

**The Florida Senate**  
**BILL ANALYSIS AND FISCAL IMPACT STATEMENT**

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

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Prepared By: The Professional Staff of the Committee on Banking and Insurance

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BILL: SB 626

INTRODUCER: Senator Brandes

SUBJECT: Insurer Guaranty Associations

DATE: March 1, 2019

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	<b>Pre-meeting</b>
2.			AEG	
3.			AP	

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**I. Summary:**

SB 626 revises provisions relating to the Florida Life and Health Insurance Guaranty Association (association)<sup>1</sup> and the Florida Health Maintenance Organization Consumer Assistance Plan (HMOCAP).<sup>2</sup> In response to recent long-term care insurer insolvencies, the bill incorporates some recent changes made to a National Association Insurance Commissioners' model act and additional recommendations of stakeholders. The bill:

- Expands the assessment base of the association to fund long-term care insurer impairments and insolvencies by including health maintenance organizations (HMOs), life insurers, and annuity insurers. Any assessments related to a long-term care insurance would be allocated 50 percent to accident and health member insurers and HMOs, and the remaining 50 percent to life and annuity member insurers. Total assessments on member insurers and HMOs is capped at 0.5 percent of premiums per year. Currently, only health insurers are assessed.
- Increases the number of directors on the association's board by requiring that one director be a member director of the HMOCAP.

The bill will have an indeterminate negative impact for corporate income tax and an indeterminate positive impact for the insurance premium tax on a recurring basis.

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<sup>1</sup> The purpose of the association is to protect policyholders against failure in the performance of contractual obligations under life and health insurance policies and annuity contracts due to the impairment or insolvency of the member insurer that issued the policies or contracts.

<sup>2</sup> The purpose of the HMOCAP is to protect subscribers enrolled with HMOs, subject to certain limitations, against the failure of their HMO to perform its contractual obligations due to its insolvency.

## II. Present Situation:

### Long-term Care

People need long-term care when they are unable to take of themselves. Long-term care services may include assistance with activities of daily living, home health care, respite care, hospice care, adult day care, or care in an assisted living facility or nursing home. Current estimates suggest the annual costs of care in a nursing home are \$85,000, and home health care can cost upwards of \$25,000 per year. The demand for long-term care has increased significantly, as people live longer and the U.S. population ages.<sup>3</sup>

### Insurer Insolvency

States primarily regulate insurance companies, and the state of domicile serves as the primary regulator for insurers. In Florida, the Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers and other risk-bearing entities.<sup>4</sup> The OIR monitors the solvency of insurers, examines insurers, and takes administrative action, if necessary.

Federal law provides that insurance companies may not file for bankruptcy.<sup>5</sup> Instead, the state through the Division of Rehabilitation and Liquidation of the Department of Financial Services (DFS) is responsible for rehabilitating or liquidating an insurer.<sup>6</sup> If an insurer is found to be insolvent and is ordered to be liquidated by a court, a receiver takes over the insurer under court supervision and processes the assets and liabilities through liquidation. Generally, once an insurance company is liquidated, an insurance guaranty association becomes liable for the policy or contract obligations of the liquidated insurance company. Insurance guaranty funds are designed to protect policyholders of liquidated insurers from financial losses and delays in claim payments, up to limits provided by law. The Florida Legislature has created five guaranty funds.<sup>7</sup>

### Florida Life and Health Insurance Guaranty Association

Part III of ch. 631, F.S., governs the powers and duties of the Florida Life and Health Insurance Guaranty Association (association).<sup>8</sup> The association services covered policies and contracts,

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<sup>3</sup> National Association of Insurance Commissioners, *Long Term Care Insurance Fact Sheet*, May 2018, available at [https://www.naic.org/documents/consumer\\_alert\\_ltc.htm](https://www.naic.org/documents/consumer_alert_ltc.htm) (last viewed Feb. 27, 2019). Life expectancy after age 65 is now 19.4 years. From 2015 to 2055, the number of people aged 85 and older is expected to almost triple from over six million to over 18 million.

