload has increased 67 percent in the number of pleadings served.

Minimum "Down Payment" for Auto Insurance

Current law requires that owners of motor vehicles obtain personal injury protection (PIP) coverage and property damage liability coverage of $10,000 each. Section 627.7295(7), F.S., provides that an applicant for a new private passenger motor vehicle insurance policy is required to make a down payment equal to at least 2 months' premium on the policy. This section also prohibits the insurer from canceling the policy for non-payment of premium during the first 60 days coverage, with certain exceptions. These provisions are intended to help enforce mandatory insurance requirements, by preventing persons from binding coverage merely to show proof of insurance at the time of registration of a vehicle.

There are several exceptions to the 2-month minimum down payment requirement, including renewal of a policy, replacement of a policy by an insurer in the same "insurer group," purchase of coverage for an additional vehicle with the insurer or an insurer in the same insurer group, and policies issued to military personnel.

One exception applies when all premium payments are paid pursuant to a payroll deduction plan or an automatic electronic funds transfer plan from the policyholder, provided that the first payment is made by cash, check, or money order.

Another exception applies if all payments to an insurer are paid pursuant to an automatic electronic funds transfer payment plan from an agent and if the policy includes, at a minimum, $10,000/$20,000 in bodily injury liability coverage, as well as mandatory PIP and property damage coverage. It is believed that non-payment cancellations are not as great a problem for full coverage policies.

Premium Financing; Maximum Interest Rate for Periodic Payments

Under the provisions s. 627.901, F.S., (applicable to insurance agents) and s. 627.902, F.S., (applicable to insurers), an agent or insurer may impose a reasonable service charge for financing insurance premiums. The service charge may not exceed $12 per year for any premium balance greater than $220. In lieu of such service charge, an agent or insurer may charge a rate of interest not to exceed 18 percent simple interest per year *on the unpaid balance*. If the service charge or interest rate is greater than this amount, the insurer or agent is subject to part XV of ch. 627, F.S., which provides for the regulation of premium finance transactions by the Department of Insurance.

By specifying that the maximum 18 percent interest rate per year is on the unpaid balance, it may be unclear whether an insurer or agent can charge a *level* interest rate each month, as compared to a *declining* interest rate calculation, even though the total amount of interest paid over a 12-month period is the same. The following chart compares the two methods:

Payment #	Unpaid Balance	Premium Payment	Interest Charge on "Unpaid Balance" @ 18% Annualized	Level Interest Charge @ 18% annualized
1	$0	$100.00	0	$8.25
2	$1,100.00	$100.00	$16.50	$8.25
3	$1,000.00	$100.00	$15.00	$8.25
4	$ 900.00	$100.00	$13.50	$8.25
5	$ 800.00	$100.00	$12.00	$8.25
6	$700.00	$100.00	$10.50	$8.25
7	$600.00	$100.00	$9.00	$8.25
8	$500.00	$100.00	$7.50	$8.25
9	$400.00	$100.00	$6.00	$8.25
10	$300.00	$100.00	$4.50	$8.25
11	$200.00	$100.00	$3.00	$8.25
12	$100.00	$100.00	$1.50	$8.25
Total Payments		$1200.00	$99.00	$99.00

Regulation of Insurance Administrators

Section 626.8805, F.S., requires any person who acts as an administrator in connection with an authorized commercial self-insurance fund or with an insured or self-insured program which provides life or health coverage to obtain a certificate of authority from the Department of Insurance. Part VII of ch. 626, F.S., delineates fidelity bond, record keeping, and other requirements for administrators or third-party administrators.

Reporting Requirements for Workers' Compensation and Private Passenger Automobile Insurers

Section 627.914, F.S., requires workers' compensation insurers and self-insurance funds to file certain premium, dividend, and loss data to the Department of Insurance by April 1 of each year. This requirement was established in 1978, when the department used this information to evaluate rates. Since then, statistical agents and rating organizations have collected calendar-year accident data, which has been used in ratemaking since the early 1980's. The department has indicated that it no longer uses the information provided by insurers because the validity of the data is questionable and the same information is available from statistical agents and rating organizations.

Presently, each insurer transacting private passenger automobile insurance in Florida is required to file certain information with the Department of Insurance on or before July 1 of each year, as provided in s. 627.915, F.S. The report contains information related to premiums earned, loss

development factors, dividends, expenses for agents' commissions, and profit and contingency factors used in rate filings.

