1989

Session Law 89-360

Florida Senate & House of Representatives

89-360

S 845 GENERAL BILL/CS/2ND ENG by Insurance; Kirkpatrick (Similar CS/1ST ENG/S 1230, Compare CS/1ST ENG/H 329, H 351, H 365, H 552, H 611, H 666, H 706, H 861, H 862, CS/CS/1ST ENG/H 1002, CS/H 1019, H 1058, H 1094, H 1109, H 1223, H 1348, H 1516, H 1530, CS/S 473, 1ST ENG/S 738, CS/1ST ENG/S 739, S 740, 1ST ENG/S 743, 1ST ENG/S 815, CS/1ST ENG/S 844, CS/S 894, 1ST ENG/S 930, CS/1ST ENG/S 934, CS/1ST ENG/S 1177, CS/1ST ENG/S 1292, S 1294, CS/S 1386, S 1400)

BILL HISTORY

Insurance (OMNIBUS): provides that interest is payable on cash surrender of insurance policy; requires certain insurers to annually submit rate filings to Insurance Dept.; provides methods & procedures; provides penalty; authorizes additional positions in dept.; provides that unearned commissions & premiums constitute asset of insurer; requires insurer to provide outline of coverage upon delivery of personal lines property or casualty policy, etc. Amends F.S. Appropriation: $271,897. Effective Date: 07/06/89 except as otherwise provided.

03/31/89	SENATE	Prefiled
04/14/89	SENATE	Introduced, referred to Insurance; Appropriations -SJ 130
04/20/89	SENATE	On Committee agenda—Insurance, 04/24/89, 10:00 am, Room-A-(LL-37)
04/24/89	SENATE	Comm. Report: CS by Insurance -SJ 199
04/25/89	SENATE	CS read first time -SJ 202; Now in Appropriations -SJ 199
05/03/89	SENATE	Extension of time granted Committee Appropriations
05/16/89	SENATE	Withdrawn from Appropriations -SJ 360; Placed on Calendar
05/30/89	SENATE	Placed on Special Order Calendar -SJ 560; CS passed as amended; YEAS 37 NAYS 0 -SJ 610
05/30/89	HOUSE	In Messages
06/02/89	HOUSE	Received, placed on Calendar -HJ 1349; Read second time; Amendments adopted; Read third time; CS passed as amended; YEAS 109 NAYS 3 -HJ 1371
06/02/89	SENATE	In Messages
06/03/89	SENATE	Was taken up -SJ 1305; Concurred; CS passed as amended; YEAS 38 NAYS 0 -SJ 1326
06/03/89		Ordered engrossed, then enrolled -SJ 1326
06/20/89		Signed by Officers and presented to Governor
07/06/89		Became Law without Governor's Signature; Chapter No. 89-360; Amended by SB 9-B (Ch. 89-528)

REVISED: _____ BILL NO. CS/SB 845

DATE: April 24, 1989 Page 1

SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

	ANALYST	STAFF DIRECTOR		REFERENCE	ACTION
1.	Andrews	Fort	1.	INS	Fav/CS
2.			2.	AP	
3.			3.		
4.			4.		

SUBJECT: Medicare Supplement Insurance

BILL NO. AND SPONSOR: CS/SB 845 by Insurance and Senator Kirkpatrick

I. SUMMARY:

A. Present Situation:

Currently, minimum standards for the regulation of Medicare supplement insurance policies are provided in part VIII of chapter 627, F.S. Effective July 1, 1988, the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) revised Medicare coverage by providing an expansion of benefits to be phased in over a 3-year period, from 1989 to 1991, and imposed other requirements directly affecting Medicare supplement insurance policies.

These requirements include mandating submission of all Medicare supplement insurance advertisements and filing the Medicare supplement insurance experience exhibit, using the National Association of Insurance Commissioners (NAIC) reporting form, with the state insurance department.

In addition, the act requires compliance with actual loss ratios, rather than anticipated ratios, mandates a "free-look" period of 30 days, and requires revision of permanent Medicare supplement insurance minimum standards by September 20, 1989.

Companies who offer Medicare supplement insurance are required to comply with the NAIC Transition Rule, part II of rule 4-51, F.A.C., until such permanent standards are implemented by the state, but if a state fails to revise its permanent standards in compliance with this act, the NAIC standards will become the new standards.

The act also requires states to add the requirements of section 4081 of the Omnibus Budget Reconciliation Act of 1987 (OBRA) (P.L. 100-203) to minimum standards for Medicare supplement insurance.

B. Effect of Proposed Changes:

This committee substitute would conform Florida Medicare supplement insurance law to the changes required by the Medicare Catastrophic Coverage Act of 1988.

For ease of understanding, a section-by-section analysis follows:

Section 1. Section 627.6735, F.S., is amended to require filing of all advertisements for Medicare supplement policies with the Department of Insurance, pursuant to rules promulgated by the department. This change complies with the Act's mandate to submit all Medicare supplement insurance advertisements to the state insurance department.

Section 2. Section 627.674(1) and (3), F.S., 1988 Supplement, is amended to revise minimum coverage standards required under

Medicare supplement policies to coordinate with new coverage provided under Medicare, which will be phased in over a three-year period, from 1989 to 1991.

The committee substitute incorporates the act's 1989 changes relating to Medicare Part A, by requiring Medicare supplement policies to cover either all or none of the inpatient hospital deductible amount and if none is covered, such lack of coverage must be prominently stated at the top of the policy. The daily copayment amount of Medicare Part A for the first 8 days of skilled nursing facility care and the reasonable cost of the first 3 pints of blood or an equivalent must also be covered.

