# SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 2060

SPONSOR: Banking and Insurance Committee and Senator Geller

SUBJECT: Department of Insurance

DATE: April 3, 2001 REVISED: _____ _____ _____ _____

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Deffenbaugh | Deffenbaugh | BI | Favorable/CS |
| 2. | | | RC | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

## I. Summary:

This bill authorizes the Department of Insurance to adopt rules and codifies provisions of current rules, based on those rules that have been identified by the department as lacking statutory authority. Certain provisions in the bill address issues that were not in rules previously identified or are not specifically addressed in current rules.

Under the standards enacted by the Legislature in 1999, the Department of Insurance (department) identified 124 rules as lacking the requisite statutory authority. In 2000, the Legislature enacted Chapter 2000-370, L.O.F., codifying the substance of some of these rules and in other instances granting specific statutory authority to adopt certain rules that were in force, in total addressing 62 of the rules identified by the department. The bill:

- Authorizes the department to adopt rules to effectuate market conduct examinations.
- Authorizes the department to adopt rules to effectuate the license application process, including the impact of criminal and law enforcement history.
- Prohibits insurers from unfairly discriminating with respect to premiums charged for motor vehicle insurance, on the basis of type of vehicle, type of the location of the risk, or accidents more than 3 years old.
- Requires that commercial motor vehicle policies that are issued to satisfy mandatory financial responsibility requirements provide first dollar coverage to third-party claimants without a deductible.
- Prohibits members of the boards of the various joint underwriting associations (JUAs) from engaging in specified activities considered a conflict of interest and limits expenses for travel and per diem.
- Requires health insurers to disclose to the insured that he or she has 10 days to return the policy for a full refund.

- Prohibits an insurer or agent from issuing a certificate of insurance that contains terms that differ from those in the policy.
- Requires that any automobile insurance policy that does not provide certain coverages make certain disclosures.
- Requires a title insurance commitment to be issued on all real estate closing transactions when a title insurance policy is to be issued and prohibits a "gap exception" from being deleted on a commitment until the time of closing.
- Requires that when a "single interest" policy is issued in connection with a finance or loan transaction, certain disclosures must be made.
- Clarifies that reimbursement for HMO emergency services are governed by
- s. 641.513(5), F.S.
- Requires HMOs to provide detailed claim experience to a subscriber group, upon request, if the group contract is not renewed due to claim experience.
- Exempts certain property insurance claims from the mandatory mediation provisions.

This bill substantially amends the following sections of the Florida Statutes: 624.3161, 626.171, 626.9541, 627.062, 627.0625, 627.0651, 727.7015, 627.7276, 627.918, 641.31, and 641.3108. The bill creates the following sections of the Florida Statutes: 626.9552, 627.385, s.627.4065, 627.41345, 627.795, and 626.9552.

## II. Present Situation:

**Administrative Procedures Act**

The Administrative Procedures Act (APA), contained in ch. 120, F.S., sets forth the general standards and procedures that all agencies must follow when adopting administrative rules. Agencies do not have inherent rulemaking authority.[1] Shaping public policy through lawmaking is the exclusive power of the Legislature.[2] The Legislature, however, may delegate to agencies the authority to adopt rules that implement, enforce, and interpret a statute.[3]

In 1996, the Legislature adopted changes to the APA that significantly narrowed the standard for rulemaking. In 1996, ss. 120.52(8) and 120.536(1), F.S., provided in relevant part that, "an agency may adopt only rules that implement, interpret, or make specific the *particular powers and duties* granted by the enabling statute." (emphasis added)

When the new provision was challenged, the First District Court of Appeals stated that the test to determine whether a rule is a valid exercise of delegated authority is whether:

> The rule falls within the *range of powers* the Legislature has granted to the agency for the purpose of enforcing or implementing the statutes within its jurisdiction. A rule is a valid

[1] *Grove Isle, Ltd. V. State Dept. or Envtl. Reg.*, 454 So.2d571, 573 (Fla. 1st DCA 1984).
[2] *Jones v. Dept. of Rev.*, 523 So.2d 1211, 1214 (Fla. 1st DCA 1984).
[3] A rule is defined by s. 120.i52(15), F.S., to mean, ". . . each agency statement of general applicability that implements, interprets, or prescribes law or policy or describes the procedure or practice requirements of an agency and includes any form which imposes any requirement or solicits any information not specifically required by statute or by an existing rule. . ."

