HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 831
SPONSOR(S): Carassas, Co-Sponsor Gannon
TIED BILLS: **IDEN./SIM. BILLS:** SB 2518

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Regulation (Sub)	9Y, 0N	Cheek	Schulte
2) Insurance		Cheek	Schulte
3) Commerce			
4) Commerce & Local Affairs (sub)			
5) Appropriations			

SUMMARY ANALYSIS

HB 831 changes various provisions relating to insurance company solvency. The bill makes the following major changes:

- Requires that transactions between affiliated parties of an insurer be in good faith, honest, reasonable, and disclosed for approval to the company's board of directors;
- Prohibits an affiliated party from self-enrichment by unfair terms or through receipt of unreasonable fees;
- Prohibits the loaning of funds to officers, directors, or stockholders of specialty insurance entities;
- Disallows a method of leverage that an insurer could use to increase its premium volume beyond safe limits;
- Provides an additional option for reinsurers to use secure letters of credit;
- Eliminates the need to make regulatory filings for organizational changes where there is no change in control or change in officers or directors; and
- Establishes risk-based capital requirements for health maintenance organizations, to take effect January 1, 2006.

The bill does not appear to have a substantial state or local government fiscal impact.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[]	N/A[x]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[]	N/A[x]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[]	No[]	N/A[x]

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

B. EFFECT OF PROPOSED CHANGES:

Background

Enforcement and Regulatory Activities by the Department of Financial Services and the Office of Insurance Regulation

Under s. 624.310, F.S., the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR) may take disciplinary action against a licensee or an affiliated party of a licensee and such persons may be removed from participating in the affairs of an insurer. Effective January 7, 2003, the Department of Insurance was transferred to the Department of Financial Services and to the Office of Insurance Regulation (Ch. 2002-404, L.O.F., "the 2002 act"). CS/CS/SB 1712 makes changes to the Insurance Code to conform to the 2002 act. Under CS/CS/SB 1712, both the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR), will exercise the powers under s. 624.310, F.S., but only with regard to the licensees that they each regulate, affiliated parties of such licensees, and unlicensed persons within their respective jurisdictions.

Disciplinary action may include issuing cease and desist orders, ordering the removal of affiliated parties, suspending or revoking the rights and privileges of the licensee, or imposing administrative fines against any person who violates the Insurance Code. An affiliated party who is removed or prohibited from participation in the affairs of a licensee may petition DFS or OIR for modification or termination of the removal, restriction, or prohibition. S. 624.310(4)(g), F.S. An "affiliated party" is defined to mean any person who directs or participates in the affairs of a licensee and who is a director, officer, employee, trustee, committee member, or controlling stockholder of a licensee, other than a controlling stockholder which is a holding company, or an agent of a licensee or a subsidiary or service corporation of the licensee. A "licensee" means a person issued a license or certificate of authority or approval under the Insurance Code or registered under the Code. However, the affiliated party is not eligible for such modification or termination unless given express authorization by DFS or OIR.

According to representatives with OIR and DFS, insurance companies quite frequently establish affiliated entities to provide services to the insurer. The services provided may include claims servicing, policy administration, premium collection, premium financing, investment management services, accounting services or other administrative or management services. Specific disclosure requirements and guidelines as to the agreements between insurers and affiliated parties are necessary, according to these representatives, in order to ensure that the affiliated entities are not unjustly enriched for the services they provide and to preserve and protect the assets of the insurer. Also, specific requirements are needed for officers, directors and stockholders of insurers to comply with affiliated party transactions. These representatives assert that many examples can be drawn from insolvencies of

other insurers and from failed companies such as Enron and Worldcom which would indicate that restrictions, prohibitions, and disclosures governing affiliated party transactions are justified.

An example of the problems related to affiliated party agreements with insurers recently occurred regarding the insolvency of a Florida automobile insurer, Aires Insurance Company (Aires), which was placed in liquidation in November 2002. According to DFS and OIR officials, the financial statements filed by Aries prior to January 7, 2003, reported that Aries had a number of affiliate companies. Included among these were a managing general agent, an adjusting company, multiple premium finance companies, a computer services company, and a collections company. Aries had substantial business transactions directly and indirectly with each of these entities. When Aires was placed in liquidation, the company's managing general agent owed several million dollars to Aires, which has not been repaid. Additional amounts are owed to Aries by other affiliates, which also have not been repaid. In motions filed with the court during the receivership process, entities which were not reported by Aries as affiliates have asserted that they are, in fact, affiliates. According to a recent *Florida Trend* magazine article, the special receiver overseeing the Aires liquidation is trying to determine what happened to "tens of million of dollars of premiums collected by the affiliates." (see *Florida Trend*, February 2003) Two affiliates collected $50 million in commissions and fees alone from Aries, and, according to the article, that amount is "in the abuse category." The article stated that the cost of Aires insolvency will approach $140 million and the "mismanagement and abuse on the part of Aries' owners and managers also hastened the company's collapse."