III. Effect of Proposed Changes:

Section 1. Amends s. 215.555, F.S., relating to the Florida Hurricane Catastrophe Fund, to revise the definition of "covered policy" to include a transferred policy and to provide a definition of "transferred policy."

The term, "transferred policy," is defined to mean a policy originally written by an authorized insurer or joint underwriting association which has been assumed by another authorized insurer, pursuant to an assumption and reinsurance agreement. To be considered a transferred policy, the following conditions must be met: 1) the policy was covered under a contract with the fund immediately prior to the assumption; 2) the department has approved the assumption and reinsurance agreement in advance; 3) the assuming insurer is obligated to pay 100 percent of the losses of the policy; 4) policyholders are provided with an assumption notice that identifies the assuming insurer; 5) all premiums and assessments due to the fund from the ceding insurer have been paid in full; 6) the assumption agreement provides for the full payment of any premiums due to the fund for the transferred policies for the balance of the contract period; 7) the assumption agreement identifies policies transferred and provides for the collection of any data necessary for the fund to determine reimbursement under the contract; 8) the assumption agreement provides for the transfer of all policies covered under the existing contract with the fund (for authorized insurers only); 9) the assumption agreement provides for the full payment of any future assessments associated with the exposure from the transferred policies; and 10) the assumption agreement is filed with the fund by the assuming insurer within 15 days after the approval by the department.

Section 2. Amends s. 624.307, F.S., relating to the general powers of the department to allow the department to specify by rule the format with respect to filings required under the Insurance Code to be furnished by a person issued a license or certificate of authority. The rules may include provisions governing electronic methodologies for use in furnishing such filings. The department must use generally accepted data systems, may not require information other than that required by statute, and must minimize the costs and administrative burden on insurers.

Section 3. Section 624.315, F.S., is amended to revise the contents of the annual report submitted to the Legislature and the Governor to exclude information concerning insurers' renewal ratios, variations of premiums charged compared to rates adopted by the Insurance Services Office, an analysis of policy size limits, insureds' selection of claims made versus occurrence coverage, trends, and loss ratios.

Section 4. Section 624.408, F.S., is amended to delete an obsolete reference to surplus requirements for any property and casualty insurer holding a certificate of authority on December 1, 1993.

Section 5. Section 624.423, F.S., relating to service of process, is amended to eliminate the mandatory use of registered or certified mail to provide a copy of the service to the insurer, and to allow the use of other methods of expeditious delivery determined appropriate by the

department, provided that admission of service is accomplished. The department is authorized to adopt by rule the method to be used in forwarding the process to the person designated by the insurer.

Section 6. Section 624.424, F.S., is revised to exempt an authorized insurer that has direct premiums in Florida of less than $1 million in any year and less than 1,000 policyholders or certificate holders of directly written policies nationwide at the end of the calendar year from submitting a statement of opinion on loss and loss adjustment expense. Any insurer subject to the exemption would be required to file an affidavit with the department by March 1 of the following year to which the exemption applies. This exemption would not apply for any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more.

Section 7. Section 624.4435, F.S., (Assets of insurers; reporting requirements) is transferred and renumbered as s. 624.4242, F.S. This section currently requires each domestic insurer to report to the department a material acquisition of assets, but is within the group of sections that otherwise apply only to multiple-employer welfare arrangements. The bill renumbers the section to clarify that it applies to domestic insurers.

Section 8. Section 625.340, F.S., relating to investments of foreign or alien insurers, is revised to require foreign insurers that are *commercially domiciled* as defined in s. 624.075, F.S., to comply with parts I and II of ch. 625, F.S. Presently, commercially domiciled insurers are required to follow the provisions of part II, except for the provisions of s. 625.340, F.S. Commercially domiciled is currently defined to mean that the insurer has written an average of 25 percent or more of direct premiums in this state than in its state of domicile during the preceding 3 years and the direct written premiums represent more than 55 percent of its total direct premiums written countrywide for the same period.

Section 9. Section 626.742, F.S., is amended to allow the Treasurer to use the most expeditious method of delivery, as determined by the department to send copies of the service process to a nonresident agent rather than mandating the use of registered or certified mail.

Section 10. Amends s. 626.8736, F.S., to allow the Treasurer to use the most expeditious method of delivery, as determined by the department, to send copies of the service process to a nonresident independent or public adjuster. Currently, such notices must be sent registered or certified mail.

Section 11. Amends s. 626.8805, F.S., to exempt certain third-party administrators from the certificate of authority requirements if the administrator has its principal place of business in another state, the administrator is not soliciting business as an administrator in this state, and in the case of any group policy or group plan of insurance serviced by an administrator, the lesser of 5 percent of their certificate holders, or 100 certificate holders reside in Florida.