> exercise of delegated legislative authority if it regulates a matter *directly within the class of powers and duties identified in the statute* to be implemented. [*emphasis added*].

In 1999, the Legislature rejected the First District's "class of powers and duties" test when it enacted 99-379, L.O.F. The APA now provides:

> An agency may adopt only rules that implement or interpret the *specific powers and duties* granted by the enabling statute. No agency shall have authority to adopt a rule only because it is reasonably related to the purpose of the enabling legislation and is not arbitrary and capricious or is within the agency's class of powers and duties, nor shall an agency have the authority to implement statutory provisions setting forth general legislative intent or policy. Statutory language granting rulemaking authority or generally describing the powers and functions of an agency shall be construed to extend no further than implementing or interpreting the specific powers and duties conferred by the same statute. (*emphasis added*).

The Legislature recognized that as a result of this amendment some existing rules might no longer be authorized, and consequently, also provided that agencies could temporarily shield unauthorized rules from rule challenges based on the amendment until July 1, 2001, as provided in s. 120.536(2)(b), F.S. In order to have shielded a rule, agencies were required to have submitted to the Joint Administrative Procedures Committee (JAPC) by October 1, 1999, a list of rules, or portions thereof, adopted prior to June 18, 1999, which exceeded the newly amended rulemaking authority standard.

The statutory directive further provided that the Legislature is required to consider at the 2000 Regular Session whether specific legislation authorizing the shielded rules, or portions thereof, should be enacted. Thereafter, agencies must begin repeal proceedings by January 1, 2001, for shielded rules for which authorizing legislation does not exist. On or after July 1, 2001, the JAPC or any substantially affected person may petition an agency to repeal any rule because it exceeds the rulemaking authority permitted by the new standard.

**Department of Insurance**

Under the standards enacted by the Legislature in 1999, the Department of Insurance (department) identified 124 rules as lacking the requisite statutory authority. In 2000, the Legislature enacted Chapter 2000-370, L.O.F., codifying the substance of some of these rules and in other instances granting specific statutory authority to adopt certain rules that were in force, in total addressing 62 of the rules identified by the department.

The specific areas of current law or rules affected by this bill are discussed in Effect of Proposed Changes, below.

## III. Effect of Proposed Changes:

**Section 1** amends s. 624.3161, F.S., Market conduct examinations.

Present Situation: The department has rules relating to insurer and agent conduct in handling and settling property insurance claims (Rules 4-266.023, 4-166.026, 4-166.027, and 166.028, F.A.C.). These rules include standards for prompt, fair and equitable settlement of claims applicable to all insurers; prohibitions against insurers or agents misrepresenting policy provisions relative to a claim; and additional standards for equitable settlement of claims applicable to homeowners and personal and commercial fires coverages, and for automobile insurance, respectively.

Effect of Section: Rulemaking authority would be created allowing the department to adopt rules necessary to effectuate the market conduct examination process to assure compliance with applicable provisions of the Insurance Code. Such rules may not exceed the authority of the statutes involved in the market conduct examination.

**Section 2** amends s. 626.171, Application for license.

Present Situation: A current department rule (4-211.031, F.A.C.) establishes standards to determine the effect of law enforcement records on applications for licensure by agents, service representatives, adjusters, managing general agents, and reinsurance intermediaries.

Effect of Section: Rulemaking authority would be created allowing the department to enact rules to administer the license application process, including requirements for photo identification, background checks and credit reports, and prelicensing courses. Rulemaking authority would also be granted to determine the impact of an applicant's criminal history check and to determine other information relevant in determining an applicant's fitness and trustworthiness to engage in the business of insurance.

**Section 3** amends s. 626.9541, Unfair methods of competition and unfair or deceptive acts or practices defined.

Present Situation: The department has several rules relating to unfair discrimination in premiums charged for private passenger motor vehicle insurance [Rules 4-175.007 (location of risk), 4-175.008 (accidents more than 3 years old), 4-175.009 (type of vehicle), 4-175.010 (years of driving experience)]. Sections 626.9541 (1)(o), F.S., currently prohibits insurers from unfairly discriminating with respect to premiums charged for motor vehicle insurance, solely on the basis of age, sex, marital status, or scholastic achievement.

Effect of Section: The substance of Rules 4-175.007, 4-175.008, and 4-1.75.010, F.A.C., would be codified in the unfair trade practice section of law, by prohibiting insurers from unfairly discriminating with respect to premiums charged for motor vehicle insurance, solely on the basis of location of the risk or accidents more than 3 years old. (See Section 6, below, for the codification of Rule, 4-175.009, related to type of vehicle.)

