# ECONOMIC AFFAIRS COMMITTEE
# INSURANCE & BANKING
# SUBCOMMITTEE
# FACT SHEETS

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January 12, 2011

# ECONOMIC AFFAIRS COMMITEE
# INSURANCE & BANKING SUBCOMMITTEE
# FACT SHEETS

## Insurance Overview

# Kinds of Insurance

FACT SHEET 2010

## Introduction

Florida law (Section 624.601, F.S.) specifies seven "kinds" of insurance: life insurance, health insurance, property insurance, casualty insurance, surety insurance, marine insurance, and title insurance. Each "kind" of insurance is classified into "lines" of insurance. (Section 624.6012, F.S.)

## Life Insurance

Life insurance is the insurance of human lives and provides protection to beneficiaries upon the death of the insured. Life insurance contracts take many forms: term life, whole life, credit life, and annuities.

## Health Insurance

Health insurance generally provides coverage for hospital, physician, and other medical expenses resulting from illness or injury. It includes coverage for the accidental loss of life, limb or sight, but does not include workers' compensation.

## Property Insurance

Property insurance covers the loss of or damage to the property of policyholders as the result of hurricane, theft, fire, or other disaster. The term "homeowners insurance" is sometimes used interchangeably with the term "property insurance," however, "homeowners insurance" is not defined in Florida Statutes.

Property insurance is categorized by the type of dwelling the insurance covers: personal residential, commercial residential or commercial nonresidential. Generally, "personal residential" property insurance refers to the coverage of a single-family home, mobile home, condominium unit, or apartment unit. Coverage for a condominium unit or an apartment unit typically covers contents only. The term "commercial residential" property insurance refers to property insurance covering a condominium building or an apartment building. The term "commercial nonresidential" property insurance refers to property insurance covering a business.

## Casualty Insurance

Casualty insurance generally covers policyholder liability for injures or damages suffered by other persons (i.e., third persons) or the property of others. It includes motor vehicle, workers' compensation, liability, credit, credit property, and malpractice insurance.

## Surety Insurance

A surety generally agrees to pay the debt of another person or performance of some obligation. Surety insurance includes:

- A contract bond, including a bid, payment, or maintenance bond, or a performance bond, which guarantees the execution of a contract other than a contract of indebtedness or other monetary obligation;
- An indemnity bond for the benefit of a public body, railroad, or charitable organization or a lost security or utility payment bond;
- Becoming surety on, or guaranteeing the performance of, any lawful contract where the bond is guaranteeing the execution of a contract other than a contract of indebtedness or other monetary obligation;
- Becoming surety on, or guaranteeing the performance of, bonds and undertakings required or permitted in a judicial proceeding or otherwise allowed by law, including surety bonds accepted by states and municipal authorities in lieu of deposits as security for the performance of insurance contracts;
- Fidelity insurance as defined in section 624.6065, F.S., for the purposes of the Florida Insurance Code other than part XX of chapter 627, F.S.; or
- Residual value insurance as defined in section 624.6081, F.S.

## Marine Insurance

Primarily, marine insurance covers any kinds of losses or damages to vessels, aircraft, cars, freights and all other kinds of property in connection with the risks of navigation.

## Title Insurance

Title insurance insures against losses resulting from defects of title in, or encumbrances or liens on real property.

## Relevant Florida Statutes

**Florida Statutes:**
Section 624.601, F.S.
Section 624.6012, F.S.
Section 624.602, F.S.
Section 624.603, F.S.
Section 624.604, F.S.
Section 624.605, F.S.
Section 624.606, F.S.
Section 624.607, F.S.
Section 624.608, F.S.

## Where can I get additional information?

### Florida Office of Insurance Regulation

200 East Gaines St.
Tallahassee, FL 32399
(850) 413-3140
http://www.floir.com/

### Florida House of Representatives

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

# The Office of Insurance Regulation

FACT SHEET 2010

## Introduction

The Legislature created the Office of Insurance Regulation (Office) in 2003:

> "The Office of Insurance Regulation, which shall be responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code or chapter 636. The head of the Office of Insurance Regulation is the Director of the Office of Insurance Regulation, who may also be known as the Commissioner of Insurance Regulation."
> --Section 20.121,(3)(a)1, Florida Statutes

The Office ensures insurance companies licensed to do business in Florida are financially viable, operating within the laws and regulations governing the industry, and offering insurance policy products at rates that do not unfairly discriminate against the public and are not excessive or inadequate.

The Office is, for purposes of administrative, personnel, and technology support, housed within the Department of Financial Services. Office funding is appropriated directly by the Legislature from the Insurance Regulatory Trust Fund, funded by insurance company licensing fees, fines that may be levied for non-compliance with provisions of the Insurance Code, and a portion of premium tax paid by surplus lines carriers transacting insurance in this State.

## The Insurance Commissioner

The Insurance Commissioner is appointed by, and reports to, the Financial Services Commission (Commission). The Commission is comprised of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. For appointment or removal of Insurance Commissioner, a majority of the Commission must agree on the action with at least three affirmative votes with the Governor and the Chief Financial Officer on the prevailing side. Commission action is taken by majority vote. The Commission serves as agency head of the Office for purposes of rulemaking, whereas, the Insurance Commissioner is considered the agency head for purposes of final agency action for all areas within the regulatory authority delegated to the Office.

## Organization of the Office of Insurance Regulation

The Office is divided into eight business units[1]:

1. The Property and Casualty Financial Oversight Unit
2. The Property and Casualty Product Review Unit
3. The Life and Health Financial Oversight Unit
4. The Life and Health Product Review Unit
5. The Specialty Product Administration Unit
6. The Market Investigations Unit
7. The Business Development Unit
8. The Market Research and Technology Unit.

The Office also has a Legal Services Office, an Inspector General's Office, and a Legislative Affairs Office.

### *The Property and Casualty Financial Oversight Unit*

The Property and Casualty Financial Oversight Unit monitors the financial stability of property and casualty insurers, title insurers and self-insurance funds by obtaining and reviewing financial statements and conducting on-site financial examinations.

### *The Property and Casualty Product Review Unit*

The Property and Casualty Product Review Unit reviews property and casualty rules, forms, and rate filings for homeowners, automobile, workers' compensation, liability, and other personal and commercial property and casualty lines of coverage to ensure compliance with the Florida Insurance Code.

### *The Life and Health Financial Oversight Unit*

The Life and Health Financial Oversight Unit monitors the solvency of life and health insurers by obtaining and reviewing periodic financial statements. This unit also monitors the financial condition of managed care entities by conducting actuarial reviews and field examinations and analyzing financial statements.

### *The Life and Health Product Review Unit*

The Life and Health Product Review Unit reviews and approves health insurance rates and life and health policies that are to be issued to Florida residents.

### *The Specialty Product Administration Unit*

The Specialty Product Administration Unit provides regulation and oversight to insurance administrators, continuing care retirement communities, motor vehicle service agreement companies, home warranty associations, service warranty associations, insurance premium finance companies, donor annuities, legal expense corporations, viatical settlement providers, third party administrators, and title insurance agents and insurers. This unit licenses and monitors the quality of company assets, adequacy of stated liabilities, general operating results and market conduct of these entities to assure compliance with the Florida Insurance Code.

[1] http://www.floir.com/index.aspx

### *The Market Investigations Unit*

The Market Investigations Unit examines and investigates business practices and alleged violations of the Florida Insurance Code.

### *The Business Development Unit*

The Business Development Unit identifies solvent companies suitable for expanding or moving lines of business to Florida and encourages them to apply for licensure.

### *The Market Research and Technology Unit*

The Market Research and Technology Unit collects and distributes information and resource materials relating to the oversight and development of Florida's insurance markets. This unit also provides analysis and discussion at both the national and international levels regarding insurance issues important to Florida.

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**
Section 20.121, F.S.

## Fiscal Information

For the 2009-2010 fiscal year, the OIR had 300 full-time employees with a total budget of over $28 million. One hundred percent of the OIR budget is derived from the Insurance Regulatory Trust Fund; no General Revenue funds are used. In fiscal year 2008-2009, the OIR collected over $650 million in revenue from the insurance premium tax and almost $13 million in penalties and fines.

As of June 30, 2009, the OIR regulated almost 4,000 insurance entities.

## Where can I get additional information?

### Florida Office of Insurance Regulation

200 East Gaines St.
Tallahassee, FL 32399
(850) 413-3140
Consumer Help Line: 877-693-5236 (in-state)
850-413-3089 (out-of-state)
http://www.floir.com

Economic Affairs Committee
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204 House Office Building
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Tallahassee, FL 32399-1300
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# Insurance Company Regulation

FACT SHEET 2010

## Introduction

The Office of Insurance Regulation (OIR) is the chief regulatory entity responsible for regulating insurance in Florida. The mission of the OIR is to ensure insurance companies licensed to do business in Florida are financially viable, operating within the laws and regulations governing the insurance industry, and offering insurance products at fair and adequate rates which do not unfairly discriminate against the buying public. The OIR is responsible for all activities concerning insurance companies and other risk bearing entities. These activities include licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Insurance Code.

## Regulatory Responsibility Over Insurance Companies

Insurance regulation is primarily the responsibility and function of state government. In 1945 Congress passed the McCarran-Ferguson Act – an act delegating insurance regulation to the states and granting insurance companies a limited exemption from federal antitrust laws. Within constitutional limits, states may regulate virtually any aspect of the insurance business they deem necessary and appropriate. Every state, to varying degrees, regulates insurance companies and insurer representatives (e.g. agents), rates, policy forms, and business practices.

On July 21, 2010 President Obama signed into law an overhaul of how financial services are regulated in the United States. The act establishes the Federal Insurance Office (FIO), an entity that will report to Congress and the President on the insurance industry. Insurance will continue to be regulated by the states, but the act includes a narrow preemption of state insurance laws in areas where the FIO determines that the state law is inconsistent with a negotiated international agreement and treats a non-U.S. insurance company less favorably than a U.S. insurer. The FIO has the authority to monitor the insurance industry, identify regulatory gaps or systemic risk, deal with international insurance matters and monitor the extent to which underserved communities have access to affordable insurance products. The FIO covers insurers, including reinsurers, except for health insurers.

In Florida, regulation of insurance companies and insurer representatives is expressly preempted to the state under Florida law; local governments are prohibited from requiring any authorization, permit, or registration of any kind. Florida has an extensive set of regulatory requirements for insurance. With few exceptions, these laws are found in chapters 624 through 651 of the Florida Statutes. These laws constitute the Insurance Code.

## Licensing of Insurance Companies

### *Initial Issuance of a Certificate of Authority*

Insurance companies must apply for and receive a certificate of authority from the OIR before transacting insurance business in Florida. To qualify for a certificate of authority, an insurance

company must: submit an application with associated fees and a copy of the company's financial statement, maintain certain specified reserves, meet minimum surplus requirements, and deposit funds with the OIR. Licensing requirements vary depending on the way in which an insurance company is organized. If the OIR finds an insurance company complies with all of the statutory requirements for licensure, the OIR must issue the insurance company a certificate of authority. The certificate will specify the kinds or lines of insurance the insurance company may transact. The Insurance Code places restrictions on the kinds of insurance insurance companies are authorized to transact. For instance, the same insurance company cannot, using the same corporate entity and certificate of authority, transact both property and casualty insurance and life and health insurance.

### *Maintenance of a Certificate of Authority*

Certificates of authority continue in effect until revoked or suspended by the OIR or terminated at the request of the insurance company, as long as the company pays the annual licensing fees and files an annual financial statement. Once licensed, the surplus the insurance company must maintain to keep its license is that required of existing insurance companies, rather than the minimum surplus required to obtain a license.

### *Suspension or Revocation of a Certificate of Authority*

By order, the OIR can revoke or suspend an insurance company's certificate of authority. The OIR must revoke or suspend the certificate if: the insurance company is in unsound financial condition, is operating in a way that is hazardous to its policyholders or to the public, has not timely paid outstanding judgments in Florida rendered against the company, or no longer meets the requirements for initial issuance of a certificate of authority to transact insurance. The OIR may suspend or revoke a certificate if: an insurance company has violated any order or rule of the OIR or of the Insurance Code, refused to be examined, refused to pay claims as a general business practice without cause, is affiliated with and under the same management as an unlicensed insurance company, has a premium-to-surplus ratio exceeding 4-to-1 leading the OIR to believe policyholder interests are endangered, or has an insurance licensed issued in another state suspended or revoked.

## Solvency Requirements for Insurance Companies

Insurance companies must satisfy numerous financial requirements to transact insurance. These requirements are designed to prevent insurance companies from becoming insolvent and unable to fulfill contractual obligations to policyholders. Although the specific requirements vary depending on the line of insurance and the type of insurance company, in general, the Insurance Code:

- Requires insurance companies to have and maintain a specified minimum amount of surplus, equivalent to a net worth requirement, at time of initial licensure and on an ongoing basis
- Controls the maximum amount of insurance an insurance company may write by requiring insurance companies to maintain a certain ratio of surplus-as-to-policyholder which measures an insurance company's use of underwriting capacity. (section 624.4095, F.S.)
- Describes the assets or liabilities insurance companies may include in their financial statements and the value the company can assign to their assets (Chapter 625, Part I, F.S.)

- Regulates surplus adequacy based on an insurance company's unique mix of investment, credit, off-balance sheet, and underwriting risk (section 624.4085, F.S.)
- Regulates the reserve practices of insurance companies (sections 625.041 – 625.111, F.S.)
- Regulates insurance company investments (Chapter 625, Part II, F.S.).

## Form Filing and Review Procedure and Requirements

The OIR has broad authority to review and approve forms used by insurance companies. These include application forms, policy forms, printed riders or endorsements, and renewal certificate forms. Generally, these forms must be filed with and approved by the OIR before being used by an insurance company, typically 30 days in advance. In most instances, the OIR then has 30 days to approve or disapprove the particular form, or it is deemed approved for use by the insurance company.

## Rate Filing and Review Procedure and Requirements

The insurance rate filing and review procedure and requirements are different for different lines of insurance. For example, property insurance rates are not filed and analyzed by the OIR in the same way workers' compensation insurance rates are. Thus, the rate filing and review procedure and requirements will be addressed in the Fact Sheet applicable to the line of insurance.

## Relevant Florida Statutes

**Florida Statutes:**
Sections 624.401-627.4315, F.S.
Section 627.062, F.S.
Section 627.410, F.S.

## Where can I get additional information?

### Florida Office of Insurance Regulation

200 East Gaines St.
Tallahassee, FL 32399
(850) 413-3140
Consumer Help Line: 877-693-5236 (in-state)
850-413-3089 (out-of-state)
http://www.floir.com

### Florida House of Representatives

Economic Affairs Committee
Insurance & Banking Subcommittee

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(850) 414-7365
http://www.myfloridahouse.gov

# Types of Non-Traditional Insurance Companies

FACT SHEET 2010

## Introduction

Insurance companies are classified according to a variety of characteristics:

- By authority to transact insurance: authorized or unauthorized
- By place of domicile: domestic, foreign, or alien
- By form: company, reciprocal, self-insurance fund, joint underwriting association, or reinsurance company, and
- By type of insurance written.

Two types of insurance companies that are not traditional insurance companies but are nonetheless very important in making insurance available in Florida are joint underwriting associations and reinsurance companies.

## Joint Underwriting Associations

A joint underwriting association (JUA) is a residual market entity – commonly referred to as an "insurer of last resort." JUAs provide insurance coverage for those risks unable to obtain insurance in the voluntary market from private insurance companies. In Florida, workers' compensation, motor vehicle, medical malpractice and property insurance currently have an active JUA.[1]

Each JUA in Florida is created in statute. Certain JUA policy contracts and rates are subject to approval by the Office of Insurance Regulation. The premium for insurance provided by a JUA is typically higher than the premium for similar insurance provided by a private insurance company. However, premiums for Citizens Property Insurance Corporation (Citizens), the property insurance JUA, can be lower than those from private insurance companies, in part, because Citizens' rates were frozen from 2007-2009 and are currently allowed by law to increase only up to 10 percent a year per policy.

JUA plans of operation are subject to approval by the Office of Insurance Regulation, with the exception of Citizens. The plan of operation for Citizens is approved by the Financial Services Commission which is comprised of the Governor, the Chief Financial Officer, the Attorney General, and the Agriculture Commissioner.

[1] Although another property JUA, the Property and Casualty JUA, is created in statute to help provide commercial property coverage to Florida's business community when businesses are unable to procure property insurance covering their business in the private market or from Citizens Property Insurance Corporation, this JUA is not currently active.

### *Florida Workers' Compensation Joint Underwriting Association*

The workers' compensation JUA was established in 1994 to provide workers' compensation and employer's liability insurance to employers who are required by law to have coverage but who are unable to obtain policy in the private market.

### *Florida Automobile Joint Underwriting Association*

The automobile JUA was created in 1973 to provide automobile insurance to qualified applicants unable to procure coverage in the private market.

### *Florida Medical Malpractice Joint Underwriting Association*

The medical malpractice JUA was established in 1975 to afford health care providers coverage for claims arising out of a failure to render, or the rendering of, medical care of services. This JUA provides professional liability insurance coverage in Florida for health care providers that cannot find coverage in the open market.

### *Citizens Property Insurance Corporation*

The property insurance JUA, Citizens Property Insurance Corporation, was formed in 2002 by merging the then existent Florida Residential Property and Casualty Joint Underwriting Association and the Florida Windstorm Underwriting Association. This JUA provides property insurance for personal and commercial lines risks that cannot find coverage in the private market.