Section 12. Amends s. 626.907, F.S., relating to service of process on unauthorized insurers, to allow the Treasurer to use registered or certified mail, or other methods of expeditious delivery, provided that proof of service and admission of service are accomplished, (eliminating the mandatory use of registered mail).

Section 13. Amends s. 627.7295, F.S., to add an exception to the 2-month minimum down payment requirement for a new motor vehicle insurance policy. The exception would be for a policy issued pursuant to the transfer of a book of business by an agent from one insurer to another, provided that the policy includes at least $10,000/$20,000 in bodily injury liability coverage, as well as mandatory PIP and property damage coverage. It is believed that risks of non-cancellation are low when an agent transfers a "full coverage" policy from one carrier to another.

The bill also revises the current exemption that applies when all premium payments are paid pursuant to a payroll deduction plan or an automatic electronic funds transfer plan from the policyholder, provided that the first payment is made by cash, check, or money order. As amended, the first premium payment would be allowed, but not required, to be by cash, check, or money order.

Section 14. Amends s. 627.901, F.S., to allow an insurer or agent to charge a rate of interest or service charge when financing premium payments on a property or casualty insurance policy, which may be level amounts and subject to endorsement changes, that in the aggregate do not exceed 18 percent simple interest per year on the average unpaid balance as billed over the term of the policy. This language is intended to allow for a level interest rate charge, as compared to a declining interest charge, as illustrated in the chart in Present Situation, above. Section 627.901, F.S., applies to premium financing by an insurance agent, but the revisions would also apply to premium financing by an insurer under s. 627.902, F.S., due to the cross-reference in that section to the interest rate specified in s. 627.901, F.S.

Section 15. Amends s. 627.914, F.S., to require self-insurance funds be subject to rules and statistical plans promulgated by the Department of Insurance in the recording and reporting of loss, expense, and claims experience. The section also deletes the requirement that insurers report certain workers' compensation data to the Department of Insurance, which is duplicative of data that is submitted to the department by statistical agents for the insurers; and changes the date for a rating organization to submit an aggregate compilation of payrolls, premium, losses, and expense for all companies from April 1 to July 1 of each year, which will improve the quality and timeliness of the data.

Section 16. Amends s. 627.915, F.S., to eliminate the inclusion of loss development factors and profit and contingency factors used in the rate filing from the annual reporting requirements for private passenger automobile insurers.

Section 17. Amends s. 634.161, F.S., to eliminate the mandatory use of registered or certified mail to send copies of the service process to warranty associations, and to allow the use of other methods of expeditious delivery as determined by the department, provided that proof of service and admission of service is accomplished.

Section 18. Amends s. 641.19, F.S., to provide a definition for the term, "health care risk contract." This term is defined to mean a contract under which a person or entity receives consideration or other compensation in an amount greater than 1 percent of the HMOs annual gross written premium in exchange for providing the HMO a provider network and other services, which may include administrative services. Presently, an HMO is required to report

such contracts, if the contract is greater than 10 percent of the HMOs annual gross written premium.

Section 19. Amends s. 641.2018, F.S., to correct a cross-reference.

Section 20. Amends s. 641.26, F.S., to revise the deadline for filing the HMO annual report with the department from 3 months after the end of the year to April 1 and to expand the reporting requirements for HMOs that provide services under health care risk contracts.

Section 21. Creates s. 641.263, to provide risk-based capital requirements for HMOs. Terms used in risk-based capital are defined, including:

"Adjusted risk-based capital report," means a risk-based capital report which has been adjusted by the department in accordance with paragraph (2)(b).

"Corrective action" means an order issued by the department specifying corrective actions which the department has determined are required.

"Risk-based capital level" means an HMO's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital.

"Total adjusted capital" means the sum of the HMO's net worth (statutory capital and surplus), as determined in accordance with statutory accounting principles, and other items, if any, as the instructions provide.

Each HMO is required to file prior to April 1 of each year a report of its risk-based capital levels as of the end of the calendar year with the department and the National Association of Insurance Commissioners, and the insurance regulator in any state in which the HMO is authorized to conduct business, if the regulator has requested the report.

The risk-based capital for an HMO must be determined in accordance with the formula set forth in the risk-based capital report instructions adopted by the NAIC. The formula must consider and adjust for the covariance between asset risks, credit risks, underwriting risks, and all other business risks and such other relevant risks provided in the instructions.