Changes for 1990 implemented by the committee substitute, relate generally to Medicare Part B and require coverage for the 20 percent copayment of Medicare eligible expenses, with certain exceptions, and for the reasonable cost of the first 3 pints of blood, or an equivalent.

Beginning in 1990, Medicare supplement policies must also cover the copayment amount of Medicare eligible expenses for covered home intravenous therapy drugs and for outpatient drugs used in immunosuppressive therapy, with certain restrictions.

"Medicare eligible expense" may then be defined in policies as no more restrictive than the kinds of health care expenses covered or recognized by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned on the same or less restrictive payment conditions, including applicable determinations of medical necessity.

Medicare supplement policies, beginning in 1990, must also provide benefits which cover cost sharing amounts under Medicare that will be automatically changed to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factor, and provide that premiums may be modified accordingly.

Section 3. Section 627.6745(1), F.S., 1988 Supplement, is amended to clarify that if a Medicare supplement policy provides coverage through a health maintenance organization on a service rather than reimbursement basis, incurred health care expenses are treated the same as incurred claims experience is treated under health insurance policies.

Section 4. Section 627.6746, F.S., is created to require Medicare supplement insurer compliance with all provisions of section 4081 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) (OBRA).

OBRA requires Medicare supplement insurers to agree to accept a claims notice as a claim for benefits under the policy and to agree to make payment determination based on the information provided. Medicare supplement insurers must provide notice to the participating doctor or supplier and beneficiary concerning the payment determination and provide payment directly to the participating doctor or supplier.

In compliance with OBRA, Medicare supplement insurers must also provide the beneficiary at the time of enrollment with a card listing the policy name, number and address to which notices under 42 U.S.C. 1842(h)(3)(B) regarding the policy are to be sent. Such insurers must agree to pay user fees established under 42 U.S.C. 1842(h)(3)(B) regarding information transmitted to the issuer of the policy and must provide the Secretary of the United States Department of Health and Human Services with the mailing address to which notices under 42 U.S.C. 1842(h)(3)(B) regarding the policy are to be sent, for transmittal to Medicare contracting carriers.

Section 5. The committee substitute provides that any policy or contract in force at the time of the effective date of this section, October 1, 1989, must be amended to meet the requirements of this act upon renewal or the next anniversary date of the policy or contract, whichever occurs first.

II. ECONOMIC IMPACT AND FISCAL NOTE:

A. Public:

According to the Department of Insurance, this legislation may impact insurance companies who offer Medicare supplement policies by necessitating, for example, the cost to reprint and reissue policy forms, advertisements, and outlines of coverage forms for notification of changes. Such costs would vary significantly among companies depending on their volume of Medicare supplement insurance.

B. Government:

None.

III. COMMENTS:

Requirements in the act which are not addressed by this committee substitute, have already been implemented by Florida law. With the passage of this legislation, Florida would be in full compliance with the federal Medicare supplement insurance standards as codified in the act.

IV. AMENDMENTS:

None.

CS/SB 845

COMMITTEE SUBSTITUTE FOR SENATE BILL 845 (CHAPTER 89- combines numerous insurance bills that were originally filed individually. An analysis of the bill is provided below:

1. SB 738 - Interest on Cash Surrender

Requires life insurers to pay interest to the policyholder if the cash surrender value is not paid within 30 days of demand.

2. CS/SB 1230 - Mandatory Rate Review

Requires property, casualty, and health insurers to annually make either a rate filing or an actuarial certification that their rates are actuarially sound. Annual rate filings or actuarial certification will promote rates that are adequate with the current economic conditions.

CS/SB 1230 allows property and casualty insurers to meet annual rate filing requirements by having a licensed rating organization make an annual rate filing or certification on behalf of the company.

3. CS/SB 1386 - Insurer Rehabilitation

This part of the bill provides for better handling of the assets of insolvent insurers since it provides procedures to aid the receiver in recovering assets of the insolvent insurer which are in the hands of third parties.

The committee substitute revises state law governing insurer insolvency to provide:

(1) that delinquency proceedings brought under chapter 631 are in equity;

(2) a procedure to be used when funds or other property is in the possession of third parties and the receiver demands delivery of such funds or other property;

(3) the preservation of the property or funds;

(4) for the elements of recovery should the receiver be successful in establishing claims;

(5) that unearned commission and unearned premiums constitute an asset of the insurer;

(6) that compliance with accounting requirements constitutes a requirement for continued licensure;

(7) that special deposit claims and secured claims are applicable to liquidation proceedings and revise the method for valuing the claims;

(8) that a claim offset must be fully matured as of the date of filing of a liquidation order;

(9) that transfers of an affiliate of an insurer are voidable, within the prescribed time period;

(10) that a seizure order may direct the department to take possession and control of premium funds and other property of the insurer held by an affiliate and may enjoin any affiliate from described actions; and

(11) that an insurer is defined as insolvent when an order in a delinquency proceeding has been entered.

4. CS/SB 894 - Surplus Lines

The committee substitute removes the requirement contained in s. 626.923, F.S., that requires surplus lines agents to send a completed copy of the surplus lines policy to the department within 60 days of policy issuance. However, the

committee substitute amends the reporting requirements to require that surplus lines agents shall submit copies of the policy, or other forms of insurance confirmation, within 30 days, if these documents are requested by the Department of Insurance.