## Reinsurance Companies

Reinsurance is a highly complex and global business. Reinsurance is insurance for insurance companies. It is a way of transferring some of the financial risk insurance companies assume in insuring cars, homes and businesses to another insurance company, the reinsurer. Reinsurance transactions are primarily between two insurance entities: the primary insurer that sold the original insurance policies to consumers and the reinsurance company/reinsurer. Many reinsurance companies reside in Bermuda or Europe. As an industry, reinsurance is less highly regulated than insurance for individual consumers, in part, because the purchasers of reinsurance, mostly primary insurance companies that sell car, home and business insurance, are considered sophisticated buyers.

When an insurance company buys reinsurance, the reinsurer agrees to reimburse the primary insurer for or to pay the claims policyholders make against the primary insurer. With reinsurance, the primary insurer typically must meet a deductible specified in the reinsurance contract before the reinsurance company pays the claims of the primary insurer. Thus, primary insurers rarely reinsure their entire book of business; rather these insurers use their cash on hand to pay claims up to the reinsurance deductible. Insurance companies purchase reinsurance to reduce the likelihood the company will go insolvent if there is a catastrophic event causing numerous claims as many of the claims will be paid by the reinsurance company and not directly by the primary insurer.

### *Rates for Reinsurance*

Unlike insurance rates charged by primary insurers licensed Florida, the rate for reinsurance charged by reinsurance companies is not regulated by the Florida Office of Insurance Regulation. These rates are also not regulated by the federal government. Thus, the rate charged for reinsurance is negotiated between the primary insurer purchasing the reinsurance and the reinsurance company. Reinsurance rates fluctuate from year to year and typically increase in the years following catastrophes such as hurricanes due to increased claims on the reinsurance contract as a result of the catastrophes. In addition, unlike insurance forms used by primary insurers licensed in Florida, insurance forms used by reinsurance companies for reinsurance are not regulated by the Florida Office of Insurance Regulation or the federal government.

### *Reinsurance Sold by the State of Florida*

The Florida Hurricane Catastrophe Fund (discussed in further detail in the fact sheet titled "The Florida Hurricane Catastrophe Fund") is reinsurance sold by the state of Florida to primary insurers that are licensed Florida residential property insurers. This Fund reimburses (reinsures) insurers for a portion of their hurricane losses to residential property in accordance with the reimbursement contract entered into between the State and the primary insurer. Primary insurers pay a premium to the State for the reinsurance provided by the State in the reimbursement contract.

## Relevant Florida Statutes

**Florida Statutes:**
Section 215.555, F.S.
Section 627.311, F.S.
Section 627.351, F.S.

## Where can I get additional information?

### *Florida Office of Insurance Regulation*

200 East Gaines St.
Tallahassee, FL 32399
(850) 413-3140
Consumer Help Line: 877-693-5236 (in-state)
850-413-3089 (out-of-state)
http://www.floir.com

### *Florida Workers' Compensation Joint Underwriting Association*

P.O. Box 48957
Sarasota, FL 34230-5957
(941) 378-7400
http://www.fwcjua.com/

### *Florida Automobile Joint Underwriting Association*

1425 Piedmont Drive East, Suite 201 A
Tallahassee, FL 32308
(850) 681-2003
https://www.aipso.com/FL/

### *Florida Medical Malpractice Joint Underwriting Association*

c/o The Medical Protective Company
5814 Reed Road
Fort Wayne, IN 46835-3568
800-836-6003
https://www.fmmjua.com/fmmjua/index.jsp

### *Citizens Property Insurance Corporation*

P.O. Box 17219
Jacksonville, FL 32245
Customer Care: 1-888-685-1555
https://www.citizensfla.com/

### *Florida Hurricane Catastrophe Fund*

1801 Hermitage Blvd.
Tallahassee, FL 32308
(850) 413-1349
http://www.sbafla.com/fhcf/

### *Florida House of Representatives*

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

## Property Insurance

# Property Insurance – In General

FACT SHEET 2010

## Introduction

Property insurance helps pay to repair or rebuild a home or other property damaged as the result of hurricane, theft, fire, or other disaster. The term "homeowners insurance" is sometimes used interchangeably with the term "property insurance," however, "homeowners insurance" is not defined in Florida Statutes.

## Coverage of Property Insurance

Property insurance is categorized by the type of dwelling the insurance covers: personal residential, commercial residential or commercial nonresidential. Generally, "personal residential" property insurance refers to the coverage of a single-family home, mobile home, condominium unit, or apartment unit. Coverage for a condominium unit or an apartment unit typically covers contents only. The term "commercial residential" property insurance refers to property insurance covering a condominium building or an apartment building. The term "commercial nonresidential" property insurance refers to property insurance covering a business.

Florida law does not require property owners to obtain property insurance, but most lending institutions require property insurance for mortgaged homes or structures. Nevertheless, by law, homeowners can elect to exclude windstorm coverage from their property insurance policy, but if the property is subject to a mortgage or lien, the mortgage holder or lien holder must approve the exclusion.

## Rate Regulation for Property Insurance

In insurance, rate is the amount charged per unit of insurance. Premium is determined by multiplying the rate by the units of insurance purchased and is the out of pocket expense a property owner pays for insurance. In Florida, the premium for property insurance is broken down into the premium for windstorm/hurricane coverage and the premium for coverage for all other perils listed in the policy.

Although rates for property insurance in any given rating territory are the same for all property owners of similar properties, the premium property owners pay for property insurance in a rating territory is likely not the same. Some factors that make the premium for policies for similar property in the same rating territory different are: the amount of coverage purchased, the type of coverage purchased (e.g. sinkhole or mold coverage purchased), and any riders to the basic property insurance policy purchased (e.g. jewelry rider).

In Florida, the Office of Insurance Regulation (OIR) is charged with regulating insurance rates, including property insurance rates. Property insurance rating laws prohibit property insurance rates that are "excessive, inadequate, or unfairly discriminatory." These terms are defined in statute. Property insurance rates are regulated primarily to make sure insurance companies have

enough rate to remain solvent and meet their contractual obligations to policyholders (requirement of "adequate" rates), without overcharging policyholders (prohibition against "excessive" rates), and to make sure rates are not "unfairly discriminatory." "Affordability" is not a standard against which rates are evaluated by the OIR.

Section 627.0645, F.S, requires every property insurance company to make a rate filing with the OIR each year. The rate filing contains the insurance company's proposed rates. The OIR reviews the rate filing and either approves or disapproves the proposed rates. If an insurance company does not want to change its rates one year, instead of a rate filing, the insurer can file a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate.

## *The Rate Filing and Review Process*

Property insurance rates must be filed with and approved by the OIR before an insurance company can charge them. The OIR does not approve or disapprove the method an insurer uses to derive their proposed rates. In reviewing the rate filing the OIR makes a determination as to whether or not the actual proposed rates are excessive, inadequate or unfairly discriminatory. If the OIR determines the proposed rates are excessive, are inadequate or are unfairly discriminatory, the rates are disapproved. The OIR must accept a rate filing request if it complies with the law and is adequately supported by actuarial justification.

*Evaluation Criteria Used During the Rate Review Process*

The rate review process involves a review by the OIR of an insurance company's actuarial justification for a proposed rate increase or decrease, including an analysis of the company's book of business, and the anticipated future expenses. The OIR looks at factors listed in statute to determine if a rate is excessive, inadequate, or unfairly discriminatory. Areas analyzed as required by statute include an insurance company's:

- Past and prospective loss experience
- Past and prospective expenses
- Investment income
- Cost of reinsurance
- Margin for underwriting profit and contingency
- Other factors that influence the frequency or severity of claims.

*Components of a Rate Filing*

An insurance company submits supporting documentation to the OIR deemed to be relevant to the company's rate request. The following information is usually required for any rate filing:

- Cover letter and explanatory memorandum
- Statewide indication form to support statewide rate change
- Territorial support information to show proposed rate adjustments
- Support documentation for reinsurance costs
- Support documentation for catastrophe models used (if applicable)
- Any changes to underwriting rules
- Required certifications signed by actuaries and company officers.

*The Rate Filing Process*

Although the rate filing process is interactive and involves multiple communications between OIR and insurance company staff, the process generally works as follows:

- Rate filing is uploaded by the company on the OIR's I-File System
- Rate filing is assigned to a reviewer (Actuary and Actuarial Analyst)
- Clarifying information is requested by the OIR (if applicable)
- Company responds to clarifying information requested (if applicable).

After review and analysis of the rate filing, the reviewer recommends approval of the rate filing to OIR senior management or recommends issuance of a Notice of Intent to Disapprove (NOI) the rate filing. Either action is recommended within 90 days of the initial company rate filing is uploaded to the I-File System and the company is notified in writing of the action taken by the OIR on the filing.

If a NOI is issued, the company has 21 days to request a hearing with the Division of Administrative Hearings (DOAH). If a hearing is requested, DOAH conducts the hearing within 30 days after receipt of the request for hearing. The hearing officer from DOAH issues a recommended order within 30 days after the hearing or after receipt of the hearing transcript. After receipt of the recommended order, the OIR issues a final order on the rate filing. If the insurance company disagrees with the final order issued by the OIR on the rate filing, the company may appeal the final order to the First District Court of Appeal.

At any time during the rate filing and review process, the insurance company may withdraw the filing and submit a new filing, which begins the rate filing and review process anew.

## Status of the Property Insurance Market

As of the end of 2009, 206 insurance companies had active property insurance policies.[1] Citizens Property Insurance Corporation (Citizens) has the largest number of property insurance policies in Florida with 17% of the market. This corporation is the residual market property insurance entity and is not an insurer in the private market. The largest property insurer in the private market is State Farm Florida Insurance Company with 12% of the market.

Following Hurricane Andrew in 1992, national insurers began reducing their property insurance exposure in Florida. After the 2004 and 2005 hurricanes, many national insurers continued to reduce their property insurance risk in Florida, although no national insurer has pulled out of the Florida market entirely. The OIR notes national insurers are also currently reducing their property insurance risk in other coastal states.

The 2009 data indicates 81 of the 206 insurers reported underwriting gains in 2009, while 100 companies reported underwriting losses. Underwriting gains and losses are the premiums that remain after an insurance company has paid its claims and expenses. Sixty of the companies reported reductions in surplus in 2009 while 144 companies reported gains in surplus. Companies can report surplus gains for the same time period as an underwriting loss if the company puts additional funds into the company at the request of OIR or at their own volition.

[1] http://www.floir.com/pdf/KMSpeeches/Speeches/KMCabinet03232010.pdf

According to the OIR, national statistics from 2009 show property and casualty insurance companies are struggling nationally due to reduced investment yields, increases in potentially fraudulent claims, and an overall soft market. Insurance companies writing property insurance policies in Florida report to the OIR the significant cost drivers causing their underwriting losses include: increased reinsurance costs, the use of replacement costs to pay property claims, fraud, reported sinkhole claims, and reductions in premium due to the full implementation of mitigation discounts.

Two property insurers were put into receivership in 2009. This figure is consistent with the number of insolvencies in recent years.[2]

## Mitigation

Florida law requires property insurance rate filings to include mitigation discounts or credits. These discounts or credits are applied to the portion of the property insurance premium associated with hurricane risk and reduce that premium. The OIR has provided insurance companies suggested mitigation discounts for use in rate filings. Mitigation discounts are only available for personal residential and commercial residential property; discounts are not available for commercial property.

Typically, policyholders are responsible for substantiating to their insurers the existence of mitigation features in order to qualify for a mitigation discount. The Financial Services Commission (Governor and Cabinet) adopted a uniform mitigation verification form for use by all insurers to corroborate a home's mitigation features. The form must be signed by a home inspector; a building code inspector; a general, building, or residential contractor; a professional engineer, a professional architect; or any other person the insurer recognizes is qualified.

## Assessments on Property Insurance

Property insurance policies can be assessed for deficits in three property insurance related entities – Citizens Property Insurance Corporation (Citizens), the Florida Hurricane Catastrophe Fund (FHCF), and the Florida Insurance Guaranty Association (FIGA). The assessments levied by each entity can run concurrently.

The following chart outlines each type of assessment:

[2] http://www.figafacts.com/insolvencies

| | Citizens Property Insurance Corporation | Florida Hurricane Catastrophe Fund | Florida Insurance Guaranty Fund |
|---|---|---|---|
| **Lines of Insurance Assessed** | **Citizens Policyholder Surcharge:** All Citizens' policies, regardless of the account the policy is in.<br>**Regular Assessment:** All admitted and surplus lines property and casualty lines, excluding workers compensation, accident and health, medical malpractice, federal flood and federal crop. Does not include Citizens policies.<br>**Emergency Assessment:** All admitted and surplus lines property and casualty lines, excluding workers compensation, accident and health, medical malpractice, federal flood and federal crop. Does include Citizens policies. | All admitted and surplus lines property and casualty lines, excluding workers compensation, accident and health, federal flood, and medical malpractice until May 31, 2013. | Two separate Accounts to pay claims of insolvent property and casualty insurers:<br>1) Auto Liability and Auto Physical Damage (not assessed for hurricane-related insolvencies)<br>2) All Other (homeowner property, commercial, allied lines, farmowners, inland marine, earthquake, fire, burglary and theft, liability (including products liability), aircraft, boiler and machinery, medical malpractice) |
| **Percentage or amount of Assessment, with limits, if any.** | Personal Lines Account<br>**Citizens Policyholder Surcharge:** up to 15% of premium<br>**Regular Assessment:** up to 6% of premium, or up to 6% of deficit, whichever greater<br>**Emergency Assessment:** up to 10% of premium, or up to 10% of deficit, whichever greater, plus interest and other financing costs<br><br>Commercial Lines Account<br>**Citizens Policyholder Surcharge:** up to 15% of premium<br>**Regular Assessment:** up to 6% of premium, or up to 6% of deficit, whichever greater<br>**Emergency Assessment:** up to 10% of premium, or up to 10% of deficit, whichever greater, plus interest and other financing costs<br><br>High Risk Account | Emergency assessments limited to 6% per year for one year's hurricanes and 10% per year for multiple-year hurricanes. | The max assessment is 2% of each specified insurer's net direct written premiums for the previous year for the lines of insurance in each account.<br><br>Plus, an additional emergency assessment of up to 2% on the lines of insurance in the "All Other" account to pay hurricane related claims, or to issue bonds to pay such claims. The 2% emergency assessment is based on an insurer's net direct written premiums for the previous year. |

| | Citizens Property Insurance Corporation | Florida Hurricane Catastrophe Fund | Florida Insurance Guaranty Fund |
|---|---|---|---|
| | **Citizens Policyholder Surcharge:** up to 15% of premium<br>**Regular Assessment:** up to 6% of premium, or up to 10% of deficit, whichever greater<br>**Emergency Assessment:** up to 10% of premium, or up to 10% of deficit, whichever greater, plus interest and other financing costs | | |
| **Priority of Assessment** | Citizens' policyholders are assessed up to 15% of premium first. If funds collected from such an assessment are insufficient to pay the deficit, most Florida admitted and surplus lines property insurance policyholders (exceptions noted above) but not Citizens' policyholders, are assessed up to 6% of premium or of the deficit. If the funds collected from the second assessment (regular assessment) are insufficient to pay the deficit, most Florida admitted and surplus lines property insurance policyholders (exceptions noted above) including Citizens' policyholders, are assessed up to 10% of premium or of the deficit for the rest of the deficit. | None. | None. |
| **Number of Years Assessment Authorized** | Citizens Policyholder Surcharge – 1 year<br><br>Regular assessment – 1 year<br><br>Emergency Assessment – No Limit | 30 years max for emergency assessments. | 2% on each account each year<br><br>For 2% emergency assessment for bonds issued for hurricane recovery, the assessment is for the life of the bonds. |
| **Limitation of Assessment,** | Workers compensation, accident and health, medical malpractice, federal flood and federal crop. | Workers compensation, accident and health, federal flood, and medical | Impaired member companies.<br><br>Kinds of direct insurance not |

| | Citizens Property Insurance Corporation | Florida Hurricane Catastrophe Fund | Florida Insurance Guaranty Fund |
|---|---|---|---|
| **if any.** | | malpractice until May 31, 2013. | covered by FIGA are not assessed. (See s. 631.52 for a list of direct insurance not covered by FIGA.) |

## *Relevant Florida Statutes*

**Florida Statutes:**
Section 627.062, F.S.
Section 627.0629, F.S.
Section 627.4025, F.S.
Section 627.711, F.S.
Chapter 627, Part X, F.S.

## *Where can I get additional information?*

### *Florida Office of Insurance Regulation*

200 East Gaines St.
Tallahassee, FL 32399
(850) 413-3140
Consumer Help Line: 877-693-5236 (in-state)
850-413-3089 (out-of-state)
http://www.floir.com

### *Florida House of Representatives*

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

# Citizens Property Insurance Corporation

FACT SHEET 2010

## Introduction

Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market.[1] It is not a private insurance company.[2]

Citizens was created by the Legislature in 2002 by the merger of two existing property insurance associations: The Florida Residential Property and Casualty Joint Underwriting Association (FRPCJUA) and the Florida Windstorm Underwriting Association (FWUA). The FRPCJUA provided full-coverage personal and commercial residential property policies in all counties of Florida while the FWUA provided personal and commercial residential property wind-only coverage in designated territories.

## Purpose of Citizens

Citizen's purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted property insurance market.