Solvency of Insurers

Under current law, there are specified procedures utilized by insurance regulators when it is determined through financial reports, examinations, or other sources that an insurance company has failed certain solvency tests or is otherwise in unsound financial condition. According to DFS, there were a total of 17 Florida domestic insurers that became insolvent and were placed in liquidation over the past 5 years. The company may be placed under administrative supervision, however, when such protections fail, DFS may seek to be appointed as the Receiver of an insurance company through a judicial proceeding (e.g., a delinquency proceeding) for the purpose of rehabilitating an impaired insurer or, if rehabilitation is unsuccessful or otherwise inappropriate, liquidating the insolvent company. The department, as Receiver, is placed in control of the impaired or insolvent insurer. If the assets of liquidated insurers are not sufficient to meet their obligations to policyholders, then the appropriate guaranty fund must levy assessments against other insurers to pay these obligations. State law provides for the "sole and exclusive method of liquidating, rehabilitating, reorganizing, or conserving an insurer."

Examination of Insurers

The department (now, Office of Insurance Regulation) has the authority pursuant to s. 624.316, F.S., to "examine the affairs, transactions, accounts, records, and assets of each authorized insurer . . . as often as it deems advisable." These so-called "desk exams" may occur any time the department deems it necessary to protect policyholders and in the public interest. The law requires the department (office) to examine each domestic insurer not less frequently than once every 3 years, and all insurers must be examined on a schedule that depends on the length of time they have held a certificate of authority.

The department (now, the Financial Services Commission) must also adopt rules providing that, upon the agreement between it and the insurer, an examination may be conducted by an independent certified public accountant (CPA), an actuary, and a reinsurance specialist. Such rules shall provide that no agreement is required if the department (Comm.) suspects criminal misconduct on the part of the insurer; that the department must provide the insurer with a list of three firms acceptable to the department from which the insurer must make a selection to conduct the exam; the insurer must pay for the exam directly to the firm performing the exam in accordance with the agreed upon rates and terms; and, if the exam is conducted without the consent of the insurer, the insurer must pay all reasonable charges of the exam, if a finding is made of impairment, insolvency, or criminal misconduct

on the part of the insurer. Also, the department is authorized to conduct "investigations of insurance matters . . . as it deems proper."

The Insurance Code currently provides restrictions for how much in premium dollars an insurer can write against its policyholder surplus. According to the Office of Insurance Regulation, it is commonly referred to as the "writing ratio restrictions." For example, if Insurer A owns a subsidiary insurer (Insurer B), then a portion or all of Insurer's B surplus can be included in Insurer's A surplus. Since writing ratios are calculated by dividing premiums written by surplus, then Insurer A would currently be allowed to write more premiums than they would if they didn't own Insurer B. This causes Insurer A to be more highly leveraged. Since Insurer B is already allowed to write premiums based upon its surplus, Insurer A should not also be allowed to write additional premiums on Insurer B's surplus simply because it owns Insurer B.

Specifically, under this provision, whenever an insurer's ratio of actual or projected annual written premiums as adjusted to current or projected surplus as to policyholders as adjusted exceeds 10 to 1 for gross written premiums or exceeds 4 to 1 for net written premiums, the department must suspend the insurer's certificate of authority or establish the maximum gross or net annual premiums to be written by the insurer, unless such insurer can demonstrate that exceeding the ratios does not endanger the financial condition of the insurer or interests of the policyholders.

Reinsurance

Insurance companies authorized in Florida that buy reinsurance are allowed to receive credit on their financial statements if the reinsurance is a type that is authorized, accredited or trusteed. For example, an insurer is limited by state law as to the amount of premiums it may write as a percentage of its surplus ("premium to surplus ratio"). By buying reinsurance and ceding premiums to a reinsurer, the insurance company may obtain credit on its financial statements and deduct the ceded premiums from its net premium to surplus limitations. The insurer buying the reinsurance is referred to as the *ceding insurer* and the reinsurer is referred to as the *assuming insurer.*

Currently, the assuming insurer must maintain a trust fund in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and the assuming insurer must maintain a trusteed surplus of not less than $20 million.

Health Maintenance Organization

Under present law, the Office of Insurance Regulation regulated health maintenance organization (HMO) finances, contracting, and marketing activities under part I, Chapter 641, F.S., while the Agency for Health Care Administration regulated the quality of care provided by HMO's under part III of Chapter 641, F.S. Before receiving a certificate of Authority from the office, an HMO must receive a Health Care Provider Certificate from the Agency. Any entity that is issued a certificate under part III of Chapter 642, F.S., 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. Currently, there are no risk-based capital provisions applying to HMOs as there are for insurers under s. 624.4085, F.S.

