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HOUSE OF REPRESENTATIVES
COMMITTEE ON
INSURANCE
ANALYSIS

BILL #: HB 1373

RELATING TO: Solvency of Insurers and Health Maintenance Organizations

SPONSOR(S): Representative Negron

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) INSURANCE YEAS 13 NAYS 0
(2) COUNCIL FOR COMPETITIVE COMMERCE
(3)
(4)
(5)

I. SUMMARY:

The bill would revise various provisions relating to the authority of the Department of Insurance (Department) in regulating the solvency of insurers and health maintenance organizations (HMOs) and other managed care entities, the transfer of HMO payment obligations to other entities, and the payment of dividends or distributions by HMOs.

The grounds for placing an insurer under administrative supervision would be expanded by defining the phrase "unsound condition" to include the grounds for rehabilitating a company through a delinquency proceeding. An insurer would be authorized to seek review under the Administrative Procedure Act of an order of the Department placing the insurer under administrative supervision. The order would not be stayed during the review. Actions taken by the Department once the insurer is under administrative supervision could not be challenged by the insurer under the Administrative Procedure Act.

HMOs would be required to include in the actuarial certification of their annual report an assurance that they have adequately reserved for liabilities associated with transfers of payment obligations. They would not be permitted to exclude liabilities associated with these transfers if the provider has not received payment, unless the payment obligations are secured by a financial instrument. HMOs would no longer be required to file a quarterly report for the 4th quarter.

HMOs would be prohibited from paying dividends if payment would create negative retained earnings. Dividends equal to or less than the greater of 10 percent of retained earnings or prior year net income would be permitted if surplus is 115 percent of the minimum requirement, and the Department is notified 30 days prior to payment. Criteria also would be established for the Department to consider before approving certain dividend or distribution payments.

There may be a positive fiscal impact on state agencies and HMOs. Please see Section III., FISCAL ANALYSIS AND ECONOMIC IMPACT STATEMENT.

On February 20, 2002, the Committee on Insurance approved the bill with six amendments. The amendments are traveling with the bill. Please see Section VI., Amendments or Committee Substitute Changes.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1. Less Government Yes [] No [X] N/A []

While the bill would eliminate a quarterly report HMOs must now file, it would expand the authority of the Department to place an insurer under administrative supervision and limit the authority of an insurer to challenge Department actions after being placed under administrative supervision. It would also place additional restrictions on the payment of dividends or distribution by HMOs.

2. Lower Taxes Yes [] No [] N/A [X]

3. Individual Freedom Yes [] No [] N/A [X]

4. Personal Responsibility Yes [] No [] N/A [X]

5. Family Empowerment Yes [] No [] N/A [X]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Insurers and Health Maintenance Organizations

Insurers are regulated under numerous sections of the Insurance Code, including Chapter 624, as to authority to transact insurance and solvency requirements; Chapter 625, as to accounting and investments; Chapter 626, as to insurer representatives; Chapter 627, as to rates and contracts; and Chapter 631, as to insurer insolvencies.

Health maintenance organizations (HMOs) in Florida are jointly regulated under parts I and III of Ch. 641, F.S., by the Agency for Health Care Administration (Agency) and the Department of Insurance (Department). The Agency administers HMO quality-of-care practices under part III, while the Department regulates contractual, financial, and other operational requirements relating to HMOs under part I.

Administrative Supervision

The Department may place an insurer under administrative supervision[1] if upon examination or at any other time the Department determines that:

- the insurer is in "unsound condition";[2]

[1] "Administrative supervision" is an administrative proceeding initiated by the Department directing an insurer that is exceeding its powers or is of unsound condition to take certain corrective actions. This is in contrast to a "receivership," a judicial proceeding in which a court places an insolvent insurer under the control of the Department to preserve its assets for the benefit of affected parties.

[2] "(U)nsound condition" includes impairment or insolvency, failure to comply with a department order, hazardous business practices, failure to submit to examination, concealing or removing records, transferring property or willfully violating any law of this State.

- the methods or practices of the insurer render the continuance of its business hazardous to the pubic; or

- the insurer has exceeded its powers granted under its certificate of authority or applicable law.[3]

Fifteen days from the date placed under administrative supervision, the insurer must submit a corrective action plan to the Department.[4] If the insurer does not submit one, then the Department can impose a plan. The Department may require insurers to obtain Department approval before engaging in certain activities, including disposing of any assets, investing funds, lending or withdrawing funds, incurring debts, or merging with another company.