## Coverage by Citizens

An applicant for insurance coverage with Citizens is eligible even if the applicant has an offer of coverage from an insurer in the private market at its approved rates if the premium for the offer of coverage in the private market is more than 15% than the premium Citizens would charge for comparable coverage.[3]

Citizens writes various types of property insurance coverage for its policyholders. Citizens' types of coverage are divided into three separate accounts within the corporation:

1. Personal Lines Account (PLA) – Multiperil Policies
   Consists of homeowners, mobile homeowners, dwelling fire, tenants, condominium unit owners and similar policies.
2. Commercial Lines Account (CLA) – Multiperil Policies
   Consists of condominium association, apartment building, homeowner's association policies, and commercial non-residential wind-only and multi-peril policies located outside the HRA eligible area.
3. High-Risk Account (HRA) – Wind-only and Multiperil Policies

[1] Admitted market means insurance companies licensed to transact insurance in Florida.

[2] s. 627.351(6)(a)1., F.S.

[3] s. 627.351(6)(c)5.a., F.S.

Consists of wind-only and multi-peril policies for personal residential, commercial residential, and commercial non-residential issued in limited eligible coastal areas.

## Rates of Citizens

The rates charged by Citizens for coverage were frozen by law at 2005 levels from January 2007 to January 1, 2010.[4]

Current law requires Citizens' rates to be actuarially sound. Citizens' rates are set by the Office of Insurance Regulation based on a rate filing made by Citizens setting out actuarially sound rates for the corporation. However, although current law requires Citizens' rates to be actuarially sound, the law also restricts Citizens' rates from increasing more than 10 percent per policy per year until the rates are actuarially sound. Once the rates are actuarially sound, the rate increase percentage is not capped.

Citizens implemented an overall rate increase of 6.6 percent in 2010 and 9.3 percent in 2011.

## Market Share of Citizens

Citizens is currently the largest property insurer in Florida with over 1.2 million policies extending almost $457 billion of property coverage to Floridians – representing approximately 24% of the residential premium in the State.

## Financial Resources of Citizens

Citizens' financial resources include both resources typically available to private insurance companies and resources uniquely available to Citizens as a governmental entity with the statutory authority to levy assessments in the event of a deficit in Citizens' financial resources. Like typical private insurance companies, Citizens' financial resources include:

- insurance premiums
- investment income
- accumulated surplus
- reimbursements from the Florida Hurricane Catastrophe Fund due to Citizens' purchase of reinsurance from the Florida Hurricane Catastrophe Fund
- reimbursements from private reinsurance companies if Citizens purchases private reinsurance.

Financial resources unique to Citizens include: Citizens Policyholder Surcharges, regular assessments, and emergency assessments.

Citizens has almost $4.6 billion in surplus to pay claims during the 2010 hurricane season. In addition, Citizens could be reimbursed another $5.6 billion for claims it pays by the Florida Hurricane Catastrophe Fund. Citizens also has pre-event bonding in place giving the company

[4] s. 627.351(6)(m)4., F.S.

another $3.7 billion to pay claims. Thus, the maximum amount Citizens has to pay claims for the 2010 hurricane season is approximately $14 billion.

## Exposure of Citizens

Citizens' total exposure is $457 billion. The 1-in-100 year hurricane would cost almost $21 billion. Although Citizens does not have enough liquidity to pay the $21 billion in claims that are projected to result from a 1-in-100 year hurricane, for 2010 Citizens is in the best-ever financial position to pay claims during a hurricane season. The $7 billion difference between Citizens' liquidity ($14 billion) and its 1-in-100 year exposure ($21 billion) would be covered by assessments levied by Citizens on its own policyholders and on policyholders of most property and casualty insurance.

## Assessments Levied by Citizens

In the event Citizens incurs a deficit (i.e. its obligations to pay claims exceeds its capital plus reinsurance recoveries), it may levy assessments on most of Florida's property and casualty insurance policyholders in a specific sequence set by statute.[5] The three Citizens' accounts calculate deficits and resulting assessment needs independently.

### *Citizens Policyholder Assessments*

If Citizens incurs a deficit, Citizens will first levy assessments on its policyholders of up to 15% of premium per account in deficit for a maximum total of 45%.[6] This assessment can be collected for twelve months. As with each of the assessments, this assessment only applies at the time a new policy is written or at renewal of existing Citizens policy.

### *Regular Assessments*

Upon the exhaustion of the Citizens Policyholder Assessment for a particular account, Citizens may levy a regular assessment of up to 6% of premium or 6% of the deficit per account, for a maximum total of 18%.[7] The regular assessment is levied on virtually all property and casualty policies in the state, but is not levied on Citizens' policies. The assessment is also not levied on workers' compensation, medical malpractice, accident and health, crop or federal flood insurance policies. Mechanically, property casualty insurers with policies subject to the regular assessment "front" the assessment to Citizens and recover it from their policyholders at the issuance of a new policy or at renewal of existing policies.

### *Emergency Assessments*

Upon the exhaustion of the Citizens Policyholder Assessment and regular assessment for a particular account, Citizens may levy an emergency assessment of up to 10% of premium or 10% of the deficit per account, for a maximum total of 30%.[8] This assessment can be collected for as many years as is necessary to cure a deficit. Emergency assessments are levied on virtually all property and casualty policies in the state, including Citizens' own policies. However, this

[5] s. 627.351(6)(b)3.a.,d., and i ., F.S.

[6] s. 627.351(6)(b)3.i., F.S.

[7] s. 627.351(6)(b)3.a. and b., F.S.

[8] s. 627.352(6)(b)3.d., F.S.

assessment is not levied on workers' compensation, medical malpractice, accident and health, crop or federal flood insurance policies. Mechanically, property and casualty insurers with policies subject to the emergency assessment collect the assessment from policyholders at the issuance of a new policy or at renewal of existing policies and then remit the assessments periodically to Citizens.

### *Assessments Levied Due to the 2004 and 2005 Hurricanes*

Citizens levied three assessments as a result of the 2004 and 2005 hurricanes.[9] As a result of the 2004 hurricanes Citizens levied a one-time 6.8% regular assessment on property and casualty insurance companies and Citizens' policyholders. As a result of the 2005 hurricanes, Citizens levied a one-time 2.04% regular assessment on insurance companies and Citizens' policyholders and a 1.4% emergency assessment for 10 years starting July 1, 2007.

## Depopulation of Citizens

Under current law, Citizens is authorized to develop and maintain a depopulation program to reduce the number of its insured properties and financial exposure. Under the program, created by section 627.351(6)(q)3., Florida Statutes, new and existing insurance companies are encouraged to assume policies currently covered by Citizens. However, current law also allows a Citizens policyholder to remain with Citizens even though the policyholder receives an offer of coverage (assumption) from a different insurance company.

Depopulation allows Citizens to transfer policies back to the private insurance market. Depopulation benefits all Floridians by preventing or reducing special hurricane-related assessments charged to all property insurance consumers, including Citizens' policyholders, if Citizens does not have sufficient funds to cover its claims following a hurricane. Thus, allowing policyholders of Citizens to move from Citizens to an insurance company in the private market could eliminate or reduce the policyholder's assessment potential. Furthermore, depopulation leads to a healthier insurance market in Florida as more private companies offer coverage for Florida's residents.

In 2009, almost 150,000 policies were removed from Citizens by insurance companies in the private market under the Citizens' depopulation program.

## Recent Legislation Regarding Citizens

The Legislature passed legislation in 2010 changing the name of the Citizens High Risk Account to the Coastal Account, changing the method in which the Citizens Policyholder Surcharge is assessed and collected, exempting Citizens' Board of Governors from conflicting employment and contractual relationship provisions for public officers and agency employees, requiring board members to abstain from voting on issues providing gain or loss, and extending the time allowed for Citizens to reduce its probable maximum loss to avoid reducing its wind-only coverage area. The legislation, however, was vetoed by the Governor so did not take effect.

[9] These assessments were levied in accordance with prior law prescribing the mechanism and amount of Citizens' assessments.

## Relevant Florida Statutes

**Florida Statutes:**
Section 627.351(6), F.S.

## Where can I get additional information?

### Citizens Property Insurance Corporation

P.O. Box 17219
Jacksonville, FL 32245
Customer Care: 1-888-685-1555
For questions about a Citizens' policy that does not involve a claim: 1-888-685-1555
To report a claim or check on the status of an existing claim: 1-866-411-2742
https://www.citizensfla.com/

### Florida House of Representatives

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

# Florida Hurricane Catastrophe Fund

FACT SHEET 2010

## Introduction

The Florida Hurricane Catastrophe Fund (FHCF) is a tax-exempt trust fund created after Hurricane Andrew as a form of reinsurance for residential property insurers.[1] The FHCF reimburses (reinsures) insurers for a portion of their hurricane losses to residential property.

## Purpose of the FHCF

The purpose of the FHCF is to protect and advance the state's interest in maintaining insurance capacity in Florida by providing reimbursements to insurers for a portion of their catastrophic hurricane losses.

## Participation in the FHCF

Each insurance company writing insurance policies covering residential property or any policy covering a residential structure or its contents must participate in the FHCF. (s. 215.555(4)(a), F.S. and s. 215.555(2)(c), F.S.). Residential property is defined in s. 627.4025(1), F.S. to include personal lines and commercial lines residential coverage. This coverage entails the following insurance policies: homeowner's, mobile homeowner's, dwelling, tenant's, condominium unit owner's, condominium association, cooperative association, and apartment building.

## Structure of the FHCF

### *Generally*

For all residential property insurers, the FHCF must offer two options for reinsurance coverage. One of the two options is mandatory and thus must be purchased by all residential property insurers on their residential property exposure. The purchase of the other coverage, Temporary Increase In Coverage Limit Options (TICL), is optional and offers reinsurance for insurers above the mandatory coverage. In addition to these two coverage options, the FHCF must offer specified insurers $10 million of additional reinsurance coverage.

### *Mandatory Coverage*

For the FHCF mandatory coverage, the FHCF must charge insurers the "actuarially indicated" premium for the coverage provided, based on hurricane loss projection models found acceptable by the Florida Commission on Hurricane Loss Projection Methodology. Each insurer's "reimbursement premium" for this coverage is different, based on the insured value of the residential property it insures, their location, construction type, deductible amounts, and other factors.

[1] s. 215.555, F.S.

For mandatory coverage, the FHCF has a maximum amount it will reimburse insurers each year set by statute.[2] This is called the FHCF's capacity. Under current law, the FHCF's capacity is $17 billion for each contract year and does not increase until the FHCF's cash and bonding ability exceeds $34 billion. This allows the FHCF to accumulate funds to pay the maximum mandatory coverage FHCF obligations ($17 billion a year) for claims resulting from hurricanes in back-to-back seasons.[3] Once this happens, the FHCF's capacity will increase. Capacity calculated in this manner allows the FCHF's cash balance to grow in years where there are no hurricanes while keeping the FHCF's exposure (capacity) frozen so that the FHCF is less reliant on bonding to meet its mandatory coverage obligations.

For the current contract year (June 1, 2010- May 31, 2011), the insurance industry as a whole is covered for losses up to $17 billion by the mandatory coverage.[4] For the next contract year (2011-2012), the FHCF predicts the insurance industry as a whole will continue to be covered for losses up to $17 billion by the mandatory coverage.

Although the FHCF capacity is $17 billion aggregately, every insurer participating in the FHCF has its share of the aggregate coverage based on its FHCF reimbursement premium. This is the maximum amount of property insurance claims the FHCF will reimburse the insurer for under the mandatory coverage. This maximum amount of coverage is different for each insurer because it is linked directly to the amount of premiums the insurer pays to the FHCF. Thus, insurers that pay higher premiums to the FHCF have more mandatory coverage than those that pay lower premiums.

Before FHCF monies are available to pay claims each insurer must meet a retention/deductible. The retention amount for each insurer is different because this amount is based on the amount of premium the insurer pays to the FHCF. For the current 2010-11 contract year (June 1, 2010 – May 31, 2011), the insurance industry as a whole has an aggregate retention of $7.142 billion for mandatory coverage, meaning the total of all individual insurer retentions/deductibles will hypothetically total to $7.142 billion per event, assuming all participating insurers reached their retention.[5] Although the insurance industry's aggregate deductible/retention totals $7.142 billion, loss recovery from the FHCF is based on an individual insurer meeting its own retention for mandatory coverage prior to losses being reimbursed.

### *Temporary Increase In Coverage Limit Options (TICL)*

In 2007, chapter 2007-1, L.O.F., added the Temporary Increase In Coverage Limit (TICL) options to the FHCF.[6] These options allow an insurer to purchase its share of up to $1 billion in coverage, in $1 billion increments, above the mandatory FHCF coverage. For the 2010-2011 fund contract year, the maximum amount of coverage under the TICL options is $8 billion. The maximum amount of coverage decreases by $2 billion each contract year. By operation of law,

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[2] s. 215.555(4)(c)1., F.S.

[3] The funds may be accumulated from premiums and bonding.

[4] The capacity is larger than the $15 billion prescribed by statute because the statute allows the capacity to increase yearly as the FHCF's exposure increases, but limited by the FHCF's cash balance.

[5] The retention is larger than the $4.5 billion prescribed by statute because the statute allows the retention to increase yearly as the FHCF's exposure increases.

[6] s. 215.555(17), F.S.

contract year 2013-2014 is the last contract year TICL options are available to property insurers for additional FHCF coverage.

For the 2010-2011 contract year, of the $8 billion optional TICL coverage available, $1.365 billion was purchased by insurance companies. Thus, 17% of the coverage available was purchased. Comparatively, in 2009, 57% of the TICL coverage available was purchased.

### *Additional $10 Million Coverage Option for Specified Insurers*

The law also permits specified insurers to purchase an additional $10 million in coverage from the FHCF.[7] The insurer's retention level for this coverage is different for each insurer as it is a percentage of the insurer's surplus; however, the retention level is typically lower than that for the insurer's mandatory coverage. This coverage option expires by operation of law on December 31, 2011.

For the 2010-2011 contract year, 25 out of 50 insurance companies eligible to purchase the $10 million optional coverage purchased this coverage. The companies purchased the coverage at different levels; however, the total additional coverage purchased for this option totaled $411 million. The coverage selected is 41.1% of the total coverage available.

## Coverage by the FHCF

The FHCF is administered by the State Board of Administration. Participating insurers choose a percentage level of reimbursement by the FHCF. By statute, insurers can select 45, 75, or 90 percent coverage reimbursement for losses that exceed its deductible/retention for each hurricane.[8] Most insurers choose the 90 percent reimbursement percentage.[9] This means once an insurer triggers FHCF coverage, 90 percent of its losses will be reimbursed by the FHCF, up to the insurer's limit of coverage. Insurers may purchase additional reinsurance in the private market to reimburse them for their hurricane losses in amounts not covered by the FHCF. Reinsurance in the private market can also be purchased for the coinsurance amount (e.g., 10 percent) that is the insurer's responsibility for the coverage provided by the FHCF.

## Primary Sources of Revenue/Financial Resources for the FHCF

The FHCF must charge insurers the "actuarially indicated" premium for the mandatory coverage, based on hurricane loss projection models found acceptable by the Florida Commission on Hurricane Loss Projection Methodology. Each insurer's "reimbursement premium" is different, based on the insured value of the residential property it insures, their location, construction type, deductible amounts, and other factors. In addition, the premium for mandatory coverage includes a cash build up factor that is charged on top of the actuarially indicated premium. For the 2010-2011 contract year, the cash build up factor is 10 percent, meaning an insurer's premium is 10 percent greater than the actuarially indicated premium.

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[7] s. 215.555(4)(a)4., F.S.

[8] s. 215.555(2)(e)2., F.S.

[9] http://fhcf.paragonbenfield.com/pdf/08fin_pre.pdf. (last viewed January 15, 2009).

Each insurer that opts to purchase TICL coverage must pay an additional premium for this coverage. The amount of premium for this coverage is a specified factor above the premium for mandatory coverage. For the 2010-2011 contract year, the TICL premium is three times the premium for mandatory coverage.

Eligible insurers that opt to purchase the additional $10 million coverage option must pay an additional premium for this coverage.

## Exposure of the FHCF

The FHCF has different types of exposure – the potential exposure and the actual exposure. The potential exposure is the annual maximum amount the FHCF is obligated to pay to property insurers buying reinsurance in the FHCF. This exposure assumes insurers purchased the maximum amount of FHCF coverage offered. The actual exposure is the maximum amount the FHCF is actually obligated to pay property insurers based on the total amount of reinsurance in the FHCF insurers actually purchased.

For the 2010-2011 contract year, the FHCF's potential exposure is $25.461 billion. This exposure consists of: $17 billion for mandatory coverage, $8 billion for TICL coverage, and $461 million for additional coverage for specified insurers.[10]

For the 2010-2011 contract year, the FHCF's actual exposure is $18.7 billion. This exposure consists of: $17 billion for mandatory coverage, $1.365 billion for TICL coverage, and $411 million for additional coverage for specified insurers. The FHCF projects to have $5.914 billion cash on hand at the end of 2010. The FHCF has issued $3.5 billion in pre-event bonds. Thus, the FHCF has $9.33 billion to pay claims from the 2010 hurricane season.

Because the 2010 – 2011 actual exposure of the FHCF is $18.7 billion, the FHCF would have to bond for $9.363 billion to pay the maximum obligation of the FHCF. The FHCF estimates it can issue post-event bonds to cover this amount. If this bonding were to occur, the FHCF would fund the bonds with a 2.96% annual assessment over 30 years. The FHCF required maximum bonding needs of $9.63 billion for 2010 - 2011 are significantly lower than the past three years due to the reduced selection of TICL coverage and the accumulation of premiums in the recent hurricane seasons due to a lack of hurricanes and resulting claims.