The section provides that the Legislature finds that an excess of capital over the amount produced by the risk-based capital requirements contained in this section is desirable in the HMO business. The section provides that additional capital is used and useful to secure an HMO against various risks inherent in the business and not accounted for or only partially measured by the risk-based capital requirements contained in this section.

The department is authorized to adjust a risk-based capital report filed by an HMO that in the judgment of the department is inaccurate.

A company action level event includes the filing of a risk-based report that indicates that the total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company level risk-based capital.

If a company action level event occurs, the HMO is required to submit to the department a risk-based capital plan that identifies the conditions that contribute to the company action level event, a proposal of corrective actions the HMO intends to take to eliminate the company action level event, and financial projections for the succeeding 2 years (with and without the impact of the corrective actions). The HMO must also identify problems with the HMO's business including assets, business growth and associated surplus strain, mix of business, and use of reinsurance. This plan must be submitted within 45 days after the company action level event. In the event an HMO challenges the report, the tolling of the 45 days would begin after the notification that the challenge was rejected. The department has 60 days to notify the HMO that the plan must be implemented or if the plan is unsatisfactory.

If the plan is rejected, the HMO must submit a revised risk-based capital plan within 45 days after the notification from the department. If the HMO challenges the department's rejection of the plan and the HMO's challenge is rejected, the 45 days begins to toll upon notification of the rejection of the challenge.

A regulatory action level event includes the filing of a risk-based capital report that indicates that the HMO total adjusted capital is greater than or equal to its authorized control level risk-based capital but less than its regulatory action level risk-based capital; failure to file a risk-based capital plan by April 1; failure to submit a risk-based capital plan to the department within 45 days after a company action level event occurs; or notification by the department that the risk-based capital plan or revised plan is unsatisfactory and notification constitutes regulatory action level event, provided the HMO does not challenge that the determination or the challenge has been rejected; or failure of the HMO to adhere to the risk-based capital plan.

If a regulatory action level event occurs, the department must require the HMO to submit a risk-based capital plan, perform an examination or analysis of the assets, liabilities, and operations of the HMO, and issue a corrective order specifying the corrective actions that are necessary. The HMO must submit a risk-based capital plan within 45 days after the occurrence of the regulatory action level event.

An authorized control level event includes the filing of a risk-based capital plan that indicates that the HMO's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but less than its authorized control level risk-based capital; failure by the HMO to respond, in a manner satisfactory to the department, to a corrective order.

If an authorized control level event occurs, the department must take actions as are required under a regulatory control level event or take such actions that are necessary to cause the HMO to be placed under regulatory control under ch. 631, F.S. The HMO is entitled to such protections that are provided under the summary proceeding provisions of s. 120.574, F.S.

A mandatory control level event includes the filing of a risk-based capital report that indicates that the HMO total adjusted capital is less than its mandatory control level risk-based capital. If

such an event occurs, the department must take such action as deemed necessary to place the HMO under regulatory control, as provided in chapter 631, F.S. The HMO would be entitled to summary proceedings, as provided in s. 120.574, F.S. The department may delay action for up to 90 days after the mandatory control level event occurs, if the department finds that this event may be eliminated within the 90-day period.

The HMO would have a right to a confidential hearing at which time the HMO may challenge any determination or action of the department if any of the following events occurred:

1. Notification by the department of an adjusted risk-based capital report.
2. Notification by the department that the risk-based capital or revised plan is unsatisfactory and notification constitutes regulatory action level event with respect to the HMO.
3. Notification by the department that the HMO has failed to adhere to the risk-based capital plan and that the failure has a substantial adverse effect on the ability of the HMO to eliminate company level action level event.
4. Notification by the department of a corrective order.

The department is authorized to adopt rules to implement this section. The department is authorized to exempt an HMO from the risk-based capital provisions, if it writes direct business only in Florida, assumes no reinsurance in excess of 5 percent of direct written premium, and writes direct annual written premiums for comprehensive medical business of $2 million or less; or is a limited health service organization that covers less than 2,000 lives.

The section provides that there is no liability on the part of, and no cause of action can arise against, the commissioner or the department, or the employees or agents for any action taken by them in the performance of their duties under this section. All notices by the department to an HMO that may result in regulatory action are effective upon dispatch, if sent by registered or certified mail. If the notice is sent by any other means, it will be effective upon receipt by the HMO.