The insurer may contest an action or proposed action by the supervisor on the ground that it would not result in improving the condition of the insurer. The request will stay the action pending reconsideration by the Department. If the Department upon reconsideration upholds the action, then the stay will be lifted. The insurer would then be entitled to challenge the action of the Department in an administrative hearing under the Administrative Procedure Act.[5]

HMO Reporting and Transfer of Payment Obligations ("Downstreaming")

Every HMO must file with the Department an annual report including various financial statements and contract and claims information, and an actuarial certification that:

- the HMO is actuarially sound (which certification considers the rates, benefits, and expenses of, and any other funds available for payment of obligation of the organization);

- the rates charged are actuarially adequate to the end of the period for which rates have been guaranteed;

- adequate provision is made for incurred, but not reported, claims and claims reported, but not fully paid.

The annual report must be filed within 3 months after the end of its fiscal year. In addition, every HMO must file a quarterly report within 45 days after each of its quarterly reporting periods. Florida is the only state requiring HMOs to file a report for the 4th quarter.

At times, HMOs contract with and compensate unregulated entities to provide healthcare services to the HMO's subscribers such as paying claims. This is done through a capitation or other arrangement and is referred to as "downstreaming." The HMOs may then reduce their recorded liability for these obligations on the basis that the payment responsibility has been transferred. If the unregulated entity becomes unwilling or unable to satisfy these obligations, then the HMO is responsible for the liability.[6]

HMO Dividends and Distributions

[3] Section 624.81(2), F.S.
[4] For good cause shown, the Department may extend the 15-day time period. Section 624.81(3), F.S.
[5] Section 624.84, F.S. The Administrative Procedure Act is Ch. 120, F.S.
[6] Section 641.3154(3),F.S

Dividends paid by HMOs cannot exceed 10 percent of their retained earnings plus 100 percent of its prior year net income.[7] As a result, HMOs may pay dividends in the amount of their prior year net income even though their accumulated retained earnings account is negative. Some HMOs elect to be taxed in a manner similar to partners of a general partnership. Therefore, shareholders of these S-corporations have a tax incentive to annually distribute the HMO's prior year taxable income[8] because the shareholders pay income tax on the HMO's taxable income whether or not distributed.

EXAMPLE:

Net income – 1998	2,360,484
Retained earnings (deficit), 1/1/99	(4,622,019)
Net income - 1999	630,853
Dividends paid - 1999	(2,976,627)
Retained earnings (deficit), 12/31/99	(6,967,793)

Under this example, the HMO may distribute $2,360,484 even though it had no accumulated retained earnings in the current year. In this case, the HMO distributed an even greater amount than it had earned in the current year.

C. EFFECT OF PROPOSED CHANGES:

Administrative Supervision

The grounds for placing an insurer under administrative supervision would be expanded by defining the phrase "unsound condition" to include the grounds for rehabilitating a company through a delinquency proceeding.

An insurer would be authorized to seek review under the Administrative Procedure Act of an order of the Department placing the insurer under administrative supervision. The order would not be stayed during the pendency of the review. Actions taken by the Department once the insurer is placed under administrative supervision would not be subject to review under the Administrative Procedure Act.

HMO Reporting and Transfer of Payment Obligations ("Downstreaming")

HMOs would no longer be required to file a report for the 4th quarter. HMOs would be required to include in the actuarial certification included in their annual report an assurance that they have adequately reserved for liabilities associated with transfers of payment obligations to downstream entities through capitation or other agreements. They would not be permitted to exclude liabilities associated with these transfers for which the provider has not received payment, unless the payment obligations are secured by a financial instrument.

HMO Dividends and Distributions

HMOs would be prohibited from paying dividends or distribution if payment would create negative retained earnings. Dividends equal to or less than the greater of 10 percent of retained earnings or prior year net income would be permitted if surplus is 115 percent of the minimum requirement, and the Department is notified 30 days prior to payment. Criteria also

[7] Section 641.365(1), F.S.
[8] Section 641.365(1), F.S.

would be established for the Department to consider before approving a dividend or distribution payment by an HMO in excess of the maximum amount.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends paragraph (b) of subsection (4) of s. 624.404, F.S., to replace the term "approved reinsurer" with a reference to "acceptable reinsurers as defined in s. 624.610(3)(a), (b) and (c)," in definition of a "fronting company."

Section 2. Amends subsection (2) of s. 624.80, F.S., to expand and define the criteria the Department is to use to determine whether an insurer is in "unsound condition."

