HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 885 Insurance
SPONSOR(S): General Government Policy Council, Tobia
TIED BILLS: **IDEN./SIM. BILLS:**

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Insurance, Business & Financial Affairs Policy Committee	11 Y, 0 N	Reilly	Cooper
2)	Policy Council	15 Y, 0 N	Liepshutz	Ciccone
3)	General Government Policy Council	12 Y, 3 N, As CS	Reilly	Hamby
4)	Rules & Calendar Council		Hassell	Birtman
5)				

SUMMARY ANALYSIS

The bill makes changes to various aspects of insurance.

In summary, the bill:

- Specifies circumstances under which an insurer is not required to send notice of replacement of a life insurance policy to the current insurer.
- Allows coverage of spouses and dependent children under a group life insurance policy up to the amount for which the employee is insured under the policy.
- Bars the sale or transfer of annuities, which were purchased as part of a settlement to satisfy Medicare secondary payer requirements, to third parties that are not connected with the settlement.
- Excludes specified supplemental or limited benefit insurance policies from providing coverage of certain mandatory health benefits.
- Specifies that continuation or renewal of a guaranteed renewable long-term care policy through timely payment of premiums does not constitute the issuance of a new policy for any purpose, including for purposes of incorporating into the policy changes in regulations or legislation governing insurance policies.
- Codifies that an insurer may revise long-term care insurance rates on a class basis.
- Provides that, for motor vehicle service agreements (a type of warranty agreement), there is no violation of knowingly over or undercharging, if the motor vehicle service agreement company refunds the excess premium within 45 days, or if the licensed sales representative's commission is reduced by the amount of any premium undercharge.
- For purposes of group life insurance, prohibits creation of a class of employees consisting solely of employees covered under the employer's group health plan.
- Provides that granting premium credits to insureds under Medicare supplement policies does not constitute an unfair method of competition or unfair or deceptive act or practice.
- Permits insurers that offer Medicare supplement policies to enter into agreements with in-patient facility networks that agree to waive the Medicare Part A deductible in whole or in part.
- Provides that a person is not liable for any penalty for failure to obtain health insurance coverage.
- Authorizes the Attorney General to pursue litigation on behalf of any person penalized for failure to obtain or maintain health insurance coverage.

The fiscal impact associated with provisions allowing the Attorney General to pursue litigation is indeterminate at this time.

The bill takes effect upon becoming law.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Replacement of Life Insurance

An insurer that sells a life insurance policy that will replace an existing policy owned by a person must send notice of the replacement policy to the current insurer, among other responsibilities.[1] The notice is intended to give the current insurer the opportunity to contact the policyholder to discuss the current policy before it is canceled.[2]

House Bill 885 creates s. 627.4605, F.S. The section provides that an insurer is not required to send notice of replacement life insurance to the current insurer when the replacement policy is issued by the same insurer or an affiliate of the insurer of the policy that is to be replaced. Specifically, notice of replacement life insurance does not need to be sent to the current insurer for transactions involving:

- An application to the current insurer that issued the current policy when a contractual change or conversion privilege is being exercised.
- A current policy is being replaced by the same insurer pursuant to a program approved by the Office of Insurance Regulation.
- A term conversion privilege is being exercised among corporate affiliates.

This section is consistent with model standards adopted by the National Association of Insurance Commissioners (NAIC).[3]

Dependent Coverage under Group Life Insurance Policies

Thirty-five states have statutory provisions relating to coverage of spouses and dependent children under group life insurance policies.[4] Twenty of these states do not specify a coverage limitation;[5] 12 allow coverage

[1] Rule 69O-151.007, F.A.C., implementing ss. 624.307(1), 626.9521, 626.9541, 626.9641, 626.99, F.S. The insurer is also required to provide certain information to the prospective purchaser of the replacement policy.

[2] Correspondence between representatives of the life insurance industry (Paul Sanford) and staff of the Insurance, Business & Financial Affairs (IBFA) Policy Committee. On file with the IBFA Policy Committee.

[3] National Association of Insurance Commissioners, "Life Insurance and Annuities Replacement Regulation" (July 2006). Available from the NAIC website: http://www.naic.org.

[4] *See* American Council of Life Insurers, "Law Survey: Dependent Caps on Group Life Insurance" (July 2009). A copy of the survey is on file with the IBFA Policy Committee.

up to the amount for which the employee is insured under the group policy;[6] and three states, including Florida under s. 627.5575(3), F.S., [7] allow coverage of up to 50% of the amount for which the employee is insured under the group life insurance policy. The NAIC model, which was adopted in the 1980s, limits coverage for spouses and dependent children under group life insurance policies to 50% of the amount for which the employee is insured.[8]

The bill removes the 50% cap, and allows spouses and dependent children to be insured under a group life insurance policy up to the amount for which the employee is insured.