The section provides for a phase in of the risk-based capital requirements. For reports filed in 2002, 2003, and 2004 by an HMO for 2001, 2002, and 2003 annual statement data:

1. If a company action level event occurs, the department will take no regulatory action.
2. If a regulatory action level event as provided in subparagraphs (4)(a) 1., 2., or 3. occurs, the department will take action as required for a company action level event.
3. If a regulatory action level event as provided in (4)(a) 4., 5., 6., 7., 8., or 9. occurs or an authorized control level event occurs, the department must take the actions required for a regulatory action level event.
4. If a mandatory action level event occurs or an authorized control level event occurs, the department must take the actions required under an authorized control level event.

The Legislature intends that risk-based capital information be used solely by the department in monitoring the solvency of HMOs, and as to any need for possible corrective action. The

confidential risk-based capital information may not be used by the department for ratemaking, nor may it be admissible as evidence in any rate proceeding, or for use in setting appropriate premium levels or rate of return for any line of insurance. (The confidentiality of the HMO risk-based capital reports is provided in a separate bill, CS/SB 2082.)

Section 22. Amends s. 641.35, F.S., to require an HMO to provide reserves for claims arising for services provided to subscribers through a health service risk contract. This adjustment would not be required if obligations under such contracts are secured by a financial instrument acceptable to the department. This requirement would not apply to a contract with a provider when the contract is limited to services provided by such provider under the scope of that provider's license.

Sections 23, 24, and 25. Amends ss. 641.495, 817.234 , and 817.50, F.S, to correct cross-references.

Section 26. Repeals s. 641.2342, F.S., which requires an HMO to file financial statements of their contracted providers with the department, if such providers have assumed 10 percent or more of the HMO's risk.

Section 27. Provides that except as otherwise provided in this act, the act takes effect July 1, 2001.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Section 21 of the bill requires health maintenance organizations to file risk-based capital reports with the department. A separate bill, CS/SB 2082, provides for an exemption for such reports from the Public Records Law, ch. 119, F.S. While the state constitution provides that records and meetings of public bodies are to be open to the public, it also provides that the Legislature may create exemptions to these requirements by general law if a public need exists and certain procedural requirements are met. Article I, s. 24, Fla. Const. governs the creation and expansion of exemptions to provide, in effect, that any legislation that creates a new exemption or that substantially amends an existing exemption must also contain a statement of the public necessity that justifies the exemption. Article I, s. 24, Fla. Const. provides that any bill that contains an exemption may not contain other substantive provisions, although it may contain multiple exemptions.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Presently, HMOs are required to file quarterly and annual financial statements with the department. The elimination of the fourth quarterly report should result in some administrative savings for the HMOs. The HMOs would no longer be required to file financial statements of their contracted providers, if the providers have assumed 10 percent or more of the HMO's risk.

HMOs would be required to reserve in its annual actuarial certification for any risk which is down streamed to another entity and which exceeds 1 percent of the HMO's annual written premium.

Property and casualty insurers will experience cost savings associated with the elimination of reporting requirements that are obsolete, duplicative or unnecessary.

Insurers who have written less than $1 million in premiums in any calendar year and less than 1,000 policyholders or certificate holders of directly written premiums would no longer be required to submit an annual actuarial statement. Approximately 400 insurers would be eligible for this exemption. Third party administrators would be exempt from licensure if its principal place of business is located in another state, it was not soliciting business in Florida, and if less than 5 percent or 1,000 policyholders or certificate holders reside in Florida. The number of potential exempted administrators is indeterminate.

Foreign insurers that are commercially domiciled, as defined in s. 624.075, F.S., would be required to comply with parts I and II of ch. 625, F.S. According to the department, this may impact 20 carriers.

The implementation of the risk-based capital is not expected to impose any significant costs for most HMOs and a minimal cost for HMOs that are not currently using the risk-based capital software.

The changes regarding calculation of interest when an insurer or agent finances a premium would allow for level interest charges each month, as compared to declining interest charges, but the total interest rate that may be charged to a policyholder by an insurer over a 1-year period is not changed (18 percent simple interest per year).

C. Government Sector Impact:

By eliminating the mandatory use of registered or certified mail for the delivery of the notice of service process, the department expects to adopt a more cost-effective means to provide notice delivery.

It is not anticipated that the implementation of the risk-based capital will impose any significant additional costs on the department.

VI. Technical Deficiencies:

None.

VII. Related Issues:

CS/SB 2082 provides a public records exemption for risk-based capital reports, plans, related documents, hearings, and information of health maintenance organizations.

VIII. Amendments:

None.