PROPERTY INSURANCE

CS/SB 1108 — Insurance

by Banking & Insurance Committee and Senator Williams

This bill amends and creates various provisions within the Florida Insurance Code, primarily affecting property insurance and creation of the Holocaust Victims Insurance Act. The bill provides:

- Extending the moratorium limiting the number of residential property insurance policies that an insurer may cancel and nonrenew for the purpose of reducing hurricane exposure for a period of 2 years (from June 1, 1999, to June 1, 2001) under ss. 627.7013 and 627.7014, F.S. Since 1993, the Legislature has restricted the ability of insurers to cancel or nonrenew personal lines residential policies (i.e., homeowners, mobile home owners, condominium unit owners, and similar policies) for the purpose of reducing an insurer's potential hurricane losses. The current versions of the moratorium on hurricane-related cancellations and nonrenewals (i.e., one version covers personal lines residential policies, and the other covers condominium association policies) expire on June 1, 1999. (This provision is the substance of CS/SB 2054 by Banking and Insurance Committee and Senator Diaz-Balart.)

- A prohibition on expanding the current geographical boundaries of the Florida Windstorm Underwriting Association (FWUA) pursuant to s. 627.351, F.S. The FWUA is a state-created insurer which provides windstorm (hurricane) coverage in areas within 29 of Florida's 35 coastal counties. Prohibiting further expansion of the FWUA mitigates the growth in the number of policies and exposure insured by the FWUA and reduces the potential for unfunded liability. In 1997, the Legislature passed a law (ch. 97-55, L.O.F.) which temporarily suspended the expansion of areas eligible for windstorm coverage from the FWUA until October 1, 1998. This year's bill provides for an indefinite prohibition on future expansion. (This provision is the substance of SB 232 by Banking and Insurance Committee.)

- The creation of the "Holocaust Victims Insurance Act" under s. 626.9543, F.S., to provide that the potential and actual insurance claims of Holocaust victims and their heirs and beneficiaries be expeditiously identified and properly paid and that such victims and their families receive appropriate assistance in filing and payment of their rightful claims. The bill requires insurers

doing business in this state that receive a claim from a Holocaust victim or their beneficiaries, descendants, or heirs to investigate the claim, allow the claimant to meet a reasonable standard of proof as established by the Department of Insurance, and permit claims, regardless of any statute of limitations imposed either by statute or contract, under the policy. Claimants would have until 10 years after the effective date of the bill to submit their claims. (This provision is the substance of SB 2540 by Senator Geller and others.)

The bill would impose an affirmative duty upon insurance companies to ascertain and report to the department, within 90 days of the effective date of the bill and on an annual basis, any legal relationship it might have with an international insurer that issued a policy to a Holocaust victim between 1920 and 1945, as well as the number and total value of such policies, attempts made to locate beneficiaries of such policies, any claims filed by such victims, beneficiary, heir, or descendent which was paid, denied, or is pending and an explanation of such denial or pending claim. The department in turn would annually report to the Legislature certain prescribed information relating to the above. Furthermore, the department would be required to establish a toll-free number to assist Holocaust victims or their beneficiaries, descendants, or heirs in filing claims for life, property, and education insurance policies.

Insurers or persons who violate provisions contained in the bill are subject to a $1,000 per day administrative penalty. Additionally, a private cause of action to recover damages caused by a violation of the provisions of the act is authorized and persons who sustain damages shall recover three times the actual damages sustained as well as costs up to $50,000, plus attorneys' fees.

- The exemption of commercial inland marine insurance policies from rate and form approval by the Department of Insurance under ss. 627.021, 627.0651, and 627.410, F.S. Commercial inland marine insurance covers property of a business that is portable or movable in nature or an instrumentality of transportation or communication. Examples of commercial inland marine risks are cellular towers, bridges, commercial goods in transit, and tunnels.