CS/SB 894 increases the time that surplus lines agents must retain a copy of the policy from 3 to 5 years. In addition to the longer period of retention, the committee substitute requires that all forms of insurance confirmation must be retained for 5 years.

5. CS/SB 934 - Outline of Coverage

Requires insurers to provide an outline of coverage to consumers who purchase automobile insurance policies or homeowner insurance policies. The outline will provide the consumer with an easy to understand summary of the policy they are purchasing.

6. CS/SB 1292 - Solvency

This part of the committee substitute amends several financial requirements of insurers in order to prevent insolvencies. Stronger surplus requirements, premium limitation, reinsurance certification, investment limitation, and other changes are included in order to decrease the possibility of insurer insolvency.

7. CS/SB 930 - Excess Rates

This part of the committee substitute requires insurers to complete a signed consent form when charging premiums that are in excess of approved rates. The signed consent form must list the filed rate and the excess rate that will be charged to the policyholder.

The committee substitute limits the number of excess rate policies to no more than 10 percent of commercial insurance policies and no more than 5 percent of personal line policies.

8. SB 1294 - Primary Agent

Prohibits suspended or revoked insurance agents from continuing to work in an insurance agency, thereby eliminating the likelihood of further violations of the Insurance Code by such agents and fraudulent acts upon consumers.

9. SB 1400 - Agents Bill

Provides tighter constraints and more severe penalties on misconduct of insurance agents, such as prohibiting agents from overinsuring a policyholder or from requiring auto insurance policyholders to purchase travel club memberships.

10. CS/SB 844 - Housekeeping Bill

This bill cleans up various errors and problems with insurance statutes. It provides a limited grandfather exemption for certain religious organizations to undertake insurance activities.

11. SB 815 - Administrative Supervision

This bill creates a procedure whereby an insurer would be placed under administrative supervision (supervision) of the Department of Insurance (department). Administrative supervision would be a step short of court-ordered receivership under chapter 631, authorizing rehabilitation, conservation, or liquidation. Under administrative supervision, department personnel, or their agents, would have prior approval authority over all significant business decisions made by the company.

The department may initiate the process to place an insurer under supervision if it finds that:

(1) the insurer is in unsound condition;

(2) the insurer's business practices are hazardous to the public;

(3) the insurer has exceeded its authority; or

(4) the insurer gives consent.

An insurer is in an "unsound condition," if:

(1) surplus, capital, or capital stock is impaired;

(2) the insurer continues to write new business when it has failed to maintain the required surplus or capital; or

(3) the insurer attempts to dissolve or liquidate without first making satisfactory provisions for liabilities.

If placed under supervision, the insurer has 60 days from the date of notice to comply with the department's requirements. If the condition which placed the insurer under supervision is remedied, the department is required to release the insurer from supervision. Supervision may be extended by 60-day increments. However, the insurer may request an administrative hearing pursuant to chapter 120, in the event the department extends the supervision.

12. CS/SB 739 - HMO's

Requires that HMO salesmen must be qualified health insurance agents. HMO's have to license their salesmen just as insurance companies license their health insurance agents. To qualify for licensure with an HMO, an individual must meet identical requirements of health insurance agents, as provided in ch. 626, F.S., including passage of an

examination. All provisions of the Insurance Code applicable to licensing of health insurance agents, including disciplinary procedures, apply to HMO's and their licensed agents.

The bill also modifies the fine imposed for filing an annual report late, from "$1,000" to "up to $1,000," and from "$2,000" to "up to $2,000," to give the Department of Insurance the discretion to fine a lesser amount.

In addition, annual reporting requirements are simplified and consolidated by eliminating the filing of unnecessary information.

The bill disallows use of intercompany receivables from the parent company or affiliate to the HMO in meeting statutory surplus requirements, except under certain circumstances. This clarifies existing law which provides that "advances" to officers, employees, etc. are not permitted assets.

Finally, the bill requires the Department of Health and Rehabilitative Services to only contract with Medicaid HMO's whose principals have no criminal connections related to the delivery of Medicare or have not been found guilty of fraud, income tax evasion, or obstruction of justice.

13. CS/SB 1177 - Fictitious Groups

Authorizes insurers to sell private passenger auto insurance and homeowners insurance on a group basis, which will result in lower premiums to consumers due to the reduced administrative costs associated with group policies as compared to individual policies.

14. SB 743 - Bail Bondsmen

This bill tightens up various regulations of bail bondsmen and also revises language to assure that surety companies pay bail bonds to the courts when defendants fail to appear.

15. CS/SB 473 - Confidentially of Risk Management Claims

This bill provides for the confidentially of risk management of the state and local governments claim files in order to promote a policy decision to encourage risk safety management in order to reduce the frequency of accidents giving rise to litigation.

CS/SB 473 also provides that claims meetings held by the state and local governments that evaluate claims or determines settlement assessments are not subject to sunshine laws.

16. CS/SB 845 - Medicare Supplement

This bill conforms Florida's Medicare supplement insurance law to the changes required by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) which address the advertisement of Medicare supplement policies and revise minimum coverage standards.