## Assessments Levied by the FHCF

If the cash balance of the FHCF is not sufficient to cover losses, the law allows the issuance of revenue bonds, which are funded by emergency assessments on property and casualty policyholders.[11] The FHCF is authorized to levy emergency assessments against all property and casualty insurance premiums paid by policyholders (other than workers' compensation, accident and health, federal flood and, until May 31, 2013, medical malpractice), including surplus lines policyholders, when reimbursement premiums and other FHCF resources are insufficient to

[10] Estimated Claims Paying Capacity Presentation, May 2010, presented to the FHCF Advisory Council.

[11] s. 215.555(6)(a)1., F.S.; s. 215.555(6)(b)1., F.S.

cover the FHCF's obligations.[12] Annual assessments are capped at 6 percent of premium with respect to losses from any one year and a maximum of 10 percent of premium to fund hurricane losses from multiple years.[13] Revenue bonds issued by the FHCF may be amortized over a term up to 30 years. Thus, the FHCF may levy assessments for as long as 30 years. The 2009 FHCF assessment base is $33.313 billion.[14]

Currently, the FHCF is levying an assessment against all property and casualty insurance policyholders subject to the assessment. This assessment is the result of a FHCF deficit associated with the 2005 hurricanes. This is the first time the FHCF had to levy assessments to cover a deficit since its creation in 1993. A 1% assessment was levied and paid by insurers from January 1, 2007 – December 31, 2010 and was passed through to policyholders. The 1% assessment will be increased to 1.3% starting January 1, 2011 due to increasing losses from the 2005 hurricanes. The 1.3% assessment will be levied from January 1, 2011 – December 31, 2016.

## Recent Legislation Regarding the FHCF

Legislation enacted in 2009 (ch. 2009-87, L.O.F.) made numerous changes to the FHCF. The most significant changes to the FHCF made by this legislation were: reducing the TICL options by $2 billion each year for six years, increasing the cost of the TICL options, implementing a cash build up factor to increase the premium for mandatory FHCF coverage, and changing the FHCF's contract year to January 1st – December 31st. Two bills impacting the FHCF were enacted in 2010 (ch. 2010-10, L.O.F. and ch. 2010-141, L.O.F.). The 2010 legislation returned the FHCF's contract year to June 1st – May 31st, changed what insurer data is used in the FHCF's retention calculation, changed the way the FHCF's capacity for mandatory coverage is calculated, and allowed medical malpractice insurance policies to continue to be exempt from FHCF assessments until May 31, 2013.

## Relevant Florida Statutes

**Florida Statutes:**
Section 215.555, F.S.

## Where can I get additional information?

### Florida Hurricane Catastrophe Fund

1801 Hermitage Blvd.
Tallahassee, FL 32308
(850) 413-1349
http://www.sbafla.com/fhcf/

### Florida House of Representatives

[12] s. 215.555(6)(b)1., F.S.; s. 215.555(6)(b)(10), F.S.
[13] s. 215.555(6)(b)2., F.S.
[14] Estimated Claims Paying Capacity Presentation October 2010, presented to the FHCF Advisory Council.

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
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http://www.myfloridahouse.gov

# Motor Vehicle Insurance

# Motor Vehicle Insurance

FACT SHEET 2010

## Introduction

Florida motorists are required to carry a minimum of $10,000 of personal injury protection coverage (PIP) and $10,000 of property damage liability coverage.[1,2] PIP is no-fault automobile insurance coverage.

Florida is one of 12 states[3] with no-fault motor vehicle[4] insurance provisions. The purpose of the Florida Motor Vehicle No-Fault Law (No-Fault Law)[5] is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault, and to require motor vehicle insurance to secure these benefits. In return for assuring payment of these benefits, the No-Fault Law provides limitations on the right to bring lawsuits arising from motor vehicle accidents. The No-Fault Law was repealed on October 1, 2007,[6] but was revived and reenacted effective January 1, 2008.[7]

## Personal Injury Protection (PIP) Coverage

PIP provides $10,000 of coverage for bodily injury sustained in a motor vehicle accident without regard to fault as follows:

- 80 percent of reasonable medical expenses
- 60 percent of loss of income
- Death benefit of $5,000 or the remainder of unused PIP benefits, whichever is less

PIP covers:

- The named insured
- Relatives residing in the same household
- Persons operating the insured motor vehicle
- Passengers in the insured motor vehicle

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[1] Section 627.7275, F.S.

[2] Under Florida's Financial Responsibility Law (ch. 324, F.S.), motorists also must provide proof of ability to pay monetary damages for bodily injury and property damage liability at the time of motor vehicle accidents or when serious traffic violations occur.

[3] Michigan, New Jersey, New York, Pennsylvania, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, North Dakota, and Utah also have no-fault automobile insurance systems. See the Insurance Information Institute's issue update on "No-Fault Auto Insurance." Available at: http://www.iii.org/media/hottopics/insurance/nofault/.

[4] Motor vehicle" is defined in s. 627.732, F.S., to mean any self-propelled vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of this state and any trailer or semitrailer designed for use with such vehicle and includes: (a) A "private passenger motor vehicle," which is any motor vehicle which is a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional, or business purposes, a motor vehicle of the pickup, panel, van, camper, or motor home type. (b) A "commercial motor vehicle," which is any motor vehicle which is not a private passenger motor vehicle. The term "motor vehicle" does not include a mobile home or any motor vehicle which is used in mass transit, other than public school transportation, and designed to transport more than five passengers exclusive of the operator of the motor vehicle and which is owned by a municipality, a transit authority, or a political subdivision of the state.

[5] Sections 627.730-627.7405, F.S.

[6] The Motor Vehicle No-Fault Law was repealed pursuant to s. 19, ch. 2003-411, L.O.F.

[7] The Motor Vehicle No-Fault Law was revived and reenacted pursuant to ch. 2007-324, L.O.F.

- Persons struck by the motor vehicle

PIP provides the policyholder with immunity from liability for economic damages (medical expenses) up to the $10,000 policy limits and for non-economic damages (pain and suffering) for most injuries. Specifically, the immunity provision protects the insured from tort actions by others (and conversely, the insured may not bring suit to recover damages) for pain, suffering, mental anguish, and inconvenience arising out of a vehicle accident, except in the following cases:[8]

- Significant and permanent loss of an important bodily function
- Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement
- Significant and permanent scarring or disfigurement
- Death

Lawsuits for pain and suffering may commence only if the injuries meet these threshold levels.

## Property Damage Liability Coverage

Property damage liability coverage pays for the physical damage expenses caused by the insured to third parties in the accident. It covers property such as fences, utility poles, buildings, and automobiles.

## Optional Coverages[9]

In addition to the compulsory PIP and property damage liability coverages. the following optional coverages may be available for purchase by motorists.

### *Bodily Injury*

This coverage pays for death or serious and permanent injury to others when the policyholder is legally liable for an accident involving his/her automobile. The insurance company will pay for injuries up to the limits of the policy and provide legal representation if the policyholder is sued.

### *Collision*

Collision coverage pays for repair or replacement of the policyholder's vehicle if it collides with another vehicle, flips over, or crashes into an object, regardless of who causes the accident. It does not cover injuries to people or damage to property other than the covered automobile.

### *Comprehensive*

Comprehensive coverage pays for losses from incidents other than a collision, such as fire, theft, windstorm, vandalism, or flood. It also covers damages caused by failing objects or from hitting an animal.

### *Uninsured/Underinsured (UM) Motorist Coverage*

[8] See s. 627.737, F.S.

[9] For additional information *see* "Automobile Insurance: A Guide for Consumers," published by the Florida Department of Financial Services. Available at: http://www.myfloridacfo.com/Consumers/Guides/Auto/index.htm.

UM coverage pays for bodily injuries to the policyholder, his/her family members, and any other person occupying the covered automobile should they be caused by the negligence of an uninsured or underinsured motorist. UM pays for medical expenses and lost wages (after PIP coverage is exhausted) that the policyholder and his/her passengers may incur. The coverage includes payment for pain and suffering if there is a permanent injury or death. UM motorist insurance comes in stackable and nonstackable coverage.[10] Companies must offer stackable coverage, but may or may not offer a nonstackable option.

### *Medical Payments*

This coverage pays for medical expenses for accidental injury up to the limit of the policy. It covers the policyholder's medical expenses, plus those of family members or passengers, regardless of fault (unlike bodily injury liability insurance). It applies whether the policyholder is in his/her automobile or someone else's, or if he/she is hit by an automobile while walking or bicycling. Since PIP covers only 80 percent of medical expenses, medical payments insurance could cover the remaining 20 percent, depending on the policy provisions. Medical payments will also cover the amount in excess of the PIP limit, up to the limit specified in the policy.

### *Towing*

Towing and road service may be added to an automobile insurance policy. However, the insurance company may cancel the policy for too many towing claims, even if the policyholder does not have any accidents.

## Premiums

Automobile insurance companies are required to submit their rates to the Office of Insurance Regulation for rate approval. Florida has the fifth highest automobile insurance rates in the country, with an average expenditure for private passenger automobile insurance of $1,043 in 2007.[11]

## Fraud

Nationwide, it is estimated that claim fraud and buildup (the inflation of an otherwise legitimate claim) add 13 to 18 percent in excess payments to automobile insurance claims (between $4.8 and $6.8 billion in excess payments).[12] For each year from 2007 to 2009, Florida had the greatest number of questionable staged accident claims in the country.[13]

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[10] Stackable UM coverage combines the coverage limits for each automobile insured under your policy. For example, you may insure three automobiles and obtain stackable coverage with limits of $10,000 per person and $20,000 per accident for each automobile. Your stackable, or combined, coverage will total $30,000 per person and $60,000 per accident. If these policies were nonstackable, then the limit of coverage for each vehicle would be $10,000 per person and $20,000 per accident. Insurance companies may offer nonstackable coverage at a reduced cost.

[11] Insurance Information Institute, "Auto Insurance Fact Sheet." Available at: http://www.iii.org/media/facts/statsbyissue/auto/.

[12] Insurance Research Council news release, "Fraud and Buildup Add 13 to 18 Percent in Excess Payments to Auto Injury Claims" (November 24, 2008). Available at: http://www.ircweb.org/News/Index.htm. Findings based on automobile injury insurance claims closed with payment in 2007.

[13] National Insurance Crime Bureau, "Forecast Report" (May 6, 2010). On file with the Florida House of Representatives.

Florida's no-fault automobile insurance system has been characterized as experiencing severe fraud and abuse problems.[14] The most common types of PIP fraud are health care clinic fraud and staged accidents.[15] For Fiscal Year 2009/2010, the Florida Division of Insurance Fraud reports that 34% of its convictions[16] involved "Personal Injury Protection Fraud/by Provider" and that it received 1,523 complaints of fraudulent activity committed by health care providers.[17]

## Relevant Florida Statutes and Administrative Rules

**Florida Statutes:**
Sections 627.730-627.7405, F.S.

**Florida Administrative Code:**
Chapters 69O-175, 69O-176.

## Where can I get additional information?

### Florida Department of Highway Safety and Motor Vehicles

Customer Service Center
(850) 617-2000
http://www.flhsmv.gov/

### Florida Department of Financial Services

Consumer Helpline
(877) 693-5236
http://www.myfloridacfo.com/Consumers/Guides/Auto/index.htm

[14] "Fraud & the P/C Insurance Industry. Focus on No-Fault Auto Insurance." Presentation by the Insurance Information Institute (III) at the New York Insurance Fraud Summit on April 21, 2010. Available at: http://www.iii.org/presentations/fraud-the-pc-insurance-industry-focus-on-no-fault-auto-insurance.html. The III also informs that PIP claim frequency in Florida increased by over 35 percent during the first quarter of 2010 compared to the number of PIP claims in the first quarter of 2009 and that PIP claim severity increased by 8 percent over the same time period.

[15] See Report Number 2006-102, "Florida's Motor Vehicle No-Fault Law," by staff of the Florida Senate Banking and Insurance Committee. Available at: http://www.flsenate.gov.

[16] 240 of a total of 706 convictions.

[17] For the same fiscal year, the Division of Insurance Fraud reports that it made 337 PIP-related arrests, representing 32% of its total number of arrests (1,042 arrests).

***Florida House of Representatives***
Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
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# Workers' Compensation Insurance

# Workers' Compensation

FACT SHEET 2010

## Introduction

Chapter 440, Florida Statutes, is Florida's workers' compensation law. For work-related injuries, workers' compensation provides:

- Medically necessary remedial treatment, care, and attendance, including medications, medical supplies, durable medical equipment, and prosthetics [see s. 440.13(2) (a), F.S.]
- Compensation for disability when the injury causes an employee to miss more than 7 days of work [see s. 440.12(1), F.S.]

Workers' compensation is the injured employee's remedy for "compensable" workplace injuries (injuries that are covered under workers' compensation). Employees generally cannot sue a covered employer for workplace injuries [see s. 440.11(1), F.S.].

The Division of Workers' Compensation within the Department of Financial Services provides regulatory oversight of Florida's workers' compensation system.

## Employers Required to have Workers' Compensation Insurance

Whether an employer is required to have workers' compensation insurance depends upon the employer's industry (construction, non-construction, or agricultural) and the number of employees.

### *Construction Industry Employers*

Construction industry employers with 1 or more employees are required to have workers' compensation insurance [see s. 440.02(17) (b)2, F.S.]. In the construction industry, sole proprietors, partners, and corporate officers are considered employees [see ss. 440.02(15)(c) 1; 440.02(15)(d)8].

### *Non-Construction Industry Employers*

Non-construction industry employers with 4 or more employees are required to have workers' compensation insurance. In the non-construction industry:

- Corporate officers are considered employees, unless they elect to exempt themselves from workers' compensation coverage requirements [see s. 440.02(15)(b)1]
- Sole proprietors and partners are not considered employees unless they elect to be employees [see s. 440.15(c)1, F.S.]

### *Agricultural Employers*

Agricultural employers with more than 5 regular employees and 12 or more seasonal employees who work more than 30 days are required to have workers' compensation insurance [see s. 440.02(17)(c)2, F.S.].

## Workers' Compensation Premium Rates

Workers' compensation premium rates (per $100 of payroll) are set annually by the Office of Insurance Regulation, upon a review of rate filings made by the National Council of Compensation Insurance (NCCI), a workers' compensation rating organization. The premium a particular employer will pay for a workers' compensation insurance policy is dependent upon various factors, including the employer's loss history (in workers' compensation), total payroll, and the employer's industry.

## Three Ways for Employers to Obtain Workers' Compensation Coverage

1. Purchase a workers' compensation insurance policy from an authorized insurance company [see s. 440.38, F.S.]
2. Purchase coverage from the Workers' Compensation Joint Underwriting Association [for employers that are unable to purchase a workers' compensation insurance policy from an authorized insurance company – see s. 627.311(5)(a), F.S.]
3. Qualify as a self-insurer [see s. 440.38, F.S.]

## Injuries Covered by Workers' Compensation

Workers' compensation provides medical benefits and, in some cases, compensation for disability for workplace injuries that arise out of work performed by an employee in the course and scope of employment. [s. 440.09(1), F.S.]. The workplace injury must be the "major contributing cause" for medical treatment and remain as such to continue medical treatment. "Major contributing cause" is the cause which is more than 50% responsible for the injury as compared to all other causes combined for which treatment or benefits are sought [see s. 440.09(1), F.S.].

### *Reporting Injuries*

Employees are required to inform employers of their injury within 30 days of the injury or initial manifestation of the injury. The failure to report within this timeframe may result in the inability to claim benefits [see s. 440.185(1), F.S.].

Employers are required to report a workplace injury to their workers' compensation insurance company no later than 7 days after the employer has knowledge of the injury [see s. 440.185(2), F.S.]. Administrative fines will be imposed against employers that do not timely report injuries [(see s. 440.185(9), F.S.].

## Workers' Comepensation Benefits

### *Medical Benefits*

- Medically necessary remedial treatment, care, and attendance, including medications, medical supplies, durable medical equipment, and prosthetics [see s. 44013(2)(a), F.S.]
- Services must be provided by certified workers' compensation health care providers and authorized by the workers' compensation insurance company prior to being provided (except for emergency care) [see s. 440.13(3)(a), F.S.]. When the insurance company has knowledge of a work-related injury, it will provide the injured employee with an authorized workers' compensation provider.
- Authorized services and treatment are provided at no cost to the injured employee [see s. 440.13(14)(a)].
- Employees are required to pay a $10 co-payment for medical services provided after they have reached "maximum medical improvement" [see s. 440.13(14)(c), F.S.]. The date of maximum medical improvement is the date after which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability [see 440.02(10), F.S.].
- Injured employees are entitled to one change of physician during the course of treatment for any one accident [see s. 440.13(2)(f), F.S.].
- After the initial examination and diagnosis, the workers' compensation physician is required to submit a proposed course of treatment to the workers' compensation insurance company to determine whether such treatment would be recognized as reasonably prudent [see s. 440.13(2)(e), F.S.].

### *Compensation for Disability*

- Payable only to employees who miss at least 8 days of work due to a compensable workplace injury [see s. 440.12(1), F.S.]
- Payable retroactively from the first day of disability (to include compensation for the first seven days of missed work) to employees who miss more than 21 days of work due to a compensable workplace injury [see s. 440.12(1), F.S.]

- Generally payable at 66 2/3% of the employee's average weekly wage, up to the maximum weekly benefit established by law [see ss. 440.15(1)-(4), F.S.]
- Payable every two weeks [see s. 440.20(2)(a), F.S.]
- Generally payable for up to 104 weeks, with the following exceptions:
    - Injured employees who are permanently and totally disabled receive monetary benefits during the continuance of their total disability [see s. 440.15(1)(a), F.S.].
    - Employees with a permanent disability (but who are not totally disabled) are entitled to impairment income benefits they day after they reach maximum medical improvement or upon the expiration of temporary benefits, whichever occurs earlier [see ss. 440.15(3); 440.15(2)(a), F.S.].