Medicare

Medicare Supplement Policies

Medicare is health insurance for people 65 years of age and older and for those under age 65 with a disability or End Stage Renal Disease. Under federal law,[9] Medicare beneficiaries age 65 and older, who are also enrolled in Medicare Part B,[10] have a guaranteed right to purchase a Medicare supplemental policy (Medigap insurance) during an open enrollment period.[11] Medigap insurance helps pay some of the health costs not covered by Medicare, including copayments, coinsurance, and deductibles.

The Department of Health and Human Services (HHS) defines the parameters and provides guidelines for standardized Medigap policies. HHS has opined that a network arrangement wherein the facility agrees to waive all or a portion of the Medicare Part A in-patient deductible does not violate standardization provisions.[12] In addition, HHS has opined that, if products containing such provisions are permitted to be marketed and sold in a state, the waiver of the Part A premium deductible and the premium credit must be factored into the loss ratio calculation and into the policy premium.[13]

The bill allows insurers that offer Medigap insurance policies to enter into agreements with in-patient facility networks that agree to waive the Medicare Part A deductible in whole or in part. The insurer is not required to file a copy of the network agreement with the OIR. Such network agreements are not subject to OIR approval. The bill also provides that premium credits granted to insureds under Medigap insurance policies for using in-network in-patient facilities do not constitute an unfair method of competition or unfair or deceptive trade practice. The waiver of the Medicare Part A deductible and premium credit are required to be factored into the insurer's loss-ratio calculation and policy premium.

Secondary Payer Rule

42 U.S.C. 1395y(b)(2) sets forth Medicare secondary payer (MSP) requirements.[14] Annuities may be purchased as part of a settlement to satisfy MSP requirements. The bill bars the sale or transfer of such annuities to third parties that are not connected with the settlement.

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[5] Arkansas, Delaware, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Missouri, Montana, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, and Utah.

[6] Arizona, California, Hawaii, Illinois, Maryland, New Jersey, Texas, Vermont, Virginia, Washington, and West Virginia. New York permits the spouse to be insured for up to 100% of the amount for which the employee is insured under the group life policy, but limits coverage for a dependent child to a maximum of $25,000.

[7] Kansas and Nebraska also provide a 50% limitation.

[8] Correspondence between representatives of the life insurance industry (Paul Sanford) and IBFA Policy Committee staff. On file with the IBFA Policy Committee.

[9] 42 U.S.C. 1395ss.

[10] Medicare Part B helps cover doctors' expenses and outpatient care.

[11] Medicare beneficiaries may be able to purchase Medigap insurance after the open enrollment period has ended. However, insurance companies can use medical underwriting criteria in determining whether to issue a policy.

[12] HHS letter of December, 3, 2009 to the Florida Office of Insurance Regulation. A copy of the letter is on file with the IBFA Policy Committee.

[13] *Id.*

[14] The term Medicare secondary payer refers to situations in which Medicare is not responsible for paying first.

Health Insurance

Mandates and Mandated Offerings

A health insurance mandate is a legal requirement that an insurance company or health plan cover services by particular health care providers, specific benefits, or specific patient groups. Mandated offerings, on the other hand, do not mandate that certain benefits be provided. Rather, a mandated offering law can require that insurers offer an option for coverage for a particular benefit or specific patient groups, which may require a higher premium and which the insured is free to accept or reject. Health insurance mandates are covered under chs. 627 and 641, F.S.

The bill provides that specific-accident, specific-disease, hospital indemnity, limited benefit, disability income, Medicare supplement, long-term care policies, or other supplemental or limited benefit policies described in s. 627.6561 (b)-(d) are not required to provide coverage for mandates identified in the bill. The excluded mandates include benefits such as insurance rebates for healthy lifestyles, maternity care, diabetes treatment services, payment of acupuncture benefits to certified acupuncturists, and coverage for osteoporosis screening, diagnosis, treatment, and management.[15]

Long-term Care Insurance Policies

Long-term care insurance policy means 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 maintenance or personal care services provided in a setting other than an acute care unit of a hospital.[16] A long-term care insurance policy may not be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.[17] The bill specifies that continuation or nonrenewal of a guaranteed renewable long-term care policy through timely payment of premiums does not constitute the issuance of a new policy for any purpose, including for purposes of incorporating into the policy changes in regulations or legislation governing insurance policies.[18] It also codifies that an insurer may revise long-term care insurance rates on a class basis.

Health Insurance Reform

The bill states that it is Florida's public policy that all persons within the state be free from governmental intrusion in choosing or declining to choose any mode of securing health insurance coverage without penalty or threat of penalty, and that this policy is consistent with constitutional rights of liberty. It further provides that persons who do not obtain or maintain health insurance coverage are not liable for any penalty or fine. The bill authorizes the Attorney General, for any impingement by the Federal Government upon a person's right to chose whether or not to obtain and maintain health insurance coverage, to pursue litigation in court or in any administrative forum.