- The revision of the composition of the Board of Governors of the Workers' Compensation Joint Underwriting Association (JUA) pursuant to s. 27.311, F.S. The composition shall include representatives of five of the 20 domestic insurers and five of the 20 foreign insurers, with the largest voluntary direct premiums written in this state for workers' compensation and employer's liability insurance, which shall be elected, respectively, by the 20 domestic and 20 foreign insurers, eliminating the requirement that a certain number be representative of assessable mutual insurers, commercial self-insurance funds, and group self-insurance funds. The term "domestic insurer," as defined in s. 624.06(1), F.S., means an insurer formed under

the laws of this state, which includes authorized insurers, assessable mutual insurers, commercial self-insurance funds, and group self-insurance funds, formed under Florida law. One person, appointed by the Insurance Commissioner would serve as the chair, and the bill maintains board membership for the Insurance Consumer Advocate and one representative of the largest property and casualty insurance agents' association in the state. The bill allows members of the board to serve consecutive terms. Additionally, the bill prohibits insurers in the voluntary market from providing workers' compensation insurance and employer liability insurance to persons who are delinquent in their payment of premiums to the JUA.

- Exemption of payroll deduction plans or automatic electronic funds transfer payment plans from the requirement under the private passenger motor vehicle insurance provision that policies may be initially issued only if the insurer has collected from the insured an amount equal to 2 months premium under s. 627.7295, F.S.

If approved by the Governor, these provisions take effect July 1, 1998.
Vote: Senate 36-0; House 113-0

HB 3597 — Family Day Care Homes/Insurance

by Financial Services Committee, Rep. Safley and others (CS/SB 226 by Banking & Insurance Committee)

This bill (Chapter 98-6) creates s. 627.70161, F.S., to prohibit insurance carriers from denying, canceling, or nonrenewing residential property insurance policies solely on the basis that a family day care home is operated on the property, except in limited circumstances. Insurers would be able to deny, cancel, or nonrenew policies if the homeowner provided day care for more children than allowed by law, if the homeowner failed to maintain separate liability coverage for the day care activities, if the homeowner failed to comply with the applicable licensing and registration laws, or if certain wilful or grossly negligent acts or violations of law or rule were discovered.

The bill also provides that a residential property insurance policy must exclude coverage for claims arising out of the operation of a family day care home, unless such liability coverage was specifically provided in the policy or in a rider or endorsement attached to the policy.

These provisions were approved by the Governor and take effect October 1, 1998.
Vote: Senate 31-0; House 117-0

WORKERS' COMPENSATION

CS/CS/SB 1406 — Workers' Compensation Compliance and Fraud

by Ways & Means Committee; Banking & Insurance Committee; and Senator Clary

During the past several years various groups have reviewed the issues of workers' compensation compliance and fraud. Both the Workers' Compensation Oversight Board and the Fourteenth Statewide Grand Jury issued reports suggesting ways to strengthen the compliance and enforcement provisions of the workers' compensation law and various constituent groups, including insurers, employer and employee representatives, trade associations, and governmental entities, have also focused on these issues.

This bill amends ch. 440, F.S., to incorporate many of the recommendations offered by these interested parties to provide:

- For the Division of Workers' Compensation, Department of Labor and Employment Security, to enter any place of business and inspect records to ascertain employer compliance with the workers' compensation coverage requirements under ch. 440, F.S. Employers are required to keep true and accurate records, to maintain such records within this state and make them available for review by the division. The enforcement powers of the division are broadened to include subpoena authority to compel the attendance of witnesses and production of records. (CS/SB 1408 by Banking and Insurance Committee and Senator Clary, which also passed, provides a public records exemption specifically related to this provision.)