**Section 4** creates s. 626.9952, F.S., Single interest contracts.

Present Situation: The department has a rule (4-184.016, F.A.C.) that provides where a "single interest" is written at the expense of the purchaser or borrower, in connection with a finance or loan transaction, a clear and concise statement "should" be furnished advising the purchaser or

borrower that the insurance effected is solely for the interest of the financing entity (finance company, bank and other lending institutions), and that no protection exists for the benefit of the purchaser or borrower. The rule prohibits the insurer from making any effort to recover the amount of any payment from the borrower. The policy must be stamped, "Single Interest Only -- No Subrogation." Such insurance may only be placed after it has been determined that no other kind of insurance can be placed on the risk, except, with the consent of the purchaser or borrower, single interest may be written for inland marine installments sales floater policies. The rule provides additional requirements to notify the purchaser or borrower of the purchase and cost of coverage and a 30-day time period after the notice for the purchaser to obtain acceptable insurance without charge for the single interest coverage.

Effect of Section: The substance of Rule 4-186.011, F.A.C., described above, would be codified in statute. The bill additionally specifies that the section does not apply to title insurance.

**Section 5** amends s. 627.062, F.S., Rate standards.

Present Situation: Section 627.062, F.S., currently requires property and casualty insurers to file rates for approval with the department pursuant to specified procedures and standards. A department rule requires that three copies of a rate filing be included in each rate filing.

Effect of Section: The section would require insurers to file "copies" rather than "a copy" of rates, rating schedules, rating manuals, and changes thereto with the department.

**Section 6** amends s. 627.0625, F.S., Commercial property and casualty risk management plans.

Present Situation: The department has a rule establishing standards for deductibles in commercial motor vehicle liability policies used to satisfy financial responsibility requirements of a state or local government. (Rule 4-175.011, F.A.C.) The rule was aimed at a problem involving liability coverage that was obtained by certain taxicab companies that provided a large deductible for liability coverage. The rule requires that policies provide first dollar coverage by the insurer to third party claimants for losses for which the insured is liable. However, the rule does not prohibit a policy provision that requires the insured to reimburse the insurer for a specified amount of each third party claims paid by the insurer. The rule contains additional requirements related to adjustment of claims under the policies covered by this rule.

Effect of Section: The bill provides that commercial motor vehicle policies that are issued to satisfy mandatory financial responsibility requirements of a state or local government must provide first dollar coverage to third-party claimants without a deductible. With respect to such practices, the bill authorizes the department to adopt rules to assure that claims are administered fairly as required by law.

**Section 7** amends s. 627.0625, F.S., Commercial property and casualty risk management plans.

Present Situation: The department has adopted a rule that prohibits an auto insurer from imposing a surcharge or discount for liability coverages based on the type of vehicle without actuarial justification. [Rule 4-175.009, F.A.C.].

Effect of Section: The substance of Rule 4-175,009, described above, would be codified in statute.

**Section 8** creates s. 627.385, F.S., Conduct of residual market board members.

Present Situation: The department has a rule governing the conduct of the members of the boards of the various joint underwriting associations (JUAs) -- Florida Medical Malpractice JUA, Florida (Auto) JUA, Florida Comprehensive Health Association, Florida Windstorm Underwriting Association, Florida Property and Casualty JUA, and Florida Residential Property and Casualty JUA (Rule 4J-4.002, F.A.C.). The rule prohibits board members from engaging in specified activities considered a conflict of interest, including acting as a servicing carrier or administering entity for the plan, other than a claim adjustment contract open to all members of the plan, or using his or her position to foster any financial gain for him or his company. The rule also limits expenses for travel as set froth in s. 112.061, F.S., for state employees, and subject to approval by the department.

Effect of Section: The substance of Rule 4J-4.002, F.A.C., described above, would be codified in statute. However, the bill also applies to the Florida Workers' Compensation Joint Underwriting Association, which the current rule does not.

**Section 9** creates s. 627.4065, F.S., Insured's right to return policy; notice.

Present Situation: The department has a rule requiring insurers issuing individual health insurance policies in this state to disclose to the insured that he or she has 10 days to return the policy for a full refund (4-154.003, F.A.C.).

Effect of Section: - The substance of Rule 4-154.003, F.A.C., describe above, would be codified in statute.