Motor Vehicle Service Agreements

Chapter 634, F.S., governs the regulation of warranty associations, which include motor vehicle service agreement companies. Motor vehicle service agreements provide vehicle owners with protection when the manufacturer's warranty expires. They indemnify a vehicle owner (or holder of the agreement) against loss

[15] A comprehensive listing of excluded mandates is set forth in the bill.
[16] *See* s. 627.9404(1), F.S.
[17] *See* s. 627.9407(3)(a), F.S.
[18] These provisions are in response to a decision of the Third District Court of Appeal in *Bell Care Nurses Registry v. Continental Casualty Company,* 25 So.3d 13 (Fla. 3d DCA 2009). In *Bell,* the court held that renewal of the insurance contract through timely premium payment constituted making of a new contract. Therefore, the resulting new contract incorporated into the policy changes made in statutes regulating insurance contracts.

caused by failure of any mechanical or other component part, or any mechanical or other component part that does not function as it was originally intended.[19] While a warranty is not considered a traditional insurance product, it protects purchasers from future risks and associated costs. In Florida, warranty associations are regulated by the OIR.

Certain acts of motor vehicle service agreement companies are considered unfair methods of competition and unfair or deceptive acts or practices, including provisions relating to illegal dealings in premiums. The bill provides that, for motor vehicle service agreements, there is no violation of knowingly over or undercharging, if the motor vehicle service agreement company refunds the excess premium within 45 days, or if the licensed sales representative's commission is reduced by the amount of any premium undercharge.

Group Life Insurance

Section 627.552, F.S., governs employee groups for purposes of group life insurance policies. The bill prohibits employers from creating a class of employees eligible for such insurance that consists solely of employees covered under the employer's group health plan.

B. SECTION DIRECTORY:

Section 1. Amends s. 626.9541, F.S., relating to inpatient facility networks.
Section 2. Creates s. 627.4605, F.S., relating to notice replacement life insurance.
Section 3. Amends s. 627.464, F.S., relating to annuity contracts.
Section 4. Amends s. 627.552, F.S., relating to group life insurance policies.
Section 5. Amends s. 627.5575, F.S., relating to group life insurance for dependents.
Section 6. Creates s. 627.6011, F.S., relating to mandated coverages exclusion.
Section 7. Amends s. 627.6741, F.S., relating to issuance, cancellation, nonrenewal, and replacement of insurance policies.
Section 8. Amends s. 627.6745, F.S., relating to loss ratio standards.
Section 9. Amends s. 627.9403, F.S., relating to long-term care insurance policies.
Section 10. Amends s. 634.282, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices.
Section 11. Sets forth the state's public policy regarding an individual's right to obtain and maintain health care coverage, and authorizes the Attorney General to pursue litigation for impingement of this right.
Section 12. Provides for the bill to become effective upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   See notes in "Fiscal Comments" section.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

[19] *See* s. 634.011(8), F.S.

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The fiscal impact associated with provisions allowing the Attorney General to pursue litigation is indeterminate at this time.

D. FISCAL COMMENTS:

The fiscal impact associated with provisions allowing the Attorney General to pursue litigation is indeterminate at this time.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

B. RULE-MAKING AUTHORITY:

None

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On April 9, 2010, the General Government Policy Council adopted four amendments, which made the following changes:

- Changes the title of the bill to an act relating to insurance.
- Bars the sale or transfer of annuities, which were purchased as part of a settlement to satisfy Medicare secondary payer requirements, to third parties that are not connected with the settlement.
- Excludes specified supplemental or limited benefit insurance policies from providing coverage of certain mandatory health benefits.
- Specifies that continuation or renewal of a guaranteed renewable long-term care policy through timely payment of premiums does not constitute the issuance of a new policy for any purpose,

including for purposes of incorporating into the policy changes in regulations or legislation governing insurance policies.

- Codifies that an insurer may revise long-term care insurance rates on a class basis.
- Provides that, for motor vehicle service agreements (a type of warranty agreement), there is no violation of knowingly over or undercharging, if the motor vehicle service agreement company refunds the excess premium within 45 days, or if the licensed sales representative's commission is reduced by the amount of any premium undercharge.
- For purposes of group life insurance, prohibits creation of a class of employees consisting solely of employees covered under the employer's group health plan.
- Provides that granting premium credits to insureds under Medicare supplement policies does not constitute an unfair method of competition or unfair or deceptive act or practice.
- Permits insurers that offer Medicare supplement policies to enter into agreements with in-patient facility networks that agree to waive the Medicare Part A deductible in whole or in part.
- Provides that a person is not liable for any penalty for failure to obtain health insurance coverage
- Authorizes the Attorney General to pursue litigation on behalf of any persons that are penalized for failure to obtain or maintain health insurance coverage.