### *Educational and Training Benefits*

- Payable to employees for up to 26 weeks [see s. 440.491(6)(b), F.S.]
- Employees may receive temporary total disability, temporary partial disability payments, or educational and training benefits, or a combination of the three benefits prior to reaching maximum medical improvement, but for no more than a maximum of 104 weeks [see ss. 440.15(4)(e); 440.491(6)(b), F.S.].

### *Death Benefits*

Funeral expenses up to $7,500 and death benefits may be payable to a deceased worker's dependents when an employee dies as a result of a work-related injury [see ss. 440.16(1)(a), 440.16(1)(b), F.S.]

## Denial of Benefits by the Insurance Company

Injured employees have the right to file a Petition for Benefits with the Office of the Judges of Compensation Claims for any benefit that is ripe, due, and owing [see s. 440.192(1), F.S.].

- Within 14 days of receipt of the Petition for Benefits, the workers' compensation insurance company is required to either pay the requested benefits or file a response to the petition [see s. 440.192(8), F.S.].
- Within 40 days after the Petition for Benefits has been filed, the Judge of Compensation Claims will notify the parties that a mediation conference has been scheduled. The mediation will take place within 130 days after the filing of the Petition for Benefits [see s. 440.25, F.S.].
- An emergency conference on the Petition for Benefits may be held before the Judge of Compensation Claims where a bona fide emergency involving the health, safety, or welfare of an employee exists [see s. 440.25(4) (f), F.S.].

## Relevant Florida Statutes and Administrative Rules

**Florida Statutes:**
Chapter 440, F.S.

**Florida Administrative Code:**
Chapter 69L, F.A.C.

## Where can I get additional information?

Employee Assistance Office
Division of Workers' Compensation
(800)- 342-1741
http://www.myfloridacfo.com/wc

### Florida House of Representatives

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

# Oversight of Health Care Plans

FACT SHEET 2010

## Introduction

The Financial Services Commission was created within the Department of Financial Services. It is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. The Office of Insurance Regulation is one of two structural units of the Commission. The Director is also known as the Commissioner of Insurance Regulation.[1]

## Office of Insurance Regulation

The Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities authorized under the Florida Insurance Code.[2]

### *Financial condition monitoring*

The OIR's Life and Health Financial Oversight unit monitors the financial condition of all regulated health entities through the use of internal financial analysis and on-site examinations.[3] Periodic financial report submission is part of the monitoring process.

### *Rate review and approval*

The OIR reviews rates to insure they are not excessive, inadequate, or unfairly discriminatory. Generally, rates must be filed annually.[4] They must be actuarially sound,[5] and the carrier must provide the methodology[6] used in developing the rates. Rates may be "file and use", or "file, approve, and use".

### *Policy forms review and approval*

The OIR reviews applications, contracts, certificates, riders, endorsements, summary plan descriptions, etc. They must be filed and approved prior to use.[7, 8]

### *Market conduct monitoring*

Health insurance entities are subject to advertisement approval,[9] and the OIR is charged with enforcement of statutory prohibitions.[10] The Department of Financial Services monitors agents through the licensure process.[11]

### *Certificate of Authority*

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[1] Section 20.121(3), F.S.
[2] Chapters 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code".
[3] http://www.floir.com/lh/oir_LHFO_index.aspx
[4] Section 627.0645, F.S.
[5] Rule No. 69O-149.003, F.A.C.
[6] Id.
[7] Section 627.410, FS.
[8] Section 624.4412, F.S.
[9] Rule No. 69O-150.005, F.A.C.
[10] Rule No. 69O-231, F.A.C.
[11] http://www.myfloridacfo.com/Agents/Licensure/General/docs/2-15.htm

Prior to being granted approval to sell health insurance in the state of Florida a company must be issued a Certificate of Authority[12] by the OIR. A review of management information, to include a list of officers, directors, and major shareholders, is conducted. Background checks are conducted.

### *Claims handling*

As part of its oversight responsibilities, the OIR monitors claims handling for compliance with applicable law.

## Consumer Protection

In addition to protections provided through the OFR's oversight, there are other entities offering health care consumer safeguards. These include the Department of Financial Services Division of Consumer Services,[13] the Office of the Consumer Advocate,[14] and the Agency for Health Care Administration through the Subscriber Assistance Program.[15]

The Division of Consumer Services provides online databases and guides to assist individuals with making informed decisions. In addition, a consumer help line is available. It is staffed by employees capable of answering questions and providing assistance regarding any line of insurance.

The Office of the Consumer Advocate represents the general public and insurance consumers and recommends specific action or findings in regulatory matters under consideration. It is tasked with increasing consumer awareness and assists consumers in matters affecting insurance issues. It reviews and analyzes proposed legislation for purposes of preparing public testimony to support or oppose legislation affecting insurance consumers. The Insurance Consumer Advocate reports directly to the Chief Financial Officer.

The Subscriber Assistance Program is available to Exclusive Provider Organization, Health Maintenance Organization, and Pre-paid Health Clinic consumers requiring assistance with grievances that have not been satisfactorily resolved. The consumer must first complete the entire grievance process of the plan before filing a grievance with the Program. A hearing is held before an independent panel. After the hearing, the panel makes a recommendation based on the finding of fact either to the Agency for Health Care Administration or the Office of Insurance Regulation.

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**
Chapter 20, F.S.
Chapter 408, F.S.
Chapter 624, F.S.
Chapter 627, F.S.

[12] http://www.floir.com/ac/is_ac_domestic_coa_lh.aspx
[13] http://www.myfloridacfo.com/sitePages/agency/sections/ConsumerServices.aspx
[14] Section 627.0613, F.S.
[15] Section 408.7056, F.S.

**Florida Administrative Code:**
Chapter No. 69O-149, F.A.C.
Chapter No. 69O-150, F.A.C.
Chapter No. 69O-231, F.A.C.

## *Where can I get additional information?*

### *Florida Department of Financial Services*
200 East Gaines Street
Tallahassee, FL 32399-0319
(850) 413-2863
http://www.myfloridacfo.com

### *Florida Office of Insurance Regulation*
200 East Gaines Street
Tallahassee, FL 32399-0326
(850) 413-3140
http://www.floir.com

### *Florida Department of Financial Services*
Division of Consumer Services
200 East Gaines Street
Tallahassee, FL 32399-0321
(850) 413-3030
1-877-693-5236
http://www.myfloridacfo.com/sitePages/agency/sections/ConsumerServices.aspx

### *Florida Department of Financial Services*
Office of the Insurance Consumer Advocate
200 East Gaines Street
Tallahassee, FL 32399-0308
(850) 413-5923
http://www.myfloridacfo.com/sitePages/agency/sections/ica.aspx

### *Florida House of Representatives*
Economic Affairs Committee
Insurance & Banking Subcommittee
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# Types of Health Care Plans

FACT SHEET 2010

## Introduction

Health care plan designs which may be available to individual consumers and employers differ in access to providers, financial responsibilities, and covered benefits.

## Preferred Provider Organization (PPO) Plan

A PPO is a health plan that has contracts with a network of "preferred" providers from which one can choose.[1] The carrier contracts with those providers to provide services at a reduced rate. It is not necessary to select a primary care physician (PCP), nor are referrals required to see other providers. If one receives care from a doctor, hospital, or other provider in the preferred network, the individual will only be responsible for a specified copayment, or a defined percentage of the discounted charges. Some PPOs require the individual pay the full discounted rate until an annual deductable amount has been met. Then one begins paying a percentage of the discounted rate. Providers are not permitted to balance bill the patient for any difference between the discounted rate and the full charges. Filing a claim with the carrier for reimbursement is not necessary when network providers are utilized. If one receives services from a doctor or hospital that is not in the preferred network (known as going "out-of-network"), payment of a higher amount is required and balance billing is permitted. One is billed by the provider, pays the provider directly, and then must file a claim with the PPO to get reimbursed.

PPO plans are managed care plans with predictable costs when one utilizes network providers. The plan design typically incorporates an annual out-of-pocket maximum limit to individual or family costs, and may include a lifetime maximum limit on benefits received. Coverage for a pre-existing condition may be excluded for a specified period of time. During that time the individual is financially responsible for all costs associated with the pre-existing condition.

## Exclusive Provider Organization (EPO) Plan

An EPO is a health plan that has contracts with a network of providers from which one can choose.[2] The carrier contracts with those providers to provide services at a reduced rate. Some EPOs incorporate the gate-keeper concept along with prospective approval of referrals to specialists or providers outside the EPO. When one receives care from a doctor, hospital, or other provider in the preferred network, the individual will only be responsible for a specified copayment, or a defined percentage of the discounted charges. EPOs require the individual pay the full discounted rate until an annual deductable amount has been met. Then one begins paying a percentage of the discounted rate.

EPO plans are similar to PPO plans except that they do not provide any benefit if the insured chooses a non-preferred provider, except for some cases of emergencies or when network providers are not reasonably available. The plan design typically incorporates an annual out-of-

[1] Chapter 627, F.S.
[2] Section 627.6472, F.S.

pocket maximum limit to individual or family costs, and may include a lifetime maximum limit on benefits received. Coverage for a pre-existing condition may be excluded for a specified period of time.

Available to State of Florida EPO consumers requiring assistance with grievances that have not been satisfactorily resolved is the Subscriber Assistance Program.[3] The consumer must first complete the entire grievance process of the EPO before filing a grievance with the program. A hearing is held before an independent panel. After the hearing, the panel makes a recommendation based on the finding of fact, either to the Agency for Health Care Administration or the Office of Insurance Regulation.

## Health Maintenance Organization (HMO) Plan

An HMO is a health plan that has contracts with a network of providers, including physicians and hospitals, within a defined service area.[4] Some HMOs require that care be coordinated through a primary care physician (PCP) or gate-keeper, while others provide direct access to all network providers. Florida provides for direct access to certain providers, such as dermatologists, even for those plans requiring a PCP.[5] For coverage, services must be received from a network provider. When one receives care from a doctor, hospital, or other network provider, the individual will only be responsible for a specified copayment, or a defined percentage of the discounted charges.

Except for emergency care, there is no provision for going out-of-network. Emergency care means medical services provided after the sudden or unexpected onset of a medical condition manifesting itself by acute symptoms, including injury caused by an accident, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's life or health would be placed in serious jeopardy
- Vital bodily functions would be seriously impaired
- There would be serious and permanent dysfunction of a bodily organ or part

HMOs emphasize preventative care, believing that regular doctor visits will result in lower health care costs in the long run. Utilization review, case management, and disease management are tools utilized to manage care and control costs. The plan design typically incorporates an annual out-of-pocket maximum limit to individual or family costs; however, there is no lifetime maximum limit on benefits received. There are no claim forms to file, nor are patients subject to balance billing. HMOs do not exclude coverage for a pre-existing condition.

In order for an HMO to do business in Florida, it must be independently accredited by a national review organization.[6, 7]

The Subscriber Assistance Program is available to State of Florida HMO consumers requiring assistance with grievances that have not been satisfactorily resolved.[8] The consumer must first

[3] Section 408.7056, F.S.
[4] Chapter 641, Part I, F.S.
[5] Section 641.31(33), F.S.
[6] Section 641.512, F.S.
[7] Agency for Health Care Administration approved accreditation organizations are: National Committee for Quality Assurance; Accreditation Association for Ambulatory Health Care; and, American Accreditation HealthCare Commission/URAC.
[8] Section 408.7056, F.S.

complete the entire grievance process of the HMO before filing a grievance with the program. A hearing is held before an independent panel. After the hearing, the panel makes a recommendation based on the finding of fact, either to the Agency for Health Care Administration or the Office of Insurance Regulation.

## Prepaid Health Clinics (PHC) Plan

A PHC is a health plan that provides health care services to groups and individual subscribers who have made regular prepaid per capita or pre-paid fixed sum payments to the plan.[9] These plans emphasize effective cost and quality controls. A PHC does not provide for inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services.

Florida's PHCs are dually regulated by the Agency for Health Care Administration and the Department of Financial Services. PHCs must be independently accredited by a national review organization.[10, 11]

Available to State of Florida PHC consumers requiring assistance with grievances that have not been satisfactorily resolved is the Subscriber Assistance Program.[12] The consumer must first complete the entire grievance process of the PHC before filing a grievance with the program. A hearing is held before an independent panel. After the hearing, the panel makes a recommendation based on the finding of fact, either to the Agency for Health Care Administration or the Office of Insurance Regulation.

## Medicare Advantage Plan

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans", are health plans offered by private companies approved by Medicare.[13] To participate in a Medicare Advantage Plan, an individual must be enrolled in Medicare Parts A[14, 15] & B[16, 17] and pay the Part B premium. MA Plans must follow rules set by Medicare. However, each plan can charge different out-of-pocket costs and have different rules for how you access services, such as whether you need a referral to see a specialist, or if you have to go to only doctors, facilities, or suppliers that belong to the plan. MA Plans must cover all the services that Medicare covers, except hospice care. (Original Medicare covers hospice care even if one is in a Medicare Advantage Plan.) They always cover emergency and urgent care. Most include prescription drug coverage without the requirement to

[9] Chapter 641, Part II, F.S.
[10] Section 641.512, F.S.
[11] Agency for Health Care Administration approved accreditation organizations are: National Committee for Quality Assurance; Accreditation Association for Ambulatory Health Care; and, American Accreditation HealthCare Commission/URAC.
[12] Section 408.7056, F.S.
[13] http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx
[14] Hospital insurance – Inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care. Normally, no premium is involved, but it has a deductible.
[15] http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-a.aspx
[16] Medical Insurance – Doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, outpatient physical and occupational therapy, including speech-language therapy.
[17] http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-b.aspx

enroll in Medicare Part D.[18] Many offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs.

## Medicare Supplement Plan

Medicare Supplement Plans, also known as Medigap Plans) are a type of private insurance that helps pay some of the costs for Medicare-covered services, such as coinsurance, copayments, and deductibles, that Medicare doesn't cover.[19, 20] Medigap policies do not include prescription drug coverage, nor do they cover long-term care (such as in a nursing home). Medicare Supplement Plans consist of fourteen (14) standardized plans identified by the letters A through N. Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it. Cost is usually the only difference between Medigap policies with the same letter, but sold by different insurance companies.

## Long-term Care Plan

Long-term Care Plans[21, 22] are a type of private insurance developed specifically to cover the costs of long-term care services, most of which are not covered by traditional health insurance or Medicare. These include services in one's home such as assistance with Activities of Daily Living (ADL),[23] as well as care in a variety of facility and community settings. Most policies use ADL and Cognitive Impairment[24] (CI) as triggers for benefits. The policy pays benefits when one needs help with two or more of the six ADLs or when one has a CI.

Most policies have a benefit period or lifetime benefit maximum, which is the total amount of time or total amount of dollars up to which benefits will be paid. Common benefit periods for long-term care policies are two, three, four, and five years, and lifetime or unlimited coverage. Most policies translate these time periods into dollar amounts and do not actually limit the number of days for which they will pay for care – just the overall dollar amount that the policy will pay. Premiums are pre-paid, and different payment options may be available. These include: payment according to a schedule - monthly, quarterly, semi-annually or annually; a lump sum payment; payment only for a specified period – most often 10, 15, or 20 years; and, premium payment only until age 65. Typically, premiums are waived during the time one is receiving benefits.

## Supplemental Plans

There are a variety of supplemental health insurance plan designs, with each crafted to fulfill a specific need.[25, 26]

[18] http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx
[19] http://www.medicare.gov/medigap/default.asp
[20] Chapter 627, Part VIII, F.S.
[21] http://www.longtermcare.gov/LTC/Main_Site/index.aspx
[22] Chapter 627, Part XVIII, F.S.
[23] Bathing; continence; dressing; eating; toileting; and, transferring.
[24] Inability to pass certain mental function tests.
[25] Section 627.643, F.S.
[26] Rule No. 69O-154.106, F.A.C.

### *Basic medical expense insurance*

These policies are sometimes called "first dollar" insurance, because unlike major medical expense insurance, they provide benefits up front, without requiring the insured to satisfy a deductible first. Coverages are classified according to categories of medical care: hospital expense, surgical expense, and physician's (non-surgical) expense.

- Hospital expense insurance reimburses the cost of hospital confinement. In addition to the room and board, hospital expense policies cover "hospital extras", or miscellaneous charges, such as drugs, x-rays, anesthesia, lab fees, dressings, use of the operating room, and supplies, up to a specified limit. Some policies provide for payment of a definite sum each day for a maximum number of days while others pay the actual bill or a percentage of the actual amount
- Surgical expense insurance provides coverage for the cost of a surgeon's services, whether the surgery is performed in the hospital or at an outpatient facility. Under the surgical schedule method, every surgical procedure is assigned a dollar amount by the insurer. If the surgeon's bill is more than the allowed charge set by the insurer, it is up to the insured to pay the difference.
- Basic physicians' expense insurance provides benefits for nonsurgical physicians' services, such as office visits and the care by a physician in a hospital for a nonsurgical reason. These benefits are usually limited.

Although the coverage is not as broad as in a comprehensive major medical insurance plan, it is usually significantly less costly and operates under the premise that the individual is more readily able to pay the less costly office visits and not the more costly hospital stays.

### *Hospital confinement indemnity insurance*

These policies pay a fixed dollar amount for each day the insured is confined to the hospital. It provides cash benefits to use as one sees fit. The benefits are predetermined and paid regardless of any other insurance in effect. This method of payment is in contrast with most other medical expense insurance that reimburses the insured on the costs incurred.