****AS PASSED BY THE 1989 LEGISLATURE****

STORAGE NAME: CS/SB 845-f.inx
DATE: July 7, 1989

HOUSE OF REPRESENTATIVES
INSURANCE COMMITTEE
FINAL STAFF ANALYSIS & ECONOMIC IMPACT STATEMENT

BILL #: CS/SB 845

RELATING TO: Insurance

SPONSOR(S): Committee on Insurance and Senator Kirkpatrick

EFFECTIVE DATE: Upon becoming law, except as otherwise provided

DATE BECAME LAW: July 6, 1989, except for those sections designated by an asterik (*) in Section-by-Section analysis which take effect October 1, 1989

CHAPTER #: 89-360, Laws of Florida

COMPANION BILL(S): See comments section

OTHER COMMITTEES OF REFERENCE: (1) Appropriations

(2)

****

I. SUMMARY:

A. PRESENT SITUATION:

(See section-by-section analysis)

B. EFFECT OF PROPOSED CHANGES:

(See section-by-section analysis)

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Presently, s. 627.475(2)(b), F.S., requires a life insurer to pay the cash surrender value on a life insurance policy within 6 months after demand by the policyholder. There is no provision for interest when insurers take an extended period of time to make payment. This section requires insurers who fail to pay cash surrender values on life insurance policies within 30 days of demand to include interest at the rate specified in the Moody's Corporate Bond Yield Average--Monthly Average Corporates. An exception is provided if the Department of Insurance (Department) determines that the payment of interest will threaten the solvency of the insurer.

Sections 2-4.* Currently, insurers are not required to file their rates with the Department (DOI) unless they intend to change them. These sections require property and casualty insurers (excepting workers' compensation and commercial liability lines) to submit rate filings no less frequently than

once every twelve months demonstrating that rates are not inadequate. Health insurers would be required to make annual filings demonstrating that benefits are reasonable relative to premiums. These sections authorize five new positions for the Department: an actuary, three actuarial analysts, and one secretary.

Sections 5-16. These sections revise state law governing insurer insolvency. **Section 5** excludes "claims based on mere possession" from the definition of secured claims. **Section 6** provides that delinquency proceedings brought under chapter 631 are in equity. **Section 7** establishes a procedure to be used when funds or other property in the possession of a third party are demanded by the receiver (DOI). It provides for the preservation of such property or funds when they are allowed to remain in the hands of the third party. **Section 8** provides for counting unearned commissions and unearned premiums collected by agents among the assets of an insurer in receivership. **Section 9** requires a court to determine the value of any security held by a secured creditor if there is no agreement between the parties. **Section 10** disallows a claim of offset unless it was fully matured as of the date of the filing of a liquidation order. **Section 11** makes voidable described transfers of property which give preference to a particular creditor of an insurer who within four months comes under a delinquency proceeding. **Section 12** makes voidable any transfer or obligation incurred without fair consideration by an insurer or affiliate who within one year comes under a delinquency proceeding. **Section 13** authorizes a court to issue a seizure order directing DOI to take possession and control of premium funds and other property held by an affiliate of the insurer and to enjoin affiliates from described actions. **Sections 14 and 15** require a successfully rehabilitated insurer to reimburse the Florida Insurance Guaranty Association (FIGA) or Florida Life and Health Insurance Guaranty Association (FLHIGA) for all claims made on the insurer's behalf. **Section 16** increases the cap on FIGA and FLHIGA assessments for administrative expenses from $50 to $250 per member insurer per year.

Sections 17-21.* These sections specify that no person shall act as agent for an unauthorized insurer, regardless of whether the subject of insurance is located in this state. They relieve surplus lines agents of their present responsibility to forward all policies and documents to DOI. Instead, agents would be required to supply a listing of all policies in their quarterly reports to the Department, to furnish records requested by the Department within 30 days, and to keep records for five years rather than three. Finally, the Department is given the ability to levy fines against agents for failure to comply with the quarterly reporting requirement.

Section 22. Provides for repeal of s. 627.331(4), Florida Statutes, which requires insurers to file with the Department any underwriting rules for private passenger automobile insurance and homeowners' insurance not contained in rating manuals. This section of the bill was subsequently repealed by SB 9-B.

Section 23.* Currently, s. 627.642, Florida Statutes, requires insurers to provide an outline of coverage for individual health insurance policies. This section requires a similar summary of benefits, exclusions, limitations, deductibles, cancelation provisions, surcharges and riders for automobile and homeowner's insurance policies delivered in Florida.

Sections 24-52. These sections relate to assuring the solvency of companies operating in Florida.

Section 24 strengthens the authority of the Department to deny a company's certificate of authority based upon an applicant's administrative and/or criminal record. **Section 25*** increases the initial capitalization requirements for new insurers. The section defines capitalization requirements in terms of "surplus as to policyholders," which is analogous to "net worth" and is more commonly understood than the current law's references to "paid in capital stock, unimpaired surplus, or net trust funds" and "special surplus."

The current initial capitalization and surplus requirement is $750,000 in capital plus surplus of at least $1 million. Additional surplus is required based on net reserves. (**For life insurers:** 3 percent of net reserves for annuities plus 5 percent of other net reserves, except for accrued liabilities and fully reserved single premium life and annuity policies. **For property and casualty insurers:** 10 percent of net reserves). Health insurers are currently not included in these requirements. This section requires an initial surplus as to policyholders equal to the greater of 2.5 million or: (1) for life insurers, 4 percent of total liabilities; (2) for life and health insurers, 4 percent of total liabilities plus 6 percent of health insurance liabilities; or (3) for all other insurers (including property and casualty insurers) 10 percent of liabilities. Consistent with the present law, the required surplus may not exceed $100 million.

Section 26* requires a new insurer to maintain surplus as to policyholders not less than the greater of $1.5 million or the same percentage of liability amounts used for initial surplus requirements in Section 25. For existing insurers, the surplus requirements are phased in over a two and a half year period ending December 31, 1991, at which time existing insurers and new insurers would be subject to identical surplus requirements.