**Section 10** creates s. 627.41345, F.S., Certificate of insurance.

Present Situation: In 1994 the department issued Information Bulletin 94-014 to all property and casualty insurers that stated that may cities, counties and corporate insureds had modified certificates of insurance to incorporate clauses that differ from the language in the policy. The bulletin stated that certificates of insurance are merely evidence of insurance in lieu of an actual copy of the policy and are to be used to show evidence of insurance, but not to modify the terms of the policy itself. It further stated that no insurer or agent should issue or sign a certificate of insurance that contains terms or conditions that differ from those in the underlying policy. The department has never adopted any rule that incorporated the provisions of this informational bulletin.

Effect of Section: The bill prohibits an insurer or agent from issuing or signing a certificate of insurance that contains terms or conditions that differ from those in the policy under which the certificate is issued. In the event of a conflict, the terms of the policy shall control.

**Section 11** amends s. 627.7015, F.S., Alternative procedure for resolution of disputed property insurance claims.

Present Situation: Section 627.7015, F.S., provides an alternative procedure for the resolution of disputed property claims. This section was enacted during the Special Legislative Session in November 1993, in response to claims arising from Hurricane Andrew, and allowed property claims to be mediated, in certain cases, rather than going through the "potentially expensive and time-consuming adversarial appraisal process prior to litigation." 627.7015(1), F.S. The Department of Insurance promulgated rules establishing the property insurance claims mediation program.

Under Rule 4-166.031, F.A.C., guidelines were set up for resolution of property claims through mediation. The definition of "claim" was revised from the 1993 rule, Rule 4-166.030, to exempt situations where the insurer has a reasonable basis to suspect fraud, or where, based upon agreed facts as to the cause of loss, there is clearly no coverage for the claim. Unless the parties agree to mediate a claim involving a lesser amount, a "claim" involves a request for $500 or more to settle the dispute, or the difference between the positions of the parties is $500 or more, notwithstanding any applicable deductible. Also, in order to qualify as a "claim", a policy must have been in effect at the time of the loss. Disputes from property mediation may be rejected if the dispute does not meet the definition of "claim."

The Joint Administrative Procedures Committee (JAPC) had determined that the department may exclude cases from mediation which involved suspected fraud or cases where there was no coverage, as this Rule 4-166.031 was in effect prior to the changes in the Administrative Procedures Act (APA) in 1996. When the department filed proposed amendments to the rule to exclude cases involving material misrepresentation from mediation, JAPC determined that under the new APA act, the department had no statutory authority to do so. In October 1998, JAPC suggested that the department seek a clear legislative directive in the form of a statutory amendment in order to give the department the authority to create definitions to exempt certain matters from mediation.

Effect of Section: The bill defines the term "claim" for purposes of the mediation program set forth in s. 627.7015, F.S. The section codifies the provisions of the current department rule and exempts the following types of claims from the mandatory mediation provisions: (a) claims for which the insurer has a reasonable basis to suspect fraud; (b) claims for which there is no coverage under the policy, based on agreed-upon facts as to the cause of loss; (c) where the insurer has a reasonable basis to believe that the claimant has intentionally made a material misrepresentation of fact relevant to the claim and the claim ahs been denied on the basis of the material misrepresentation; and (d) if the amount in controversy is less than $500.

**Section 12** amends s. 627.7276, F.S., Notice of limited coverage.

Present Situation: The current statute requires an automobile insurance policy that does not contain coverage for bodily injury and property damage to clearly stamp or print that such coverage is not included and does not comply with any financial responsibility law. The department has rules specifying that any insurance agent, dealer, bank, finance company, other lending institution that arranges for insurance covering a motor vehicle or other personal property must deliver to the retail buyer (applicant for insurance) a receipt or binder and a clear and concise description of such insurance. The rule requires any insurance agent who places a

policy of insurance for property damage to obtain from the insured a signed form acknowledging the requirement that (personal injury protection) security be maintained pursuant to the Florida Motor Vehicle No-Fault Law. Additional disclosures are required by the rules. (Rules 4-184.011 and 4-184.012, F.A.C.).

Effect of Section: The bill revises the statutory notice requirement to apply to any automobile insurance policy that provides coverage only for first-party damage to the vehicle, but does not provide coverage for bodily injury liability, property damage liability, or personal injury protection. The notice is revised to refer to these coverages and to state that the coverage does not comply with any financial liability law or with the Florida Motor Vehicle No-Fault Law.