### *Major medical expense insurance*

Major medical expense insurance provides coverage for hospital, medical, and surgical expenses. These include: hospital room and board expenses; surgical fees; anesthetic services; doctor visits (in or out of the hospital); and, out-of-hospital diagnostic x-rays and tests. A variety of additional benefits are also provided. Copayment, coinsurance, annual deductibles, and dollar limits to the various benefits apply to these policies.

### *Supplemental major medical insurance*

Supplemental major medical insurance provides coverage for expenses left uncovered by the initial basic policy. After the basic policy's limits are reached, the insured must pay a deductible, after which the supplemental major medical coverage begins to pay. A supplemental policy is likely to include a stop-loss limit and a maximum lifetime benefit limit. Some plans have a per-cause (injury or illness) deductible, while others may use an all-cause or annual deductible. With a per-cause deductible, the insured pays one deductible for all expenses incurred from the same illness or injury.

### *Disability income protection insurance*

Disability income protection insurance policies provide for periodic payments for a specified period during a disability resulting from sickness or injury. These policies specify a waiting period, or number of days one must have to be unable to work before income benefits start to be paid. Shorter waiting periods result in higher premiums. The policy will also specify a "benefit period", or period of time for which benefits will be paid. Longer periods result in higher premiums. Some policies provide for a recurring disability benefit. The claim may be regarded as one continuous period of disability if one suffers a recurrence of the same or a related disability. In those cases, the requirement to complete a new waiting period is waived.

### *Accident-only insurance*

The policy provides coverage for death, dismemberment, disability, or hospital and medical care caused by an accident. Benefits are paid directly to the individual regardless of any other insurance coverage.

### *Limited benefit insurance*

The policy provides coverage for a specifically named disease or diseases, specifically named accident, or a specifically named limited market. Benefits are paid directly to the individual regardless of any other insurance coverage.

## International Health Insurance Policy

An international health insurance policy[27] may only be sold to a person who is not a resident of the United States. The policy is not required to comply with coverage, underwriting, and other provisions of the Florida Insurance Code. However, it must comply with coverage, underwriting, and other insurance regulatory provisions of the individual's country of residence.

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**
Chapter 627, F.S.
Chapter 641, F.S.

**Florida Administrative Code:**
Rule No. 69O-154, F.A.C.

## Where can I get additional information?

### Florida Office of Insurance Regulation

200 East Gaines Street
Tallahassee, FL 32399-0326
(850) 413-3140
http://www.floir.com

### Florida House of Representatives

[27] Section 624.123, F.S.

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

### *U.S. Department of Health & Human Services*
### *Centers for Medicare & Medicaid Services*

http://www.cms.gov
http://www.medicare.gov

### *National Clearinghouse for Long-Term Care Information*

http://www.longtermcare.gov

# Florida-Specific Health Care Plan Offerings

FACT SHEET 2010

## Introduction

Individual consumers and employers have access to a number of health care plan offerings which are unique to the State of Florida and fulfill specific needs.

## Cover Florida Health Care Access Program

Known as "Cover Florida", the program was created in 2008.[1, 2] January 1, 2009 was the earliest date for which coverage could be effective. Those eligible for enrollment are individuals age 19 to 64 who are not eligible for a public health insurance program such as Medicaid or Medicare, and who have been without health insurance for at least six months.

Initially, six carriers were chosen to participate, however only two (BlueCross BlueShield of Florida and United Healthcare) offered plans in all 67 Florida counties. Two of the original six, Medica Health Plan and Total Health Choice, withdrew from Cover Florida early in 2010. Those two were available only in Broward & Miami-Dade counties, and had few enrollees. United Healthcare and Blue Cross Blue Shield of Florida ceased issuing new policies in September and November 2010 respectively. Those plans accounted for the majority of enrollment through Cover Florida. Effective January 1, 2011, Cover Florida will only have an offering in Flagler, Miami-Dade, and Volusia counties.

Participating carriers are required to offer two benefit options plans, one of which must include catastrophic coverage. The offerings are guaranteed-issue,[3] subject to exclusions for pre-existing conditions approved by the Agency for Health Care Administration and the Office of Insurance Regulation. Portability provides that an individual can remain covered regardless of employment status or the cost sharing of premiums.

## Florida Health Choices Program

Florida Health Choices was created in 2008 as a single, centralized market for the sale and purchase of various health care products.[4, 5] These products include, but are not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent.

Florida Health Choices, Incorporated was established by law. The corporation is governed by a 15-member board which includes three ex-officio, nonvoting members (Agency for Health Care Administration, Department of Management Services, the Office of Insurance Regulation), four

[1] http://www.coverfloridahealthcare.com
[2] Section 408.9091, F.S.
[3] The health plan must allow one to enroll regardless of health, age, gender, or other factors that might predict use of health services.
[4] http://myfloridachoices.org
[5] Section 408.910, F.S.

appointed by the Governor, four appointed by the President of the Senate and four appointed by the Speaker of the House. The Corporation will:

- Determine eligibility of employers, vendors, individuals, and agents
- Establish operational procedures including application, enrollment, risk assessment, plan administration, performance monitoring, and consumer education
- Collect contributions from employers and individuals
- Pay premiums and other disbursements
- Establishes criteria for disenrollment and exclusion of vendors
- Develop a public awareness campaign
- Hire staff and/or consultants

The program was enacted during the 2008 legislative session, but has not been fully implemented.

## Health Flex Program

The Health Flex Program was created in 2002 as a pilot program to expand the availability of health options for low-income uninsured state residents.[6] The Program encourages development of alternative approaches to traditional health insurance that emphasize coverage for basic and preventive health care services. It is available in Broward, Hillsborough, Miami-Dade, Palm Beach, and Polk counties. While the initial expiration date of the pilot program was July 2004, the 2008 Legislature extended the program through July 2013.

## Florida Comprehensive Health Association

Established in 1983 to cover individuals unable to purchase health insurance on the open market due to pre-existing conditions, the Florida Comprehensive Health Association is financed through premiums and assessments on insurers.[7] This State of Florida high-risk insurance pool has been closed to new enrollment since 1991. Current enrollment has dwindled to less than 300 from a high of approximately 7500.

## Florida Health Insurance Plan

The Florida Health Insurance Plan[8] was created in 2004 to replace the Florida Comprehensive Health Association. The plan, its board of directors and plan of operations have not yet been established. The board of directors may not implement the plan until the funds are appropriated by the Legislature. To date, no funds have been appropriated. Until the plan is fully implemented, the Florida Comprehensive Health Association remains in effect.

## Pre-Existing Condition Insurance Plan (PCIP)

The Pre-Existing Condition Insurance Plan[9, 10, 11] was created in 2010 as part of the federal Patient Protection and Affordable Care Act. Florida has elected to have the plan administered by

[6] Section 408.909, F.S.
[7] Section 624.6488, F.S.
[8] Section 627.64872, F.S.
[9] http://www.pcip.gov
[10] H.R. 3590, Public Law 111-148, Title I, Sec. 1101
[11] http://www.healthcare.gov/

the United States Department of Health and Human Services. The Plan provides for coverage until 2014 when Exchanges will commence offering plans without pre-existing condition exclusions.

### *Eligibility:*

- The applicant is a citizen or national of the United States, or lawfully present in the U.S.
- The applicant has been uninsured for at least six months.

The applicant has been denied or had difficulty getting insurance due to a pre-existing condition.

### *2011 Benefit design:*

- Three plan options (Standard Option/ Extended Option/ Health Savings Account Option)
- Premiums vary by plan option and age bracket
- Calendar year deductibles vary by plan option
- Standard and Extended Option prescription deductibles differ
- Prescription copayments and coinsurance vary by plan option
- For all options, preventative care, to include annual physicals, flu shots, routine mammograms and cancer screening, is paid at 100% with no deductible when an in-network indicates a preventative diagnosis.

## Florida Kidcare Program

The Florida Kidcare Program[12, 13] was created to provide a defined set of health benefits to uninsured, low-income children. The Program includes health benefits coverage provided to children through the following program components:

- Medicaid
- Medikids as created in s. 409.8132, F.S.
- The Florida Healthy Kids Corporation as created in s. 624.91, F.S.
- Employer-sponsored group health insurance plans approved under ss. 409.810-409.821, F.S.
- The Children's Medical Services network established in Chapter 391, F.S.

Except for Title XIX-funded coverage under the Medicaid program, coverage under the Florida Kidcare Program is not an entitlement.

## State Group Health Insurance Program

The State Group Health Insurance Program[14, 15] offers health care coverage to the following categories of eligible subscribers:

- Employees of all branches or agencies of state government holding salaried positions and paid by state warrant or from agency funds, and employees paid from regular salary appropriations for 8 months' employment, including university personnel on academic contracts.
- All full-time employees of the state universities.
- Employees of Miami-Dade Expressway Authority

[12] http://www.floridakidcare.org
[13] Sections 409.810-409.821, F.S.
[14] Section 110.123, F.S.
[15] Section 110.12315, F.S.

- Employees of Tri-Rail (a.k.a. South Florida Regional Transportation Authority)
- Employees of the Florida Board of Bar Examiners
- Employees of the West Coast Inland Navigation District
- Employees of the Florida Inland Navigation District
- Surviving spouses of deceased state officers and employees if covered at the time of the officer's or employee's death
- COBRA participants
- State retirees who continue coverage upon retirement (Note: If a retiree fails to continue coverage or drops coverage, the retiree can not subsequently enroll or re-enroll.)
- Employees of small counties, small municipalities, and district school boards within those counties[16] (Note: These participants, if any, would be in a separate risk pool. To date, there have been no applicants.)

Eligible dependents can be covered through the subscriber's enrollment.

The Program provides for both a PPO and an HMO option. Each is available as either a standard or a high deductible health plan. For those active employees electing a high deductible health plan, the State makes a monthly contribution into their Health Savings Account.[17]

The State Group Health Insurance Plan is a self-insured PPO. The Third Party Administrator (TPA) for the medical component is BlueCross BlueShield of Florida. The Pharmacy Benefits Manager (PBM) is Caremark. This option is available to active employees and retirees worldwide. The Program also includes a fully insured HMO option available only to those living or working in the HMOs' service areas. All state-contracted HMOs participating in the Program are not available in each of Florida's 67 counties.

Funding for the Program is provided through the State Employees' Group Health Self-Insurance Trust Fund. Employer and participant contributions are deposited into the Trust Fund. The contributions are the same regardless of whether one chooses the self-insured PPO or one of the fully insured HMOs. Contributions vary depending upon coverage tier (E.g., Individual or Family).

The Legislature, annually, through the General Appropriations Act:

- Establishes the employer, employee, and retiree contribution amounts
- Establishes or modifies copayments and coinsurance
- Modifies benefits specific to State Group Health Insurance Program

The Department of Management Services is responsible for contract management and day-to-day management of the Program. Benefits administration was outsourced to Convergys and branded as People First. In March 2010, Convergys sold its Human Resources Management line of business, including People First, to NorthgateArinso, a global software and services provider, with world headquarters in the United Kingdom. NorthgateArinso is moving its North American headquarters from Atlanta to the former Convergys facility in Jacksonville, FL.

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**

[16] Section 110.1228, F.S.
[17] Section 110.123(12), F.S.

Chapter 110, F.S.
Chapter 408, F.S.
Chapter 409, F.S.
Chapter 624, F.S.
Chapter 627, F.S.

**Florida Administrative Code:**
Chapter No. 60P, F.A.C.

## *Where can I get additional information?*

### *Florida Department of Management Services*
### *Division of State Group Insurance*
4050 Esplanade Way, Suite 215200 East Gaines Street
Tallahassee, FL 32399
(850) 921-4600
http://dms.myflorida.com/human_resource_support/state_group_insurance

### *Florida House of Representatives*
Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

### *Cover Florida Health Care*
http://www.coverfloridahealthcare.com

### *Florida Health Choices*
225 South Adams St, Suite 250
Tallahassee, FL 32301
Phone: 850.222.0933
http://myfloridachoices.org

### *Florida KidCare*
http://www.floridakidcare.org

### *Healthy Kids*
https://www.healthykids.org

### *Children's Health Insurance Program*
http://www.InsureKidsNow.gov

### *Pre-Existing Condition Insurance Plan*
http://www.pcip.gov

# Continuation of Health Plan Coverage

FACT SHEET 2010

## Introduction

Employees and dependents are provided the opportunity to continue their health benefits through an employer-sponsored group health plan under certain circumstances.

## Consolidated Omnibus Budget Reconciliation Act

The Consolidated Omnibus Budget Reconciliation Act (COBRA)[1] provides employees and their dependents the right to continue group health benefits provided by their group health plan for a limited period of time under specified circumstances where coverage under the plan would otherwise be lost. COBRA applies to group health plans sponsored by employers with 20 or more employees and provides for identical benefits. The employer need not continue to make any contribution towards the premium. Thus the participant is responsible for the entire cost, to which a 2% administrative fee may be added. Premium payments are made to employer or plan administrator.

The specified circumstances which trigger COBRA rights are known as "qualifying events". The type of qualifying event determines the eligible beneficiaries and the maximum length of time COBRA coverage must be offered.

Qualifying events for employees are:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in the number of hours of employment

Qualifying events for spouses and dependent children are:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee becomes entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee
- Loss of dependent child status under the plan rules

An individual must be provided written notice of COBRA rights and the opportunity to elect continuation coverage. Upon receipt of the notice or the last day of coverage, whichever is later, the individual has 60 days to decide whether to elect COBRA. The initial premium must be paid within 45 days of electing coverage. There can be no break in coverage, and the initial premium payment must be for the full amount necessary to bring the account up to date. COBRA participants have until the last day of the coverage month to make payment for the month.

The normal length of time for which COBRA coverage is available is 18 months. A Social Security Administration written determination of disability can extend COBRA coverage for an

[1] http://www.dol.gov/dol/topic/health-plans/cobra.htm

additional 11 months, or 29 months total. Should there be a second qualifying event, such as a divorce involving the former employee who elected COBRA coverage, an additional 18 month extension would be available to the ex-spouse. Thirty-six months is the maximum length of time allowable for coverage under COBRA. Plans can charge 150% of the premium cost for the extended period of coverage.

## Florida Health Insurance Coverage Continuation Act

Because the Consolidated Omnibus Budget Reconciliation Act does not apply to employers with fewer than 20 employees, Florida enacted the Florida Health Insurance Coverage Continuation Act,[2] sometimes referred to as "mini-COBRA". It provides for continuation coverage for employees of small employers who employ 19 or fewer employees. Participants pay the entire premium for coverage, up to 115% of the cost of the plan. Premium payments are made direct to the carrier.

Mini-COBRA also utilizes "qualifying events" to determine the eligible beneficiaries and the maximum length of time coverage must be offered.

Qualifying events for employees are:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in the number of hours of employment

Qualifying events for spouses and dependent children are:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee becomes entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee
- Loss of dependent child status under the plan rules

Qualifying event for a retiree, or the spouse or child of a retiree is:

- Losing coverage within 1 (one) year before or after commencement of a bankruptcy proceeding under Title XI of the United States Code by the employer from whose employment the covered employee retired

The normal length of time for which mini-COBRA coverage is available is 18 months. A Social Security Administration written determination of disability can extend coverage for an additional 11 months, or 29 months total. Mini-COBRA does not provide for a second qualifying event. Therefore, 29 months is the maximum period for coverage under mini-COBRA. Plans can charge 150% of the premium cost for the extended period of coverage.

## Conversion Policies

Conversion policies provide for coverage under an individual insurance policy when group health plan benefits are lost. While not required by federal law, under COBRA rules, employers that do offer an individual conversion option to active employees must make that option available to COBRA qualified beneficiaries as well. The right to convert to an individual health

[2] Section 627.6692, F.S.

insurance policy applies only to those qualified beneficiaries who have exhausted their maximum COBRA coverage periods. Beneficiaries whose COBRA coverage terminates early are not eligible to convert to individual coverage under the plan. Early COBRA termination may be the result of:

- Nonpayment of premium
- Cancellation of the entire group health plan
- A qualified beneficiary acquiring other health insurance, such as coverage under a new employer's health plan

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**
Chapter 627, F.S.

## Where can I get additional information?

### Florida Office of Insurance Regulation

200 East Gaines Street
Tallahassee, FL 32399-0326
(850) 413-3140
http://www.floir.com

### Florida House of Representatives

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

### U.S. Department of Labor

http://www.dol.gov/dol/topic/health-plans/cobra.htm

# Health Insurance Portability and Accountability Act of 1996 (HIPAA)

FACT SHEET 2010

## Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions designed to protect individuals by limiting the use of pre-existing condition exclusions, safeguarding an individual's health information, and improving portability and continuity of health insurance coverage. An additional purpose is to provide for improved efficiency and effectiveness of the health care system.

## HIPAA Right of Portability

Some individuals may be eligible to purchase individual health insurance policies without being subject to exclusions for pre-existing medical conditions. These individuals must have had coverage under a group health plan, including COBRA continuation coverage, without a break in coverage of more than 62 days. If there is a "significant break in coverage" of 63 days or longer, HIPAA protections are lost. In the case of COBRA beneficiaries, all coverage under COBRA must be exhausted before being eligible for guaranteed access to individual health coverage under HIPAA.

HIPAA portability applies only when:

- An employee leaves a job with group health plan coverage and moves to another job with group health plan coverage
- An employee loses groups health plan coverage and wants to purchase individual health insurance coverage
- A person has coverage under an individual health insurance policy and enrolls in a new group health plan.

HIPAA does not provide portability rights when a person has individual health insurance coverage and moves to other individual coverage.

## HIPAA Privacy and Security Rules

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II), resulted in national standards regarding privacy and security of protected health information.[1, 2] The HIPAA Privacy and Security Rules apply only to covered entities, as defined. Covered entities are health care providers, health plans, and health care clearinghouses.