Section 27* imposes stricter premium-to-surplus limitations. Currently all insurers other than life or health insurers are limited in the amount of premiums they write based upon the amount of their surplus. The current limitation is that the ratio of gross written premiums to surplus may not exceed 10 to 1, and the ratio of net premium (deducting reinsurance) to surplus may not exceed 4 to 1. This section applies a multiplying factor of 1.25 to casualty premiums and of .90 to property premiums, recognizing the greater volatility and long term reserve requirements associated with casualty (liability)

insurance. The section also imposes premium-to-surplus limitations on health insurance for the first time, with a .80 multiplier and an exemption for companies having a surplus as to policyholders greater than $40 million. Life insurance remains exempt from these requirements. **Section 28*** makes a conforming technical change.

Section 29* increases the deposit requirements for domestic and foreign insurers. For domestic property insurers the deposit requirement is increased from $75,000 to $100,000; for domestic casualty insurers the increase is from $75,000 to $250,000; for title insurers and surety insurers the amount of deposit remains at $100,000. A domestic insurer authorized to transact more than one kind of insurance is not required to deposit more than $300,000. For foreign property insurers the deposit requirement is increased from $75,000 to $100,000; for foreign casualty insurance the increase is from $75,000 to $150,000; for foreign title and surety insurers the deposit requirement remains at $100,000. The deposit requirement for a foreign insurer authorized to transact more than one kind of insurance is increased from a limit of $100,000 to a limit of $200,000. Under current law, a foreign insurer with a surplus as to policyholders of $1.5 million or more is not required to make a deposit. This section increases this threshold to $10 million. This section also allows the Department to require an additional deposit of not less than $100,000 (currently $75,000) or more than 25 percent of the insurer's obligations in this state up to $2 million. This additional deposit may be required if the Department determines that the financial condition of an insurer has deteriorated or that the policyholders' best interests are not being preserved.

Section 30* authorizes DOI to adopt by rule the form for quarterly financial statements approved by the National Association of Insurance Commissioners. **Section 31*** allows the Department to issue a certificate of authority prior to an insurer getting its rates and forms approved. However, rates and forms must be approved prior to the insurer actually writing any premiums. **Section 32*** authorizes DOI to allow insurers to renew coverage during a period of suspension (but not after revocation) if the Department finds that the insurer is capable of servicing renewal coverage. **Section 33*** increases the maximum period for suspension of a certificate of authority from 1 year to 2 years or until such time as the reason for the suspension has been remedied. This section also deletes the provision in current law for automatic reinstatement.

Section 34* amends s. 624.424 regarding financial statements. Currently, an insurer is required to submit audited financial statements with an accompanying report and opinion of a certified public accountant. An exception is provided for insurers with less than 1,000 policyholders. This section specifies that the insurer must have less than 1,000 policyholders or certificate holders in order to qualify for the exception. To qualify for an exception, an application must be filed prior to the end of the calendar year for which the exemption is being sought. If the

request is made after the end of the year, an administrative fine may be imposed. The section also authorizes the Department to impose an administrative fine on an insurer who fails to notify the Department of completion by the CPA of the requirements of this section. It allows the Department to immediately suspend an insurer's certificate if the insurer willfully fails to file any report or statement within 10 days after receipt from the CPA.

Section 35* clarifies that any insurer desiring to discontinue the writing of any kind or line of insurance must give the Department 90 days advanced written notice. It also requires (with specific exceptions) the removal of any line of insurance from an insurer's certificate if the insurer does not write any premiums in that kind or line within a calendar year. **Section 36*** deletes subsection (8) of s. 624.609 because of an inaccurate statutory cite.

Section 37* requires insurers ceding risks to reinsurers to file with the Department a certification that the risk has been transferred. A copy of the certification is to be sent to each reinsurer assuming any part of the risk that is being transferred. Any such reinsurer is responsible for notifying the Department if any information in the statement or certification is inaccurate.

Sections 38* and 39* define the terms "kind" and "line" of insurance as used throughout the Code. Kinds of insurance include: life, health, property, casualty, surety, marine, and title insurance. The Department is authorized to define by rule "lines" of insurance consistent with the reporting requirements of the National Association of Insurance Commissioners. **Section 40*** disallows counting as assets prepaid and deferred expenses and federal income tax refunds when a refund is not assured. **Section 41*** excludes an insurer's outstanding capital stock from the calculation of liabilities. **Sections 42* and 43*** update the cross-reference to the current N.A.I.C. edition of "Valuation of Securities" and allow the Department, by rule, to incorporate later editions. **Section 44** allows the Department to retain the services of a qualified appraiser for valuing real and personal property of an insurer if the Department and the insurer cannot agree on the value of the property.

Section 45* extends the 15 percent of admitted assets limitation on stock investments (which now applies to life insurers) to all insurers. In addition, the section authorizes the Department to limit an insurer's deposits with any one financial institution if the Department determines that the financial solvency of the insurer is threatened by a deposit in excess of such limit. **Section 46*** updates the cross-reference to the current N.A.I.C. edition of "Valuation of Securities." **Section 47*** amends s. 625.52 to include all forms of cash as an eligible deposit. It also restricts the use of United States Government obligations to bonds, notes and bills which are direct obligations issued by the Government and (rather than "or") for which the full faith and credit of the U.S. Government is pledged for the payment of principle ~~and interest~~. **Section 48** provides the Department

similar grounds for denying the application of a foreign insurer as are provided for domestic insurers in Section 24 (based upon an applicant's administrative and/or criminal record).