<sup>4</sup> Section 20.121(3), F.S.

<sup>5</sup> The Bankruptcy Code expressly provides that "a domestic insurance company" may not be the subject of a federal bankruptcy proceeding. 11 U.S.C. s. 109(b)(2). The exclusion of insurers from the federal bankruptcy court process is consistent with federal policy generally allowing states to regulate the business of insurance. *See* 15 U.S.C. ss. 1011- 1012.

<sup>6</sup> Sections 631.051 and 631.061, F.S. Chapter 631, F.S., governs the receivership process for insurance companies in Florida.

<sup>7</sup> *See* parts II-V of ch. 631, F.S. and s. 440.385, F.S. (The Florida Insurance Guaranty Association, Florida Life and Health Insurance Guaranty Association, Florida Health Maintenance Organization Consumer Assistance Plan, Florida Workers' Compensation Insurance Guaranty Association, and the Florida Self-Insurers Guaranty Association, respectively.)

<sup>8</sup> In 1979, the Florida Legislature enacted provisions of the National Association of Insurance Commissioners' *Life and Health Insurance Guaranty Association Model Act*,<sup>8</sup> which created FLAHIGA. Ch. 79-189, L.O.F. The National Association of Insurance Commissioners (NAIC) is a voluntary association of insurance regulators from all 50 states. The NAIC coordinates regulation and examination of multistate insurers, provides a forum for addressing major insurance issues, and promotes uniform model laws among the states.

collects premiums, and pays valid claims.<sup>9</sup> All insurers authorized to write life insurance policies, health insurance policies, supplemental contracts, and annuity contracts (with exceptions) in Florida are required, as a condition of doing business in this state, to be member insurers of the association.<sup>10</sup> Currently, the association does not provide coverage for or assess health maintenance organizations.<sup>11</sup>

The association's aggregate liability with respect to one life may not exceed the following:

- Life Insurance Death Benefit: \$300,000 per insured life.
- Life Insurance Cash Surrender: \$100,000 per insured life.
- Health Insurance or Long-term Care Insurance Claims: \$300,000 per insured life.
- Annuity Cash Surrender: \$250,000 for deferred annuity contracts per contract owner.
- Annuity in Benefit: \$300,000 per contract owner.<sup>12</sup>

The board of directors of the association must be composed of not fewer than five but not more than nine member insurers.<sup>13</sup> At least one member of the board must be a domestic insurer.<sup>14</sup> The member insurers elect the members of the board, and the members of the board are subject to the approval of the DFS. In approving or appointing members to the board the DFS must consider whether all member insurers are represented fairly.

The association has three operating accounts: health insurance, life insurance, and annuity for purposes of administration and assessments.<sup>15</sup> The association may impose Class A assessments for administrative costs<sup>16</sup> and Class B assessments to administer its duties relating to impaired or insolvent insurers.<sup>17</sup> Class B assessments are calculated based on the premiums collected by each assessed member insurer on policies or contracts covered for each account in proportion to premiums collected by all assessed member insurers for the three most recent years. Florida law limits assessments on a member insurer to a maximum of one percent of the sum of the insurer's written premium in Florida regarding business covered by the account received during the three calendar years preceding the year in which the assessment is made, divided by three.<sup>18</sup>

Member insurers of the association may offset the amount of an assessment against the insurance premium tax or corporate income tax.<sup>19</sup> The credit may be taken in an amount of 5 percent of the assessments for each of the 20 years following the year in which the assessment was paid.<sup>20</sup>

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<sup>9</sup> See association's website available at <http://www.flahiga.org/aboutus.cfm> (last viewed Feb. 18, 2019).

<sup>10</sup> Sections 631.713 and 631.715, F.S.

<sup>11</sup> Section 631.713(3)(e), F.S.

<sup>12</sup> Section 631.717(9), F.S. FLAHIGA, *Frequently Asked Questions*, available at <https://www.flahiga.org/FAQ> (last viewed Feb. 28, 2019).