Health care providers include:

- Doctors
- Clinics

[1] http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html
[2] http://www.cms.gov/HIPAAGenInfo

- Psychologists
- Dentists
- Chiropractors
- Nursing Homes
- Pharmacies

Health plans include:

- Health insurance companies
- Health Maintenance Organizations
- Employer health plans
- Government programs that pay for health care, such as Medicare, Medicaid, and the military and veterans health care programs

Health care clearinghouses include entities that process non-standard health information they receive from another party into a standard electronic format or data content, or vice versa.

The Department of Health and Human Services, Office for Civil Rights is responsible for administering and enforcing the HIPAA Privacy and Security Rules. It may conduct complaint investigations and compliance reviews.

If an organization is not a covered entity, it does not have to comply with the HIPAA Privacy and Security Rules.

## *HIPAA Privacy Rule*

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities. It sets rules and limits on who can look at and receive one's health information. The Privacy Rule applies to all forms of an individuals' protected health information, whether electronic, written, or oral. Protected health information includes:

- Information an individual's doctors, nurses, and other health care providers put in their medical record
- Conversations one's doctor has about their care or treatment with nurses and others
- Information about an individual in the health insurer's computer system
- Billing information about an individual at their clinic
- Most other health information about an individual held by those who must follow the Privacy Rule

The Privacy Rule does permit the disclosure of protected health information needed for patient care and other important purposes. It allows a covered entity to disclose protected health information to their "business associates". A "business associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. The types of functions or activities provided by a business associate include payment or health care operations activities. The covered entity is responsible for obtaining assurances that the business associate will use the information only for the purposes for which it was engaged by the covered entity, will safeguard the information from misuse, and will help the covered entity comply with some of the covered entity's duties under the Privacy Rule. Typically, this is done through a "business associate agreement" which may be incorporated into the contract between the covered entity and its business associate.

The HIPAA Privacy Rule provides patients with certain rights regarding their protected health information. These include the right to:

- Ask to see and get a copy of their health records
- Have corrections added to their health information
- Receive a notice that tells them how their health information may be used and shared
- Decide if they want to give their permission before their health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why their health information was shared for certain purposes

If an individual believes their rights are being denied or their health information isn't being protected, they can file a complaint with the provider, health insurer, or the U.S. Government.

### *HIPAA Security Rule*

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. It specifies a series of administrative, physical, and technical safeguards for covered entities to use to assure the confidentiality, integrity, and availability of electronic protected health information. Specifically, covered entities must:

- Ensure the confidentiality, integrity, and availability of all electronic protected health information they create, receive, maintain or transmit
- Identify and protect against reasonably anticipated threats to the security or integrity of the information
- Protect against reasonably anticipated, impermissible uses or disclosures
- Ensure compliance by their workforce

## Where can I get additional information?

### Florida Office of Insurance Regulation

200 East Gaines Street
Tallahassee, FL 32399-0326
(850) 413-3140
http://www.floir.com

### Florida House of Representatives

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

### U.S. Department of Health & Human Services

http://www.hhs.gov/ocr/privacy
http://www.cms.gov/HIPAAGenInfo

# Health Care Plan Mandates

FACT SHEET 2010

## Introduction

A "mandate" is a legal requirement that an insurance company or health plan cover, or offer coverage for, specific benefits, services by particular health care providers, or specific populations of individuals.[1] Consumers can experience a disparity in application, since self-funded plans may be exempt. There can be vast differences between the cost impacts of various mandates. Florida currently has at least 52 mandates, however all are not applicable to every plan or individual.[2, 3]

## Mandated Benefits

Florida has a number of mandated benefits. In some cases, the benefit may be gender or age-specific. Examples of mandated benefits include:

- Alcoholism/Substance Abuse
- Autism
- Bone Marrow Transplant
- Breast Reconstruction
- Cleft Palate
- Diabetic Supplies
- Mammogram
- Maternity Minimum Stay
- Newborn Hearing Screening
- Well Child Care

## Mandated Access

*Florida Statutes* provide for guaranteed access to certain types of providers, if that type of provider is in the network. That does not mean each carrier doing business in Florida must include such providers within its network. For plans using a gatekeeper business model, the mandate may require direct access within specified limits. Examples of providers for whom access is mandated include:

- Chiropractors
- Dermatologists
- Nurse/midwives
- Podiatrists

[1] http://www.ncsl.org/default.aspx?tabid=14463

[2] http://www.myfloridacfo.com/consumers/insuranceLibrary {See Health Insurance Information, Health Maintenance Organization (HMO) Insurance Information, General HMO (Individual and Group) Information, Mandated Health Insurance and HMO Benefits}

[3] http://www.myfloridacfo.com/consumers/InsuranceLibrary/Insurance/L_and_H/Health_Care/HIPAA/HIPAA_-_Specific_Benefit_Requirements.htm

## Mandated Population Groups

When an individual has "family coverage", Florida mandates that policies include coverage for specific categories of dependents. These mandates may contain time or age limits. Examples of mandated population groups include:

- Adopted children
- Dependent adults
- Dependent students
- Dependents of a dependent
- Newborns

## Mandated Offerings

Mandated offerings do not require that certain benefits be provided. They require that insurers offer a coverage option for a particular benefit or specific patient group. The insured is free to elect or reject the option, which may require a higher or additional premium.

## Health Insurance Mandate Report

Because mandates may impact the cost of health care or involve social issues, a report assessing the social and financial impact of any proposal for legislation that mandates health benefit coverage or mandates offering requirements is required.[4] It is to be submitted to the Agency for Health Care Administration and appropriate legislative committees. The report must include:

- The extent to which the treatment or service is generally used by a significant portion of the population
- The extent to which the insurance coverage is generally available
- If the insurance coverage is not generally available, the extent to which the lack of coverage results in persons avoiding necessary health care treatment
- If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship
- The level of public demand for the treatment or service
- The level of public demand for insurance coverage of the treatment or service
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts
- The extent to which the coverage increases or decreases the cost of the treatment or service
- The extent to which the coverage increases the appropriate uses of the treatment or service
- The extent to which the mandated treatment or service will be a substituted for a more expensive treatment or service
- The extent to which the coverage increases or decreases the administrative expenses of insurance companies and the premiums and administrative expenses of policyholders
- The impact of the coverage on the total cost of health care

[4] Section 624.215, F.S.

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**
Chapter 627, F.S.
Chapter 641, F.S.

## Where can I get additional information?

### Florida Department of Financial Services

200 East Gaines Street
Tallahassee, FL 32399-0319
(850) 413-2863
http://www.myfloridacfo.com

### Florida Office of Insurance Regulation

200 East Gaines Street
Tallahassee, FL 32399-0326
(850) 413-3140
http://www.floir.com

### Florida House of Representatives

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

# Categories of Health Care Purchasers

FACT SHEET 2010

## Introduction

The category of health care purchaser may determine the offerings which are available and options or protections afforded the purchaser.

## Individual

An individual health care purchaser is a person buying health care, either as a single individual or as the head of a household purchasing a "family" policy. This category would not include a "small employer" with only one (1) employee.

## Small Employer

Florida has created the category of small employer[1] to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status. A small employer must have its principal place of business in Florida and employ, on average, at least one (1), but not more than 50 eligible employees. The small employer must be actively engaged in business. In addition, the majority of the employees must be employed in Florida. A sole proprietor, self-employed individual, or independent contractor may meet the criteria required for classification as a small employer. A business, firm, corporation, partnership, or association may not be formed primarily for purposes of purchasing insurance. By Administrative Rule, carriers are provided direction regarding rate setting for small group products.[2]

For purposes of continuation coverage, there is a further breakdown within "small employer". The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides for continuation coverage for small employer groups with as few as 20 employees. Because COBRA does not apply to employers with fewer than 20 employees, Florida enacted the Florida Health Insurance Coverage Continuation Act.[3] Mini-COBRA, as it is known, provides for continuation coverage for employees of small employers who employ 19 or fewer employees.

## Large Employer

A large employer is one employing more than fifty (50) eligible employees.

[1] Section 627.6699, F.S.
[2] Rule No. 69O-149.037, F.A.C.
[3] Section 627.6692, F.S.

## Special Types of Groups

### *Labor union, association, and small employer health alliance groups*

A group of individuals may be insured under a policy issued to an association, including a labor union, if the association has a constitution and bylaws.[4] It must be comprised of at least 25 individual members. The association must have been organized and maintained for a period of one (1) year for purposes other than that of obtaining insurance.

### *Teacher and student groups*

Individuals may be insured under a policy issued to a group of teachers or students of an institution of learning.[5] The policy or contract issued may insure the spouse, dependent children, parents, or siblings of the insured student or teacher.

### *Additional groups*

- A group of employees eligible for coverage under a group life insurance policy may be insured for health insurance.[6] The spouse and dependent children may be insured for health with or without the employee being insured.
- A credit union group may purchase health insurance for its members under a policy issued to the credit union.[7] The benefit for each member is limited to a maximum of $10,000.

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**
Chapter 627, F.S.

**Florida Administrative Code:**
Rule No. 69O-149, F.A.C.

## Where can I get additional information?

### *Florida Office of Insurance Regulation*

200 East Gaines Street
Tallahassee, FL 32399-0326
(850) 413-3140
http://www.floir.com

[4] Section 627.654, F.S.
[5] Section 627.6551, F.S.
[6] Section 627.656, F.S.
[7] Id.

***Florida House of Representatives***
Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

# Categories of Health Care Plan Enrollees

FACT SHEET 2010

## Introduction

Eligibility for enrollment in a health care plan may be contingent upon a number of factors. Such factors can impact not only the ability to enroll, but also coverage and premium cost.

## Employee Participant

In order to be categorized as an "active" employee eligible for employer-sponsored group health care benefits, an employer may take a variety of factors into consideration. One criterion might be a minimum number of hours worked per week or per month. Seasonal employees and those on academic contracts may have requirements based upon the number of months worked in a given period. An employer can differentiate between a permanent and a temporary employee. A permanent employee may work enough hours part-time to be benefit-eligible, while a temporary employee working full-time may not be eligible for benefits. An initial period of employment, sometimes referred to as a "waiting period", may be specified before an individual is eligible to enroll for benefits. These factors may vary among individual employers in order to meet their business needs and/or control the cost of premiums.

When the employer is contributing towards premium cost, the amount or percentage may vary based upon:

- Enrollment tier (Employee only; Family; etc.)
- Percent of full-time employee work period worked
- Longevity with the organization
- Position within the organization

For active employees who are military retirees, if covered under an employer-sponsored group health plan, the employer's plan provides primary coverage. It is unlawful for an employer with 20 or more employees to offer any financial incentive to employed military retirees not to enroll or to terminate enrollment under its group health plan.

## COBRA/Mini-COBRA Participant

For continuing coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)[1] or the Florida Health Insurance Coverage Continuation Act (Mini-COBRA),[2] the individual must have already been enrolled in an employer-sponsored group health plan after meeting the appropriate eligibility criteria.

## Retiree Participant

Retirees may be grouped into two broad categories: Medicare-eligible retirees and non-Medicare-eligible retirees (sometimes referred to as "early retirees" or "pre-65 retirees"). Not all

[1] http://www.dol.gov/dol/topic/health-plans/cobra.htm
[2] Section 627.6692, F.S.

employers provide retirees with an option for health care benefits. For employers with collective bargaining agreements, the offering of retiree health care benefits may be part of the agreement, or an item for negotiation.

For retirees who are not eligible for Medicare, options for health care coverage under the group plan of the former employer may be available. Employers are not required by law to make that option available. If coverage under the group health plan is not available, these retirees become individual health care plan consumers.

For retirees who are eligible for Medicare and continue to be provided coverage under a group health plan, the group plan coordinates benefits with Medicare. There may be benefits available through the employer-sponsored group health plan which are not available under basic Medicare Part A and Part B. (E.g., Prescription drug coverage) For those Medicare-eligible retirees who choose not to exercise the option for coverage under the group plan, or who do not have the option, Medicare Advantage and Medicare Supplement plans may be available.

## High Risk Participant

Certain individuals are unable to buy health care coverage because they are considered "high risk". That is, the carrier perceives the pre-existing medical condition(s) are such that there is a great probability of losing more money than the individual would or could pay in premium. The carrier either declines to write a policy or the policy premium is so expensive that it is not affordable. There are some special programs and plans which have attempted to assist such high risk individuals with health care coverage. The Florida Comprehensive Health Association[3] is Florida's high-risk insurance pool; however, it has been closed to new enrollment since 1991. Cover Florida Health Care Access Program[4, 5] provides offerings that are guaranteed-issue[6], subject to exclusions for pre-existing conditions approved by the Agency for Health Care Administration and the Office of Insurance Regulation. The "Alonzo Mourning Access to Care Act"[7] provides the opportunity for individuals eligible for Medicare by reason of disability or end-stage renal disease to enroll in a Medicare Supplement policy. The Pre-Existing Condition Insurance Plan[8, 9, 10] was created in 2010 as part of the federal Patient Protection and Affordable Care Act. Florida has elected to have the plan administered by the United States Department of Health and Human Services. The Plan provides for coverage until 2014 when Exchanges will commence offering plans without pre-existing condition exclusions.

## Minor Child Participant

Some private plans offer coverage for children separate from a parent or family policy. In addition, there are a number of public health care programs which provide coverage for children. The Florida Kidcare Program[11, 12] was created to provide a defined set of health benefits to

[3] Section 624.6488, F.S.
[4] http://www.coverfloridahealthcare.com
[5] Section 408.9091, F.S.
[6] The health plan must allow one to enroll regardless of health, age, gender, or other factors that might predict use of health services.
[7] Section 627.671, F.S.
[8] http://www.pcip.gov
[9] H.R. 3590, Public Law 111-148, Title I, Sec. 1101
[10] http://www.healthcare.gov/
[11] http://www.floridakidcare.org

uninsured, low-income children. The Program includes health benefits coverage provided to children through the following program components:

- Medicaid
- Medikids[13]
- The Florida Healthy Kids Corporation[14, 15]
- Employer-sponsored group health insurance plans[16]
- The Children's Medical Services Network[17]

The Children's Health Insurance Program (CHIP) is a federal and state jointly financed program administered by the states.[18]

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**
Chapter 391, F.S.
Chapter 408, F.S.
Chapter 409, F.S.
Chapter 624, F.S.
Chapter 627, F.S.

## Where can I get additional information?

### Florida House of Representatives

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

### Cover Florida Health Care

http://www.coverfloridahealthcare.com

### Florida KidCare

http://www.floridakidcare.org

### Healthy Kids

https://www.healthykids.org

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[12] Sections 409.810-409.821, F.S.
[13] Section 409.8132, F.S.
[14] Section 624.91, F.S.
[15] https://www.healthykids.org/
[16] Sections 409.810-409.821, F.S.
[17] Chapter 391, F.S.
[18] http://www.insurekidsnow.gov/chip/index.html

***Children's Health Insurance Program***
http://www.InsureKidsNow.gov

***Pre-Existing Condition Insurance Plan***
http://www.pcip.gov

# Oversight of Financial Institutions

FACT SHEET 2010

## Introduction

The Financial Services Commission was created within the Department of Financial Services. It is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. The Office of Financial Regulation is one of two structural units of the Commission. The Director is also known as the Commissioner of Financial Regulation.[1] The Financial Services Commission has authority over Florida-chartered financial institutions, but not those which are federally chartered or chartered by other states.

## Office of Financial Regulation

The Office of Financial Regulation (OFR) is responsible for all activities of the Financial Services Commission relating to the regulation of banks, credit unions, other financial institutions, finance companies, and the securities industry. The OFR is responsible for administering Florida's financial institution codes which are comprised of:

- Chapter 655 – Financial Institutions Generally
- Chapter 657 – Credit Unions
- Chapter 658 – Banks and Trust Companies
- Chapter 660 – Trust Business
- Chapter 663 – International Banking Corporations
- Chapter 665 – Associations
- Chapter 667 – Savings banks

### *Governance*

During the process of licensing or chartering a financial institution, the OFR reviews the functioning and composition of the Board of Directors. It examines the business experience and ability of proposed officers and directors. The organization's risk management-related functions are also reviewed, along with any requirements regarding external auditors.

### *Financial reserve requirements*

Minimum surplus requirements are established in law. In like manner, limitations are placed on the institution's borrowing ability and permissible indebtedness.

### *Permissible activities*

Contained within the financial institution codes are guidelines or requirements regarding:

- Corporate/company actions
- Director/employee activities
- Interactions with customers
- Forms, contracts, agreements, marketing materials
- Disclosures

[1] Section 20.121(3), F.S.

Prohibitions are also defined.

### *Performance monitoring*

The OFR uses a variety of techniques to monitor the performance of financial institutions. In addition to its review of periodic reports submitted by the entities, it conducts audits and site visits. Should the need arise, the OFR has subpoena authority.

### *Enforcement*

The Bureau of Financial Investigations is contained within the OFR, and has a separate budget. It can conduct investigations into:

- Securities and investment fraud
- Mortgage fraud
- Consumer finance and other lending violations
- Loan broker and advance fee scams
- Banking violations

OFR has non-criminal enforcement authority. It may impose civil penalties and seek certain civil remedies. The OFR has the authority to:

- Issue cease and desist orders
- Deny, restrict, or revoke licenses
- Impose administrative fines
- Seek injunctions and appointment of receivers through the courts

OFR may refer investigations to:

- U.S. Attorney
- State Attorneys
- Attorney General
- Statewide Prosecutor

### *Additional consumer protections*

- In addition to protections provided through the OFR's oversight of financial institutions, it provides protections associated with non-depository financial service companies and related industries. These include:
  - Loan Originators and Mortgage Brokers[2]
  - Consumer Finance Companies[3]
  - Retail Installment Sales Providers[4]
  - Title Loans[5]
  - Collection Agencies[6]
  - Money Transmitters[7]
    - Funds transmitters
    - Payment instrument sellers (money orders and travelers checks)
    - Foreign currency exchangers

[2] Chapter 494, F.S.
[3] Chapter 516, F.S.
[4] Chapter 520, F.S.
[5] Chapter 537, F.S.
[6] Chapter 559, F.S.
[7] Chapter 560, F.S.