Section 49* requires insurers to notify the Department in advance of any change in management while the Department is reviewing the application for acquisition of controlling stock. It allows the Department to disapprove a material change in management if it finds that the new management is not competent or trustworthy or not in compliance with the other provisions of s. 628.461(7). **Section 50*** applies these same requirements to changes in the management of an allied lines insurer. **Section 51*** provides for Sunset review of sections 24-51 before October 1, 1991. **Section 52*** repeals s. 624.4081, the language of which is incorporated into s. 624.408 by Section 26.

Section 53.* DOI has experienced problems with certain insurers abusing the "consent to rate" provision in section 627.171. The Department suspects some insurers are attempting to avoid the rate approval process by obtaining insureds' consent to excessive rates as a general business practice for certain risks. This section limits the number of excess policies an insurer may write (10 percent of policies for commercial risks and 5 percent of policies for personal lines). The section also requires insurers to maintain for a period of three years the signed written consent forms containing the filed rate and the excess rate.

Sections 54-55.* These sections prohibit a suspended or revoked insurance agent from being employed in any capacity by an agency or agent. As a means of enforcement, each insurance agency location is required by January 1, 1990 to designate one agent as the primary agent. The primary agent will be responsible for overseeing the hiring of agents and for assuring that suspended or revoked agents are not hired. The primary agent could have his license suspended or revoked for failing in this responsibility. Any agency which fails to designate and maintain a primary agent is required to submit to agency licensing.

Sections 56-60. These sections amend Chapter 626, Florida Statutes, relating to Insurance Field Representatives and Operations. **Section 56** gives insurance agencies an affirmative responsibility to determine if employees who will be working with the public are under an order of revocation or suspension by the Department. **Section 57** specifies three additional grounds for disciplinary action against agents: (1) overinsuring in the area of health insurance; (2) failing to notify the department after pleading guilty or nolo contendere or being convicted or found guilty of a felony or a crime punishable by imprisonment of one year or more; and (3) aiding, assisting, procuring, advising or abetting anyone in the violation of the Florida Insurance Code. **Section 58** prohibits a person from being employed in any manner by an insurance agency during a period of suspension or revocation. **Section 59** requires an agent soliciting the sale of health or medicare supplement insurance, if furnished a copy of a customer's current health and/or medicare supplement policy, to explain any overlap or duplication of existing coverage. **Section**

60 adds two new provisions to the list of unfair trade practices:

> Knowingly making a material omission or failing to advise the prospective insured of a policy's pre-existing condition clause when replacing an existing life, health or Medicare supplement policy.
>
> Refusing to insure because of an insured's or applicant's failure to purchase a motor club membership or other service or insurance coverage.

Sections 61-70. These sections make a number of minor revisions to the insurance code requested by the Department of Insurance. **Section 61** remedies an incorrect cross-reference. **Section 62** exempts certain mutual aid societies formed prior to 1935 by religious organizations from most of the insurance code. **Sections 63* and 64*** provide for refunds of license tax fees only if requested in writing by an unsuccessful applicant (currently DOI is responsible for refunding such fees upon disapproval of an application). **Section 65*** increases the maximum value of advertising merchandise given away by agents from $10 to $25. **Section 66*** clarifies the method for crediting reinsurance for financial guaranty insurers. **Sections 67-69*** make technical amendments and provide a new penalty provision for Preneed Funeral Contracts. **Section 70*** provides an October 1, 1991 sunset.

Sections 71-72. These sections create a procedure whereby a financially impaired insurer could be placed under administrative supervision of the Department. Administrative supervision is a step short of court-ordered receivership (under Chapter 631). Department personnel, or their agents, will have prior approval authority over all significant business decisions made by the company. Limited sovereign immunity, as provided in section 768.28, will apply to the Department's actions during the period of administrative supervision, and any information received and meetings conducted during the period of supervision will be exempted from Public Records Law and Government in the Sunshine Law. The confidentiality provided by this bill terminates either one year after the conclusion of the entire period of supervision or when an order is entered in proceedings pursuant to chapter 631, whichever is earlier. The expenses associated with administrative supervision would be the responsibility of the company. However, the Department could defer collection of such expenses upon a showing that payment would jeopardize the insurer's rehabilitation.

The department would initiate supervision by giving written notice of its intent to place the insurer under supervision and by furnishing the insurer a list of requirements to address the conditions. The department could initiate the process if it determined that: (1) the insurer is in unsound condition; (2) the insurer's business practices are hazardous to the public; or (3) the insurer has exceeded its authority. An insurer is in an "unsound condition," if: (1) its surplus, capital, or capital stock is impaired; (2) it continues to write new business when it

has failed to maintain the required surplus or capital; or (3) it attempts to dissolve or liquidate without first making satisfactory provisions for liabilities. A company has "exceeded its powers" when it: (1) refuses to submit to an examination by the department; (2) unlawfully removes it's files or records from Florida; (3) fails to promptly comply with statutory financial reporting requirements or department requests relating thereto; (4) neglects or refuses to correct a deficiency in its capital or surplus; or (5) unlawfully reinsures its entire outstanding business, merges or consolidates substantially all of its business with another insurer.

The department must notify an insurer of its determination to place the insurer under administrative supervision. Within 15 days of such notification, the insurer must submit a plan to correct the deficiencies set forth in the department's notice. If the department and insurer agree on the plan, they shall enter into an agreement to carry out the plan. If the insurer fails to submit a plan, the department may specify a plan for the insurer. Failure to submit a plan is considered a violation of the insurance code. If the department and the insurer can not agree on a plan, the department may proceed under applicable provisions of the insurance code.