<sup>13</sup> Section 631.716(1), F.S.

<sup>14</sup> Section 624.06, F.S.

<sup>15</sup> Section 631.715(2), F.S.

<sup>16</sup> Section 631.718(2) and (3), F.S.

<sup>17</sup> *Id.*

<sup>18</sup> Section 631.718(5), F.S.

<sup>19</sup> Section 631.72, F.S.

<sup>20</sup> *Id.*

## **Health Maintenance Organization Consumer Assistance Plan (HMOCAP)**

Part IV of ch. 631, F.S., creates the Florida Health Maintenance Organization Consumer Assistance Plan. The purpose of the HMOCAP is to protect subscribers of commercial HMOs against the risk of harm resulting from an HMO's insolvency. All HMOs authorized in Florida are required to be members.<sup>21</sup> The board of directors of the HMOCAP must consist of at least five and not more than nine persons.<sup>22</sup> Member HMOs select board members, and the board members are subject to approval by the DFS. Coverage by the HMOCAP<sup>23</sup> ceases 6 months after the date of the insolvency; once the HMOCAP has provided \$300,000 in covered benefits; or when a subscriber obtains coverage with another HMO or health insurer.

To provide funds for the administration of the plan and the payment of claims, the plan may assess members of the plan to fund claims paid by the plan.<sup>24</sup> Assessments against member HMOs are levied as a percentage of annual earned premium revenue for non-Medicare and non-Medicaid contracts. The assessment in any calendar year may not exceed 0.5 percent of each member HMO's annual earned premium revenue for non-Medicare and non-Medicaid contracts.<sup>25</sup>

Section 631.828, F.S., allows a member HMO to offset against its corporate income tax liability or other liabilities, on an individual or consolidated basis, as applicable, any assessments described in s. 631.819, F.S. The credit may be taken to the extent of 20 percent of the amount of such assessment for each of the 5 calendar years following the year in which such assessment was paid.

## **Long-term Care Insurance and Insolvencies**

Many individuals buy long-term care insurance policies<sup>26</sup> to help pay for some of their long-term care needs. Despite the growing long-term care need, the number of long-term care insurance policies have fallen from 754,000 in 2002 to 129,000 in 2014. The number of insurers offering the coverage has declined from about 100 in 2002 to about a 12 today.<sup>27</sup> This may be attributable to the premium rates for newly issued policies increasing as the remaining issuers of existing policies have refined their pricing due to inaccurate pricing assumptions relating to claim costs, mortality, interest rates, and policy lapses, which lead to an underpriced product.

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<sup>21</sup> Section 631.815, F.S.

<sup>22</sup> Section 631.816, F.S.

<sup>23</sup> Section 631.817, F.S.

<sup>24</sup> Section 631.819, F.S.

<sup>25</sup> Section 631.819(3), F.S.

<sup>26</sup> In Florida, a long-term care insurance policy is any insurance policy or rider advertised, marketed, offered, or designed to provide coverage on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Section 627.9404, F.S.

<sup>27</sup> NAIC, *Long-term Care Challenges*, Jan. 14, 2019, available at [https://www.naic.org/cipr\\_topics/topic\\_long\\_term\\_care.htm](https://www.naic.org/cipr_topics/topic_long_term_care.htm) (last viewed Feb. 10, 2019).

### ***Funding Claims of Insolvent Insurers***

In 2017, Penn Treaty,<sup>28</sup> which was domiciled in Pennsylvania, was liquidated. The insurer wrote approximately 75,000 (primarily long-term care insurance) policies.<sup>29</sup> The insolvency is expected to be the second-largest insolvency in insurance guaranty fund history (the largest for an accident and health insurer).<sup>30</sup> As of December 31, 2018, there were 7,468 in-force policies in Florida.<sup>31</sup>