**Section 13** creates s. 627.795, F.S., Policy exceptions.

Present Situation: The department has a rule requiring a title insurance commitment to be issued on all real estate closing transactions when a title insurance policy is to be issued, except when there are multiple conveyances on the same property. The rule also prohibits a "gap exception" from being deleted on a commitment until the time of closing. (Rule 4-186.011, F.A.C.).

Effect of Section: The substance of Rule 4-186.011, F.A.C., would be codified in statute.

**Section 14** amends s. 627.918, F.S., Reporting formats.

Present Situation: Part XVII of chapter 627, Insurer Reporting, (ss. 627.911-627.919, F.S.) contains requirements for various types of reports that must be submitted by insurers to the department. Currently, the department is authorized by s. 627.918, F.S., to require that the reporting be made on forms established by the department or in a format compatible with its electronic data processing equipment. The department has a rule specifying how insurers are to report information in forms, including a provision authorizing insurers to make filings on computer-generated forms approved by the department (Rule 4-171.002, F.A.C.).

Effect of Section: Statutory authority would be provided allowing the department to adopt by rule standards for approving forms and format.

**Section 15** amends s. 641.31 -- Health maintenance organization contracts.

Present Situation: Florida law requires HMOs to provide coverage for emergency services and care without prior authorization or referral. [ss. 641.31(12), 641.47(7)-(8), and 641.513, F.S.] This requirement encompasses coverage for emergency care and treatment at non-contract hospitals in emergency situations not permitting treatment through the HMO's providers.

When a subscriber is present at a hospital seeking emergency services and care, the determination of whether an emergency medical condition exists must be made by a physician of the hospital or, to the extent permitted by law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The HMO must compensate the provider for screening, evaluation, and examination reasonably calculated to assist the health care provider in making this determination (even if the provider determines that an emergency medical condition does not exist). If the provider determines that an emergency medical

condition does exist, the HMO must also compensate the provider for emergency services and care, which are defined to include the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital.

Section 641.513(5), F.S., provides that an HMO must reimburse a non-contract provider for emergency services and care at the lesser of: (a) the provider's charges; (b) the usual and customary provider charges for similar services in the community where the services were provided; or (c) the charge mutually agreed to by the HMO and the provider within 60 days of submittal of the claim.

Another provision of current law, s. 641.31(12), F.S., provides that an HMO must cover emergency situations not permitting treatment through the HMO's providers, without prior notification, but that a reasonable copayment not to exceed $100 may be charged to the subscriber and not less than 75 percent of the reasonable charges for covered services and supplies must be paid by the HMO, up to benefit limits. The department has interpreted this provision as allowing an HMO to impose up to a $100 copayment, but that the provision requiring the HMO to pay at least 75 percent of the charges is in conflict with, and superseded by, the later enacted provision in s. 641.513, F.S., described above.

Effect of Section: The bill would correct the conflict in current law and codify the department interpretation of current law, by deleting the provision requiring HMOs to pay not less than 75 percent of the reasonable charges for covered emergency services, up to benefit limits. The bill would cross-reference the requirements of s. 641.513(5), which requires that an HMO must reimburse a non-contract provider for emergency services and care at the lesser of: (a) the provider's charges; (b) the usual and customary provider charges for similar services in the community where the services were provided; or (c) the charge mutually agreed to by the HMO and the provider within 60 days of submittal of the claim. The bill would clarify that the HMO may also impose a maximum $100 copayment on the subscriber.

**Section 16** amends s. 641.3108, F.S., Notice of cancellation of contract.

Present Situation: A current rule of the department provides that if a subscriber group HMO contract is not renewed due to claim experience, the subscriber group shall be entitled to receive the loss ratio of the group. If requested by a subscriber group, a detailed claim experience record may be provided at a reasonable expense. The record shall maintain subscriber confidentiality. (Rule 4-191.043, F.A.C.)

Effect of Section: The bill codifies the substance of the current department rule, providing that if a subscriber group contract is not renewed due to claim experience, the group is entitled to receive information concerning its loss ratio. If requested by the group, a detailed claim experience record may be provided at a reasonable expense. The record must maintain subscriber confidentiality.

**Section 17** provides an effective date of upon becoming a law.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill provides that commercial motor vehicle policies that are issued to satisfy mandatory financial responsibility requirements of a state or local government must provide first dollar coverage to third-party claimants without a deductible.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Amendments:

None.