If placed under supervision the insurer has 60 days (within the department's discretion, up to 120 days may be allowed) from the date of notice to comply with the department's requirements. If the condition which placed the insurer under supervision is remedied, the department is required to release the insurer from supervision.

Sections 73-80. These sections require those who sell HMO policies to be qualified health insurance agents. HMOs are required to have licensed salesmen in the same manner insurance companies license health insurance agents. In order to qualify for licensure with an HMO, an individual would have to meet the requirements to become a health insurance agent. All provisions of the Insurance Code applicable to licensing of health insurance agents, including disciplinary procedures, apply to HMOs and their licensed agents. Persons who engage in the business of analyzing or abstracting health maintenance contracts or who counsel or give advice concerning such contracts (with limited exceptions) must also be required to be licensed.

The annual reporting requirements for HMOs are simplified and consolidated, and the use of intercompany receivables (from the parent company or affiliate) are disallowed for meeting statutory surplus requirements. The Department is given discretion to allow all or a portion of such receivables if their inclusion is shown to be in the best interest of the subscribers or stockholders of the HMO. Finally, the Department is given the discretion to impose a monetary penalty of up to $1,000 per day for the fist 10 days that a HMO neglects to file its report and up to $2,000 per day thereafter. Currently these penalties are mandatory.

Section 81.* Current law prohibits any distinction or preference in personal lines property or casualty insurance based upon membership or nonmembership in any particular group or association. This section removes that prohibition and allows group policies or other preferences based upon group membership. In addition to the current limitations which apply to commercial property and casualty group policies (i.e., active risk management, benefits passed to participants, group-related actuarial basis for rates), any personal lines group policy must also satisfy the requirements similar to those specified for group life insurance polices. Personal lines groups are restricted to: employee groups, debtor groups, labor union groups, trustee groups, credit union groups, and association groups. The more general "additional group" category authorized for group life insurance policies is not included.

Sections 82-89. These sections clean-up chapters 648 and 903 relating to bail bondsmen and runners. They change the dates for reporting and the number of days within which reports must be filed. They prohibit bail bondsmen and runners from soliciting business in any location where prisoners are confined or on the property or grounds of any court. The sections provide that the Department be copied with various reports.

Section 90. This section provides that monies collected by DOI in connection with delinquency proceedings be deposited in a qualified public depository. Under current law, monies may be deposited in any state or national bank, savings bank, trust company, or savings and loan association.

Section 91. This section provides $50,000 from the Insurance Commissioner's Regulatory Trust Fund for the Bail Bond Regulatory Board to conduct a study for the sunset review of chapter 648.

Section 92. This section provides for confidentiality of claims files maintained by any risk management program administered by the state, its agencies, and its subdivisions and any discussions pertinent to the evaluation of such claims files.

Sections 93-96. These sections will conform Florida's law to changes in federal law governing Medicare and Medicare supplement policies. The new federal law requires all advertisements for Medicare supplement policies to be filed with the Commissioner of Insurance for review and approval. **Section 93** requires the filing and approval of all advertisements in accordance with rules promulgated by the Department of Insurance.

Section 94 revises the minimum coverage required under Medicare supplement policies to coordinate with the new coverage being provided under Medicare, phasing in over 1989, 1990 and 1991. Insurer are required to include a statement at the top of a policy if the policy does not cover the Medicare Part A inpatient hospital deductible amount.

Current law requires Medicare supplement policies to meet a

minimum loss ratio test, returning as benefits to policyholders a minimum percentage of the premium. **Section 95** clarifies that if a Medicare supplement policy provides coverage through a health maintenance organization on a service rather than reimbursement basis, incurred health care expenses will be treated as incurred claims experience is treated under present law. **Section 96** requires insurers to comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987.

Section 97 provides a Severability Clause. If any portion of the act is held invalid, the remainder of the act will be preserved.

Section 98 Directs the Division of Statutory Revision to prepare the necessary reviser's bill to conform all changes made under this act with other statutes.

Section 99. This section provides an effective date, which unless otherwise specified by an asterik (*), is upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring or First Year Start-Up Effects:

Sections 2-4

Insurance Commissioner's Regulatory Trust Fund	FY 89-90	FY 90-91	FY 91-92
Operating Capital Outlay	$16,965	-0-	-0-
Data Processing	18,000	-0-	-0-

Sections 71-72

Insurance Commissioner's Regulatory Trust Fund	FY 89-90	FY 90-91	FY 91-92
Operating Capital Outlay	$69,000	-0-	-0-

Sections 82-89

Insurance Commissioner's Regulatory Trust Fund	FY 89-90	FY 90-91	FY 91-92
Operating Capital Outlay	$14,310	-0-	-0-

Section 91

Insurance Commissioner's Regulatory Trust Fund	FY 89-90
Bail Bond Regulatory Board Sunset Study	$50,000

2. Recurring or Annualized Continuation Effects:

Sections 2-4

Insurance Commissioner's Regulatory Trust Fund	FY 89-90	FY 90-91	FY 91-92
Positions	5.0	5.0	5.0
Salaries and Benefits	$175,596	$234,901	$234,901
Expenses	11,363	15,150	15,150
Data Processing	16,965	-0-	-0-
TOTAL	$221,897	249,241	249,241

Sections 17-22

Insurance Commissioner's Regulatory Trust Fund	FY 89-90	FY 90-91	FY 91-92
Expenses (Travel)	$24,030	$48,030	$48,030