- Check cashers
- Deferred presentment providers (payday loan)

- Oversight of the securities industry by the Office of Financial Regulation is governed by the Florida Securities and Investor Protection Act[8] and the Certified Capital Company Act.[9]

## Federally Chartered Financial Institutions

The Office of Financial Regulation does not have any jurisdiction or exercise any statutory authority over federally chartered financial institutions doing business in Florida. Federally chartered banks are regulated by the Office of the Comptroller of the Currency.[10] Federally chartered credit unions are regulated by the National Credit Union Administration,[11] an independent federal agency. Federal savings and loan associations are regulated by the Office of Thrift Supervision.[12]

## Financial Institutions Chartered By Other States

The Office of Financial Regulation does not have any jurisdiction or exercise any statutory authority over financial institutions chartered in another state and doing business in Florida. Those institutions are regulated by the laws and statutes of the particular state in which they were chartered.

## International Banking Corporation

International banking corporations are organized and licensed under the laws of a foreign country. They must be licensed by the Office of Financial Regulation (OFR) to transact business in Florida and comply with the provisions of the financial institutions codes.

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**
Chapter 20, F.S.
Chapter 655, F.S.
Chapter 657, F.S.
Chapter 658, F.S.
Chapter 660, F.S.
Chapter 663, F.S.
Chapter 665, F.S.

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[8] Chapter 517, F.S.
[9] Chapter 288, Part XII, F.S.
[10] http://www.occ.treas.gov/
[11] http://www.ncua.gov/
[12] http://www.ots.treas.gov/

Chapter 667, F.S.

## *Where can I get additional information?*

### *Florida Department of Financial Services*
200 East Gaines Street
Tallahassee, FL 32399-0319
(850) 413-2863
http://www.myfloridacfo.com

### *Florida Office of Financial Regulation*
200 East Gaines Street
Tallahassee, FL 32399-0371
(850) 410-9800
http://www.flofr.com

### *Florida Department of Financial Services*
Division of Consumer Services
200 East Gaines Street
Tallahassee, FL 32399-0321
(850) 413-3030
1-877-693-5236
http://www.myfloridacfo.com/sitePages/agency/sections/ConsumerServices.aspx

### *Florida House of Representatives*
Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

### *Office of the Comptroller of the Currency*
http://www.occ.treas.gov

### *National Credit Union Administration*
http://www.ncua.gov

### *Office of Thrift Supervision*
http://www.ots.treas.gov

# Types of Financial Institutions

FACT SHEET 2010

## Introduction

A financial institution is a corporation or other business entity which provides financial services for its members or clients. These services can include collecting funds from the public, public institutions, or private institutions, and placing them in financial assets, providing loans, issuing credit cards, and providing personal services, such as wealth management and tax planning.

## Bank

A bank is an organization, usually a corporation, chartered by a state or federal government, authorized to accept deposits, pay interest, clear checks, make loans, act as an intermediary in financial transactions, and provide other financial services to its customers. Under Florida law, the term "bank" does not include a credit union or association.[1]

### *State-chartered bank*

State-chartered banks are regulated by the laws and statutes of the particular state in which the bank was chartered. Florida-chartered banks are licensed and regulated by the Office of Financial Regulation (OFR).[2] Banks chartered in a state other than Florida are called "home banks". The OFR does not have any jurisdiction or exercise any authority over home banks. Each state has its own process for addressing consumer complaints. The states do not share information, nor is there a central database containing complaint information.

### *National or federally chartered bank*

Federally chartered banks are regulated by the Office of the Comptroller of the Currency.[3] The OFR does not have any jurisdiction or exercise any authority over federally chartered banks. Customers seeking information, or with issues involving a federally chartered bank must contact the Office of the Comptroller of the Currency.

### *International banking corporation*

International banking corporations are organized and licensed under the laws of a foreign country. The term includes a foreign commercial bank, foreign merchant bank, or other foreign institution that engages in banking activities usually in connection with the business of banking in the country where such foreign institution is organized or operating. They must be licensed by the Office of Financial Regulation (OFR) to transact business in Florida. An international banking corporation may operate through a variety of business models, all of which must be separately licensed. These authorized business models, include:

- International bank agency

[1] Section 658.12(2), F.S.
[2] Chapter 658. F.S.
[3] http://www.occ.treas.gov/

- May make any loan, extension of credit, or investment which it could make if incorporated and operating as a bank organized under the laws of Florida
- May act as a custodian, and may furnish investment management and investment advisory services to nonresident entities or persons whose principal places of business or domicile are outside the United States, and to resident entities or persons with respect to international or foreign investments

- International branch - Any office of an international banking corporation established in Florida under Florida law
  - Has the same rights and privileges as a federally licensed international branch
  - Operations must be conducted in accordance with requirements determined by OFR as necessary to ensure compliance with the provisions of the financial institutions codes
  - Must maintain accounts and records separate from those of the international banking corporation of which it is a branch
- International representative office
  - May promote or assist the deposit-taking, lending, or other financial or banking activities of an international banking corporation
  - May serve as a liaison in Florida between an international banking corporation and its existing and potential customers
  - May solicit business for the international banking corporation and its subsidiaries and affiliates, provide information to customers concerning their accounts, answer questions, receive applications for extensions of credit and other banking services, transmit documents on behalf of customers, and make arrangements for customers to transact business on their accounts
  - May not conduct any banking or trust business in Florida
- International trust company representative office
  - May conduct any nonfiduciary activities that are ancillary to the fiduciary business of its international banking corporation or trust company.
  - Permissible activities include:
    - Advertising, marketing, soliciting for fiduciary business on behalf of an international banking corporation or trust company
    - Contacting existing or potential customers
    - Answering questions and providing information about matters related to their accounts
    - Serving as a liaison in Florida between the international banking corporation or trust company and its existing or potential customers
  - May not act as a fiduciary

### *Credit card bank*

A credit card bank is a national bank that has its principal place of business in Florida or a bank organized under Florida law, with activities limited by the Credit Card Bank Act.[4] Authorized activities are limited to:

- Accepting deposits only at a single location in Florida

[4] Section 658.995, F.S.

- Engaging only in the business of soliciting, processing, and making loans pursuant to credit card accounts and conducting such other activities as may be necessarily
- Accepting savings or time deposits of only $100,000 or more

Credit card banks may not accept demand deposits or deposits that the depositor has the ability to withdraw by check or similar means for payment to third parties or others. They are subject to the supervision, regulation, and examination by the OFR.

A credit card bank is not considered a "bank" for all purposes.[5]

## Credit Union

A credit union is a cooperative, nonprofit organization owned and operated by its members. Membership is limited to a defined group of persons designated as eligible for membership in the credit union who:

- Have a similar profession, occupation, or formal association with an identifiable purpose
- Live or work within an identifiable neighborhood, community, rural district, or county
- Are employed by a common employer
- Are employed by the credit union
- Are members of the immediate family of persons within such group.

Credit unions offer their members many of the same financial services as banks, and savings and loan associations. Credit unions can charge lower interest rates on loans and may pay higher interest rates on savings because they are exempt from state and federal taxes.

A credit union may be state or federally chartered. Florida-chartered credit unions are regulated by the OFR.[6] Foreign credit unions are those organized and operating under the laws of another state. Federally chartered credit unions are regulated by the National Credit Union Administration,[7] an independent federal agency. State and federal credit union member accounts are insured through the National Credit Union Share Insurance Fund, in a manner similar to banks and the FDIC.

A credit union may purchase for or make available to its members a variety of insurance coverage so long as it is directly related to the extension of credit or to the receipt of shares or deposits. The amounts of insurance are limited and must be related to the members' respective ages, shares, deposits, or credit balances.

## Savings and Loan Association or Thrift

Savings and loan associations may be formed as a mutual or corporate association. They may be state or federally chartered. They accept funds from depositors, provide interest bearing accounts and certificates of deposit, make home mortgage loans, and may provide other financial services. Florida chartered institutions are regulated by the OFR[8] and federal savings and loan associations are regulated by the Office of Thrift Supervision.[9] Deposit insurance is provided

[5] Section 658.995(8), F.S.
[6] Chapter 657, F.S.
[7] http://www.ncua.gov/
[8] Chapter 665, F.S.
[9] http://www.ots.treas.gov/

through the Deposit Insurance Fund which is administered by the FDIC, but separate from the bank insurance program.

Authorized activities include:

- Acquiring, holding, selling, disposing of, and conveying real and personal estate
- Mortgaging, pledging, or leasing any real or personal estate
- Issuing and selling debt
- Selling loans
- Acting as agent for others in a transaction incidental to the operation of its business
- Acting as a trustee for a trust or individual retirement account
- Contracting with schools or charitable institutions caring for minors to provide a savings plan and collect deposits for savings accounts at the facility
- Contracting with an employer with respect to the solicitation, collection, and receipt of savings by payroll deduction to be credited to a designated account
- Issuing drafts and similar instruments drawn on the association

## Savings Bank

Mutual savings banks are owned by their depositors and managed for their mutual benefit, while capital stock savings banks are owned by shareholders.[10] Services provided by savings banks are akin to those provided by banks and savings and loan associations.

Authorized activities include:

- Acquiring, holding, selling, disposing of, and conveying real and personal estate
- Mortgaging, pledging, or leasing any real or personal estate
- Issuing and selling debt
- Selling loans
- Acting as agent for others in a transaction incidental to the operation of its business
- Acting as a trustee for a trust or individual retirement account
- Contracting with schools or charitable institutions caring for minors to provide a savings plan and collect deposits for savings accounts at the facility
- Contracting with an employer with respect to the solicitation, collection, and receipt of savings by payroll deduction to be credited to a designated account
- Issuing drafts and similar instruments drawn on the savings bank

## Trust Company

A trust company is a business organization other than a bank or state or federal association authorized to engage in trust business.[11, 12] It acts as a trustee, executor, guardian, agent, or fiduciary for an individual or a business in administering trust funds, estates, or custodial arrangements.

A state bank or association may establish a trust department for the purpose of conducting trust business. Separate books and records must be maintained.

The OFR is responsible for licensure and regulation of trust business activities.

[10] Chapter 667, F.S.
[11] Chapter 658, F.S.
[12] Chapter 660, F.S.

## Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations

**Florida Statutes:**
Chapter 655, F.S.
Chapter 657, F.S.
Chapter 658, F.S.
Chapter 660, F.S.
Chapter 663, F.S.
Chapter 665, F.S.
Chapter 667, F.S.

## Where can I get additional information?

### Florida Department of Financial Services
200 East Gaines Street
Tallahassee, FL 32399-0319
(850) 413-2863
http://www.myfloridacfo.com

### Florida Office of Financial Regulation
200 East Gaines Street
Tallahassee, FL 32399-0371
(850) 410-9800
http://www.flofr.com

### Florida House of Representatives
Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov

### Office of the Comptroller of the Currency
http://www.occ.treas.gov

### Federal Deposit Insurance Corporation
http://www.fdic.gov

### National Credit Union Administration
http://www.ncua.gov

***Office of Thrift Supervision***
http://www.ots.treas.gov

Department of
Financial Services

## Introduction

The Department of Financial Services' mission is to safeguard the people of Florida and the state's assets through financial accountability, education, advocacy, fire safety, and enforcement.[1] The head of the Department of Financial Services is the Chief Financial Officer (CFO). The CFO is the chief fiscal officer of the state and responsible for settling and approving accounts against the state and for keeping all state funds and securities.[2]

The Financial Services Commission, composed of the Governor, the Attorney General, the CFO, and the Commissioner of Agriculture, exists within the Department of Financial Services. However, the Commission is not subject to control, supervision, or direction by the Department of Financial Services in any manner. The Commission directs the Office of Financial Regulation and the Office on Insurance Regulation.[3]

## Department of Financial Services

The Department of Financial Services manages the state's accounting and auditing functions, monitors the investment of state funds, investigates financial fraud, licenses and exercises oversight of insurance agents and agencies, ensures that Florida businesses have workers' compensation coverage, safeguards unclaimed property, helps consumers with financial services issues, and serves as the state fire marshal, investigating arson and promoting fire safety.[4]

The Department of Financial Services is comprised of 13 divisions. These include:

### *Division of Accounting and Auditing*

The Division of Accounting and Auditing is responsible for carrying out the Chief Financial Officer's constitutional duty to "settle and approve accounts against the state" by monitoring the expenditure of all appropriated public funds. The Division pays all the state's bills, including employees' salaries, payments for goods and services used by state agencies and benefit payments, promotes financial accountability throughout state government by providing information about its fiscal soundness, and investigates allegations of waste, fraud and abuse.

### *Division of Administration*

The Director's Office supervises the bureaus of Personnel Management, General Services, Financial & Support Services, and the Office of Budgeting. It coordinates administrative support to the Department of Financial Services. The Division develops and coordinates all activities related to financial matters. It provides services including mail, printing, purchasing, security, employee safety and emergency evacuation planning, employee recognition, maintenance and renovation, recycling, and parking.

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[1] Section 20.121, F.S.
[2] Section 17.001, F.S.
[3] Section 20.121(3), F.S.
[4] Section 20.121, F.S.

### *Division of Consumer Services*

The Division of Consumer Services helps consumers make informed insurance and financial decisions. Staff assists consumers by answering questions and providing assistance regarding any line of insurance. Online resources and guides help consumers expand their insurance knowledge. Community education programs are offered throughout the state to provide the public information on various insurance and financial topics.

### *Division of Funeral, Cemetery and Consumer Services*

The Division of Funeral, Cemetery and Consumer Services regulates for-profit cemeteries, pre-need funeral sales, funeral establishments and funeral directors and embalmers. It conducts regular audits and inspections to ensure consumers' investments are handled properly.

### *Division of Information Systems*

The Division of Information Systems plans, manages, and operates the information technology resources for the Department of Financial Services, the Office of Financial Regulation, and the Office of Insurance Regulation. These entities rely on the Division's resources and services for their operations.[5]

### *Division of Insurance Agents and Agency Services*

The Division of Insurance Agents and Agency Services is responsible for licensing insurance agents and agencies and investigating alleged violations of the Florida Insurance Code and Administrative Rules.

### *Division of Insurance Fraud*

The Division of Insurance Fraud enforces the criminal laws of Florida in relation to insurance transactions. Investigators are certified law enforcement officers with the authority to bear arms and make arrests. The Division safeguards the public and businesses in Florida against acts of insurance fraud and the resulting impact those crimes have on taxpayers, personally and financially.

### *Division of Legal Services*

The Division of Legal Services provides legal counsel, advice and representation to the regulatory, administrative, and support offices of the Chief Financial Officer and the State Fire Marshal. The Service of Process Section is also an administrative unit within the Division.

### *Division of Rehabilitation and Liquidation*

The Division of Rehabilitation and Liquidation plans, coordinates, and directs the conservation, rehabilitation and liquidation of insolvent insurance companies, unlicensed insurance companies and entities, and rehabilitates financially troubled insurance companies.

[5] IT resources and services are defined by policy to be "information processing hardware/software, communication resources, strategic applications, personnel, contracts with outside information technology consultants, facility resources, information technology maintenance, information technology training, and other related resources."

### *Division of Risk Management*

The Division of Risk Management ensures that participating State of Florida agencies receive quality workers' compensation, liability, federal civil rights, automobile liability, and property insurance coverage at reasonable rates by providing self-insurance, purchase of insurance, claims handling, and technical assistance in managing risk.

### *Division of Worker's Compensation*

The Division of Worker's Compensation actively ensures the self-execution of the workers' compensation system through educating and informing all stakeholders in the system of their rights and responsibilities, compiling and monitoring system data, and holding parties accountable for meeting their obligations.

### *Division of Treasury*

The Division of Treasury operates a cash management system; administers the receipt and disbursement of state moneys; invests excess funds; and, pays all state obligations as directed by the Division of Accounting and Auditing. The Treasury also operates a large collateral management program to protect the financial assets pledged by entities doing business in the state or with the state. It also manages a supplemental retirement program for State and other public sector employees.

### *Division of State Fire Marshall*

The Chief Financial Officer is designated as "State Fire Marshall".[6] The Division of State Fire Marshal has the responsibility for minimizing loss of life and property due to fire in Florida. It includes sworn law enforcement personnel, crime intelligence analysts, and support personnel to assist in detection, apprehension, and prosecution of those who commit arson, insurance fraud, and other related crimes.

## *Relevant Florida Statutes, Administrative Rules, and Federal Laws and Regulations*

**Florida Statutes:**
Chapter 17, F.S.
Chapter 20, F.S.
Chapter 633, F.S.

**Florida Administrative Code:**
Department No. 69, F.A.C.

[6] Section 633.01, F.S.

## *Where can I get additional information?*

### *Florida Department of Financial Services*

200 East Gaines Street
Tallahassee, FL 32399-0319
(850) 413-2863
http://www.myfloridacfo.com

### *Florida House of Representatives*

Economic Affairs Committee
Insurance & Banking Subcommittee
204 House Office Building
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 414-7365
http://www.myfloridahouse.gov