Changes to Current Law

Enforcement under the Insurance Code

The bill provides guidelines and restrictions that must be adhered to anytime an insurer enters in to a transaction or agreement with an affiliated party. It provides for a new section entitled "conflict of Interest" to provide that an affiliated party of a licensee cannot participates in any business on behalf of the licensee that would result in a conflict of the party's own interest with those of the license, subsidiary, or service corporation with which he or she is affiliated unless:

- Such business is conduced in good faith and is honest, fair and reasonable to the licensee on terms no more favorable that would be offered to a disinterested party

- A full disclosure of such business is made to the Board of Directors.

- Such business is approved in good faith by the Board, with any interested director abstaining, and such approval is recorded in the minutes.

- Any profits inuring to the affiliated party of the licensee are not at the expense of the licensee and do not prejudice the best interests of the licensee, subsidiary, or service corporation.

- Such business does not represent a breach of the fiduciary duty of an affiliated party of a licensee and is not fraudulent, illegal, or ultra vires.

The bill provides that the OIR may require disclosure by affiliated parties of a licensee of their personal interests, either directly or indirectly, in any business on behalf of a licensee, subsidiary, or service corporation. Furthermore, restrictions are imposed to govern the conduct of affiliated parties to provide the following:

- A director of a licensee cannot accept director fees unless such fees have been previously approved by the Board of Directors.

- An affiliated party may not purchase or obtain ownership of any asset of the licensee at less than fair market value.

- An affiliated party cannot have any interest of any evidence of indebtedness of the licensee.

- An affiliated party acting as proxy for a stockholder of a licensee may not transfer such vote in any consideration of a private benefit or advantage.

Examinations of Insurers

The bill removes the requirement that there must be an agreement between the department and the insurer to use CPAs, actuaries, or reinsurance specialists to conduct the exam. The bill provides that the insurer being examined must make payment for the exam directly to the firm performing the exam. According to insurance regulators, the current law significantly reduces the agency's ability to utilize resources outside the agency to supplement the examination of insurers.

Solvency of Insurers

Current law provides restrictions for how much in premium dollars an insurer may write against its policyholder surplus. This is commonly referred to as "writing ratio restrictions." This bill provides further restrictions in that surplus as to policyholders for property and casualty insurers must be calculated as follows: (actual surplus as to policyholders) minus (surplus as to policyholders of all subsidiary insurers as allowed pursuant to s. 625.325, F.S. (Section 625.325, F.S., applies to investments by insurers in subsidiaries and includes specified limitations on the costs of such investments.)

The bill provides for a similar limitation for surplus as to policyholders for life and health insurers. Such a calculation must include the reduction (minus) of surplus as to policyholders of all subsidiary insurers as allowed pursuant to s. 625.325, F.S. According to insurance regulators, this provision protects the solvency of the parent company because it prevents insurers from using the surplus of the wholly owned subsidiary to support additional premium writings of the parent company.

In addition the bill prohibits investments and loans, to prohibit premium finance companies from lending any of its funds to its officers, directors or stockholders. Specifically, this provision states that a premium finance company shall not directly or indirectly invest in or lend its funds upon the security of any note or other evidence of indebtedness of any director, officer or controlling stockholder of the finance company. According to insurance regulators, this provision will protect the solvency of the premium finance company. A similar prohibition currently applies to insurers under s. 625.332, F.S. This section is similar to Sections 8, 9, 10, and 12 of the bill which prohibits investments and loans to officers, directors, or stockholders of motor service agreement companies, home warranty associations, service warranty associations, and continuing care retirement communities, respectively.

The bill also applys the acquisition of controlling stock, to eliminate the requirement of a domestic insurer to make an acquisition filing with the Office of Insurance Regulation if a change in stock ownership is simply triggered because of a reorganization within the domestic insurer's holding company and which does not result in a change in control, or a change in officers, directors or the insurer's business plan. This provision will streamline the process by eliminating many filings which are currently required.

The bill eliminates the requirement of a specialty insurer to make an acquisition filing with the Office of Insurance Regulation if a change in stock ownership is simply triggered because of a reorganization within the specialty insurer's holding company and which does not result in a change in control, or a change in officers, directors or the specialty insurer's business plan. This provision will streamline the filing process.