According to the National Association of Insurance Commissioners (NAIC), all states regulate long-term care insurance as health insurance.<sup>32</sup> The Penn Treaty insolvency resulted in health insurers bearing the majority of the assessments because long-term care insurance is classified as health insurance. Life insurers, however, wrote the majority of long-term care insurance premiums. In Florida, health insurers have paid almost \$336 million in assessments for the Penn Treaty insolvency.<sup>33</sup> The estimated actuarial liability on December 31, 2018, which is subject to change, was \$110 million.<sup>34</sup>

To address concerns with guaranty fund coverage and assessments for any future long-term care insurer insolvency, the NAIC modified the *Life and Health Insurance Guaranty Association Model Act* to expand the assessment base to include HMOs, life and annuity insurers for funding long-term care insurer insolvencies and impairments. Assessments for long-term care impairments and insolvencies are allocated equally between the life and health accounts. The NAIC clarified the authority of the guaranty associations to adjust rates and coverage in the case of liquidation. Further, the NAIC clarified that federal programs, such as Medicare and Medicaid, are excluded from the assessment base. Life and annuity policies with long-term care insurance riders are considered the same as the underlying product, not as a health insurance product.

### **III. Effect of Proposed Changes:**

#### **Florida Association of Life and Health Guaranty Association (association) (Sections 1-7)**

**Section 1** amends s. 631.713, F.S., to subject health maintenance organizations to Class B assessments for long-term care insurer impairments or insolvencies. Currently, HMOs are exempt from assessments by the association. The section exempts long-term care contracts or riders from the interest rate cap for calculating the liability of FLAHIGA for long-term care insurance policies of impaired or insolvent insurers. The section clarifies that the association does not cover Medicare or Medicaid coverage and certain structured settlement annuity benefits.

<sup>28</sup> Penn Treaty collectively includes Penn Treaty Network America Insurance Company and its affiliate, American Network Insurance Company.

<sup>29</sup> National Organization of Life and Health Insurance Guaranty Associations (NOLHGA), Guaranty System to Provide Safety Net for Policyholders of Penn Treaty/American Network Insurance Companies, Mar. 1, 2017) available at <https://www.nolhga.com/resource/file/NOLHGAPennTreatyPressReleaseFINAL.pdf> (last viewed Feb. 20, 2019).

<sup>30</sup> Chicago Fed Letter, *The risks of pricing new insurance products: The case of long-term care*, 2018 Number 397.

<sup>31</sup> Correspondence from FLAHIGA, Feb. 24, 2019, on file with Senate Banking and Insurance Committee.

<sup>32</sup> NAIC and NOLHGA, *State of the U.S. long-term care insurance industry*, March 30, 2017.

<sup>33</sup> Assessments paid from 2015 to 2019. Correspondence on file with the Senate Committee on Banking and Insurance.

<sup>34</sup> *Id.*

**Section 2** amends s. 631.714, F.S., to provide that the term, “long-term care assessment obligations,” means long-term care impairment and insolvency assessment obligations of the association, which are subject to assessment pursuant to s. 631.715(2)(a)1. and 631.718(3)(b), F.S., in coordination with the HMOCAP. The section clarifies that all other obligations other than long-term care assessments are obligations of the association without contribution or involvement of the HMOCAP.

**Section 3** amends 631.716, F.S., to revise the board of directors for the association by increasing the maximum number of members from nine to 11. One member of the HMOCAP board of directors, or designee, must serve on the association’s board of directors, and has the right to attend all board meetings and has full voting rights on all issues. The association board of directors must confirm, subject to approval by DFS, the HMOCAP member.

**Section 4** amends s. 631.717, F.S., to revise the powers and duties of the association. The section provides that, in the event of a long-term care insurer impairment or insolvency, the association is required to coordinate its activities with the HMOCAP, including the development of any plan for administering the impairment or insolvency. Further, the association is required to share information, including data, with and assist, if applicable, the HMOCAP with the administration and collection of member HMO assessments for long-term care insurer impairments or insolvencies.

The section clarifies that the association’s maximum coverage for long-term care policies is \$300,000, and that any portion of a long-term care rider to a life insurance policy or annuity contract is considered the same type of benefit as the base life insurance policy or annuity contract to which the rider relates. The section also provides technical changes.