Sections 54-55

Insurance Commissioner's Regulatory Trust Fund	FY 89-90	FY 90-91	FY 91-92
Expenses	$14,000	$14,000	$14,000
Data Processing	1,000	1,000	1,000
TOTAL	$15,000	$15,000	$15,000

Sections 71-72

Insurance Commissioner's Regulatory Trust Fund	FY 89-90	FY 90-91	FY 91-92
Positions	15.0	15.0	15.0
Salaries and Benefits	$364,531	$364,531	$364,531
Other Personal Services	$200,000	$200,000	$200,000
Expenses	$71,036	$71,036	$71,036
Data Processing Services	$181,889	$181,889	$181,889
TOTAL	$817,456	$817,456	$817,456

Sections 82-89

Insurance Commissioner's Regulatory Trust Fund	FY 89-90	FY 90-91	FY 91-92
Positions	2.0	2.0	2.0
Salaries and Benefits	$38,615	38,615	38,615
Expense	6,060	6,060	6,060
TOTAL	$58,985	58,985	58,985

3. Long Run Effects Other Than Normal Growth:

None

4. Appropriations Consequences:

None

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring or First Year Start-Up Effects:

None

2. Recurring or Annualized Continuation Effects:

None

3. Long Run Effects Other Than Normal Growth:

Sections 82-89. Clerks of the Courts will have to mail judgments when filed to the Department of Insurance, but counties should benefit from more prompt payment of judgments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Sections 2-4. Insurance companies will bear the costs of the new requirement to make annual filings or to certify existing rates. This cost will occur only in those years when a rate filing would not otherwise have been submitted.

Section 23. Costs of printing and disseminating information to be borne by insurers. Cost unknown and dependent on number of policies issued.

Sections 93-96. Costs of reprinting and issuing policy forms, advertisements, outline of coverage forms, etc. to be borne by insurers.

2. Direct Private Sector Benefits:

Sections 2-4. According to the Department of Insurance, rate filing documentation made available on an annual basis will contribute to the Department's capacity to monitor volatile market conditions and to assure company adherence to sound business practices and fair pricing. Annual rate filings will provide a foundation of information to implement reasonable and regulatory intervention and to potentially prevent financial practices which have proved to contribute to insurance company insolvencies.

Sections 17-22. Licensed Surplus Lines Agents will benefit from the savings in their cost for administration, duplication and postage.

Section 23. May enable policyholders to better understand coverage.

Sections 73-80. According to the Department, the accessibility to HMO subscribers will increase.

3. Effects on Competition, Private Enterprise, and Employment Markets:

Sections 24-52. The aim of these sections of the bill is to decrease the number of insurance company insolvencies, which would prevent formal rehabilitation proceedings under Chapter 631, save jobs for insurance company employees, and protect policyholders. It will require companies to maintain larger surpluses and in some cases will decrease underwriting capacity. It may thereby affect competition.

D. FISCAL COMMENTS:

Sections 17-22. According to the Department, in 1987 over 200,000 surplus lines policies were filed which represents $420 million in taxable premiums, on which the department collected $12.6 million in taxes. The relaxing of the filing requirement with the department should have no effect on the revenue collected.

Sections 61-70. Passage of this bill should reduce the volume of refunds currently processed by the Receipts Processing Section.

III. LONG RANGE CONSEQUENCES:

Although this bill does not address the specific policies of the State Comprehensive Plan, it does conform with the general policy of the state by protecting Florida consumers from insolvent companies and helping to insure that Florida consumers are able to obtain affordable insurance.

IV. COMMENTS:

The mission of the Insurance Committee is to construct insurance laws which will require payment of claims when due, promote the availability of affordable insurance, stabilize insurance rates, protect the solvency of insurance institutions, and expand the ability of companies to profit from wise investments. This bill is within the mission of the Committee. It will help protect the public from premiums that are unjustifiably high and from companies that are unable to pay claims. It will help establish a stable insurance business climate where companies can prosper and contribute to Florida's economic growth.

Senate Bill 9-B (Special Session B) repealed section 22 of this bill.

CS/SB 845 combines a number of insurance bills which were originally filed individually, including:

SECTIONS	COMPANION BILLS	SUBJECT
1	H 351 S 738	Interest on cash surrender
2-4	H 365 S 1230	Annual rate filings
5-16	H 552 S 1386	Rehabilitation & liquidation
17-22	H 611 S 894	Surplus lines

SECTIONS	COMPANION BILLS	SUBJECT
22	H 666 S 740	Auto Rating (Section 4 only)
23	H 706 S 934	Outline of coverage
24-52	H 861 S 1292	Solvency
53	H 862 S 930	Excess rates (10% com; 5% per)
54-55	H 1058 S 1294	Primary Agent
56-60	H 1094 S 1400	Agents Bill
61-70	H 1109 S 844	DOI housekeeping
71-72	H 1223 S 815	Administrative Supervision
73-80	H 1348 S 739	HMO technical (licensed agnts)
81	H 1516 S 1177	Ficticious groups for P&C
82-89	H 1530 S 743	Bail bonds
90	H 1002	Receivership Funds/Deposit
91	H 1002	Bail Bond Study
92	H 1019 S 473	Confidential risk man files
93-96	H 329 S 845	Medicare Technical

V. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Sharon Jacobs and Fred Varn

Staff Director: John Guthrie

SECOND COMMITTEE OF REFERENCE:
Prepared by: _____

Staff Director: _____

APPROPRIATIONS:
Prepared by: _____

Staff Director: _____