Reinsurance

The bill would allow assuming insurers to use letters of credit to constitute up to 50 percent of their required trusteed surplus of $20 million. Such letters must be clean, irrevocable, unconditional, and evergreen letters of credit, issued or confirmed by a qualified U.S. financial institution, effective no later that December 31 of the year for which the filing is made, and in the possession of the trust on or before the filing date of its annual statement, and may be used to fund the remainder of the trust fund and trusteed surplus.

This provision allows assuming insurers more flexibility while at the same time provides protection and collateral for the ceding insurers. This also makes the provision more closely aligned with the current National Association of Insurance Commissioners (NAIC) model regulation regarding credit for reinsurance.

Risk-Based Capital

The bill provides for the adoption of risk-based capital requirements for health maintenance organizations. According to the Office of Insurance Regulation, risk-based capital is a tool utilized nationwide by regulators and adopted by NAIC to assess the risk of a company's assets and investments. The provision provides definitions; reporting of specified risk-based reports by HMOs in 2004, 2005, and 2006; the review, examination, and analysis of such reports by OIR; filing requirements; provisions for hearing challenges by HMOs before the OIR and before the Division of Administrative Hearing;; corrective action provisions, and rulemaking authority for the OIR.

C. SECTION DIRECTORY:

Section 1: Amends s. 624.310, F.S. – *Enforcement; cease and desist orders; removal of certain person; fines*, revises *definitions*; conforms provisions to a revised definition; conforms to the government reorganizations, prohibits affiliated parties from certain activities consisting a conflict of interest; provides exceptions; authorizes the Office of Insurance Regulation to require certain disclosures of personal interest; specifies certain restrictions governing affiliated party conduct.

Section 2: Amends s. 624.4095, F.S., - *Premiums written; restrictions*, conforming provisions to the government reorganization and providing a calculation for property and casualty surplus.

Section 3: Amends s. 624.610, F.S., - *Reinsurance*, conforming provisions to the government reorganization and revising requirements for securities of a trust fund for a single assuming insurer.

Section 4: Amends s. 627.8401, F.S. – *Prohibited investments and loans,* prohibiting certain investments by a premium finance company.

Section 5: Amends s. 628.461, F.S. – *Acquisition of controlling stock*, specifying additional non-application of acquisition of controlling stock provisions to changes of ownership of domestic insurer or specialty insurer.

Section 6: Amends s. 628.4615, F.S. – *Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation*, specifying additional non-application of acquisition of controlling stock provisions to changes of ownership of domestic insurer or specialty insurer.

Section 7: Amends s. 634.042, F.S. – *Prohibited investment and loans,* prohibiting certain investments by motor vehicle service agreement companies.

Section 8: Amends s. 634. 3076, F.S. - *Prohibited investment and loans,* prohibiting certain investments by a home warranty associations.

Section 9: Amends s. 634.4062, F.S. - *Prohibited investment and loans,* prohibiting certain investments by a service warranty associations.

Section 10: Creates s. 641.263. F.S. – *Risk-based Capital*, to adopt risk based capital for health maintenance organization with a delayed implementation for a 3 year period (effective 1/1/06) to provide sufficient time to come into compliance with these new requirements.

Section 11: Creates s. 651.029, F.S. - *Prohibited investment and loans,* to prohibit continuing care retirement communicates from lending any of its funds to its officers, directors, or stock holders.

Section 12: Amends s.440.20, F.S. – *Time for payment compensation; penalties for late payment*, correcting a cross reference.

Section 13: providing an effective date of October 1, 2003.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   This bill has no fiscal impact for the Department of Financial Services/Office of Insurance Regulation.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to the Department of Financial Services, the elimination of extensive reporting requirements for acquisitions where no major operations or management changes have occurred will represent cost savings to the regulated entities. By allowing trusteed reinsurers to utilize qualified letters of credit in their trusteed surplus account, it will be a more efficient method of establishing collateral for many.

The change to the reinsurance statute may allow additional competition in that reinsurers in the state of Florida will not have to post a difference form of collateral than is allowed in other states.

D. FISCAL COMMENTS:

This bill has no fiscal impact for the Department of Financial Services/Office of Insurance Regulation.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Rule making authority currently exists in the reinsurance statute.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On April 9, 2003, the Subcommittee on Insurance Regulation adopted three amendments:

Amendment 1 provides rulemaking authority to the Financial Services Commission, rather than the department; authorizes that the rates charged for the cost of external examinations must be competitive and that the firm selected to perform the examination has no conflicts of interest.

Amendment 2 removes the provision that provides for the adoption of risk-based capital to apply to health maintenance organizations and corrects a cross reference.

Amendment 3 changes “department” to “department or office” to conform with the constitutional amendment that created the Chief Financial Officer and Chapter 2002-404, L.O.F. that created the Department of Financial Services and the Financial Services Commission, both of which were effective January 7, 2002.