The association is authorized to file with the OIR for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under part III of ch. 631, F.S., if certain conditions are met. The approval authority for the association to issue certain alternative policies or contracts is changed from the receivership court to the DFS. The association is authorized to reissue policies or contracts.

**Section 5** amends s. 631.718, F.S., to establish an assessment methodology for long-term care insurer insolvencies and impairments. The methodology must provide for 50 percent of the assessment to be allocated to accident and health member insurers and 50 percent to be allocated to life and annuity member insurers. The accident and health members’ share of the assessment is calculated by including the assessable premiums of member HMOs of the HMOCAP.

The total assessment for long-term care impairments or insolvencies upon a member insurer or member HMO may not exceed 0.5 percent in any one calendar year the sum of the member insurer or member HMO premiums written in Florida covered by the account received during the calendar year preceding the year in which the assessment is made. If this information is unavailable, the member insurers of the association or the member HMOs of the HMOCAP may use other premium information.

**Section 6** amends s. 631.721, to require the association to revise its plan of operation to provide for the coordination of efforts between the association and the HMOCAP in regards to assessments for long-term care insurer impairments or insolvencies.

**Section 7** creates s. 631.738, F.S., to exempt any member insurer from long-term care assessment obligations if the member insurer has been adjudged insolvent by a court of competent jurisdiction, or has been determined insolvent by the DFS on or before the effective date of this act.

**Health Maintenance Organization Consumer Assistance Plan (HMOCAP)  
(Sections 8-12)**

**Sections 8-11** amend ss. 631.816, 631.818, 631.819, and 631.820, F.S. The HMOCAP is required to designate a representative to serve on the association's board of directors, subject to approval by the DFS. In the event of a long-term care insurer impairment or insolvency, the HMOCAP must:

- Collect and transmit all information requested by the association to determine the appropriate assessment base;
- Levy and collect assessments from member HMOs;
- Coordinate the administration and collection of member assessments with the association insolvency;
- Issue a certificate of contribution to each member HMO paying a long-term care insurer assessment; and
- Revise the plan of operations by including procedures for coordinating the administration and collection of member HMO assessments with the association.

**Section 12** amends s. 631.821, to provide a technical conforming change.

**Section 13** directs the Division of Law Revision to replace the phrase, "effective date of this act" wherever it occurs in this act with the date this act becomes law.

**Section 14** provides this bill will 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. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

**V. Fiscal Impact Statement:**

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The expansion of the assessment base will provide access to more funds for the payment of policyholder claims in a more expedient manner.

For future impairments or insolvencies of long-term care insurers, life and annuity insurers and HMOs would be subject to assessments. Subject to certain conditions, assessments may offset insurance premium tax liabilities or corporate income tax liabilities. Currently only health insurers are subject to assessments. This would expand the assessment base, and potentially reduce future assessments for health insurers.

C. Government Sector Impact:

According to the Revenue Estimating Conference, any impact of the bill is dependent upon future insolvencies and the size and timing of future assessments. The bill is expected to have an indeterminate negative fiscal impact for corporate income tax and an indeterminate positive for the insurance premium tax on a recurring basis.<sup>35</sup>

**VI. Technical Deficiencies:**

References to the Florida Health Maintenance Organization Consumer Assistance Plan did not include the term, "Florida."

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends the following sections of the Florida Statutes: 631.713, 631.714, 631.716, 631.717, 631.718, 631.721, 631.816, 631.818, 631.819, 631.820, and 631.821. This bill creates the section 631.738 of the Florida Statutes.

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<sup>35</sup> Revenue Estimating Conference, *Insurance Premium Tax/Corporate Income Tax, SB 626*, Feb. 15, 2019, available at <http://edr.state.fl.us/Content/> (last viewed Feb. 24, 2019).



**IX. Additional Information:**

- A. **Committee Substitute – Statement of Changes:**  
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

- B. **Amendments:**

None.

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This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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