Section 3. Amends subsection (1) and (6) of s. 624.81, F.S., to establish the authority of the Department to apply the administrative supervision provisions of Part VI, Chapter 624, F.S. without the insurer's consent; and to authorize the Department to promulgate implementation rules consistent with the certain model rules of the National Association of Insurance Commissioners (NAIC).

Section 4. Amends s. 624.84, F.S., to provide that an insurer would be authorized to seek review under the Administrative Procedure Act of an order of the Department placing the insurer under administrative supervision. The order would not be stayed during the pendency of the review. Actions taken by the Department once the insurer is placed under administrative supervision would not be subject to review under the Administrative Procedure Act.

Section 5. Amends paragraph (f) of subsection (1) and subsections (3) and (8) of s. 641.26, F.S., to require HMOs to include in their annual actuarial certifications assurance that they have adequately reserved for liabilities associated with downstream risk that are required by s. 641.35(3)(a), F.S., proposed by the bill. The bill would eliminate the requirement for HMOs to file a 4th quarter report, and specifies the due dates for the filing of their 1st, 2nd, and 3rd quarter reports. The bill also requires HMOs to file quarterly reports and the annual report with the NAIC, and to pay fees assessed by the NAIC.

Section 6. Amends paragraph (a) of subsection (3) of s. 641.35, F.S., to require HMOs to exclude liabilities associated with transfers of payment obligations to third parties for which the provider has not received payment, unless the payment obligations are secured by a financial instrument

Section 7. Amends subsections (1) and (2) of s. 641.365, F.S., to provide that HMOs may not pay dividends or distributions if their retained earnings would be less than zero and to place limits on HMO dividends or distributions similar to those applied to domestic stock insurers under s. 628.371, F.S.

Section 8. Provides for an effective date of October 1, 2002.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Indeterminate savings. There would be a revenue savings of an indeterminate amount associated with a workload reduction by eliminating the requirements that HMOs file a report for the 4th quarter.

2. Expenditures:

Minimal indeterminate expense to the Department would be associated with adopting certain rules.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There will be a revenue savings for HMOs since they will no longer be required to file a 4th quarter report.

HMOs may incur a cost by having to provide a financial instrument assuring their payment when they enter into a capitation or other agreement to transfer payment obligations to an unregulated entity.

D. FISCAL COMMENTS:

None.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

The bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority of counties or municipalities to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

The bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

The Department would be authorized to adopt rules consistent with the NAIC's 1997 "Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition."

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On February 20, 2002, the Committee on Insurance adopted six amendments that are traveling with the bill. The amendments are as follows:

Amendment 1, with title, by the Committee on Insurance (page 4 , lines 7 through 21): The amendment would restore current law allowing an insurer to contest being placed under administrative supervision. The amendment also would provide that a review under the Administrative Procedure Act does not operate as an automatic stay of the order.

Amendment 2 by the Committee on Insurance (page 6, line 18, through page 7, line 2): The amendment would:

- replace the term "capitation or other contractual arrangement" with "health care risk contract" to more accurately reflect the type of contract;
- revise the terms of the proposed waiver of liability by permitting a waiver not only when the HMO secures a financial instrument acceptable to the Department, but also when the HMO has an escrow or withhold agreement approved by the department to pay the claims; and
- provide an exception for contracts with sole providers where the contract is limited to services provided under the scope of the health care license.

Amendment 3 by the Committee on Insurance (page 7, line 26): The amendment would limit the proposed prohibition against payment of dividends or distributions through the HMO's accumulated retained earnings account when it is negative, by allowing payment from this account if the insurer receives prior written approval from the Department.

Amendment 4 by the Committee on Insurance (page 9, line 8): The amendment would remove the term "Industrywide financial conditions" and replaces it with "History of capital contributions" to take into account past retained earnings when reviewing payment of dividends or distributions.

Amendment 5, with title, by the Committee on Insurance (page 9, between lines 13 and 14): The amendment would include a definition of "Health care risk contract" for purposes of the Health Maintenance Organization Act, Part I of Chapter 641, F.S.

Amendment 6 by the Committee on Insurance (page 3, line 30 through page 4, line 4): The amendment would further delineate the proposed authorization for the department to adopt rules, specifically to define standards of a hazardous financial condition and corrective action consistent with the National Association of Insurance Commissioner's (NAIC) Model Regulation.

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Monique H. Cheek	Stephen Hogge