- For the Division of Workers' Compensation to disapprove or revoke the certificate of exemption of a sole proprietor, partner or corporate officer if such exemption is based on invalid information. The bill provides that sole proprietors, partners, and corporate officers in the construction industry who file notices of election to be exempt from workers' compensation coverage requirements must file such notices every 2 years. The fee for filing a notice is a mandatory $50 fee. Persons not involved in the construction industry who file notices of election to be exempt and persons filing notices to be included for workers' compensation coverage are not affected by the fee provisions of this bill. Certain documentation is required to be submitted with the exemption notice to the division by the person seeking the exemption and the bill provides that knowingly making false statements on an exemption notice is a third-degree felony and mandates a warning on every exemption notice to this effect.

- That an independent contractor who provides the general contractor with both an affidavit stating that he/she meets the requirements of an independent contractor and a certificate of exemption is not an employee and may not recover benefits under this chapter. It also clarifies

that the certificate of exemption for an independent contractor must be as a sole proprietor, corporate officer, or partner. The bill specifies that for purposes of determining the appropriate premium for workers' compensation coverage, that carriers may not consider any person who meets the requirements of these provisions to be an employee.

- For an increase in liquidated damages awarded to a prevailing plaintiff who loses a bid on a construction contract to a person who knew or should have known that he/she violated certain workers' compensation requirements. The words "minimum premium policy" or the equivalent thereof must be placed on insurance policies.

- That the Division of Workers' Compensation must notify the workers' compensation carrier identified in the request for exemption when the division revokes the exemption. The bill mandates the division to notify a certificate holder with notice of the expiration date of his/her exemption and an application for renewal of the exemption within 60 days prior to the expiration date of a construction industry certificate of exemption.

- For the revision of penalties for various offenses relating to workers' compensation fraud depending on the value of the money or property involved in the offense. If the amount is less than $20,000, the current third-degree felony penalties would apply. If the amount is $20,000 or more, but less than $100,000, the offense would be a second-degree felony. If the amount is $100,000 or more, the offense would be a first-degree felony. The statute of limitations provision, currently 3 years, is lengthened to 5 years.

- That a judge of compensation claims and an administrative law judge may deny workers' compensation benefits if the employee has intentionally committee fraud.

- For the expiration of the term of office for members of the Statewide Nominating Commission which nominates persons to the Governor for appointment as Judges of Compensation Claims, as well as staggered terms for new appointments. The bill bifurcates the nomination process of judges by requiring that the nominating commission first determine if a current judge's performance is satisfactory, then, if the Governor does not reappoint the judge, the commission would submit a list of three nominees. The bill also revises the term of office, qualifications, and method of nomination for the Chief Judge of the Office of the Judge of Compensation Claims.

- That insurance carriers, as a condition to issuance of a policy, may require the employer to release certain employment and wage information maintained by the Division of Unemployment Compensation. This will allow insurance carriers to compare the employment information provided by the employer with the data provided to the Unemployment Compensation Division.

- That the Division of Workers' Compensation and the Division of Fraud prepare and submit a "joint performance report" as to the results obtained in achieving compliance with workers' compensation coverage requirements and reducing the incidence of fraud to the Senate President and House Speaker by November 1 of each year for the next 2 years, and then every 3 years.

- An appropriation of $1.1 million from the Workers' Compensation Administration Trust Fund and 15 FTE's to the Department of Labor and Employment Security to carry out the provisions of the act.

If approved by the Governor, these provisions take effect January 1, 1999, except as otherwise provided.
Vote: Senate 40-0; House 118-0

SB 1972 — Workers' Compensation/Employee's Injury

by Senator Lee

This bill amends s. 440.09, F.S., to revise the standard for rebutting a presumption that an employee's injury was caused by intoxication or influence of drugs. It provides that if the employer has implemented a drug-free workplace, the presumption may be rebutted only by evidence that there is no reasonable hypothesis that the intoxication or drug influence contributed to the injury. This revision is in response to the Florida Supreme Court opinion in *Recchi America v. Hall*, 692 So.2d 153 (Fla. 1997) which reviewed the standard for rebutting a presumption as it related to a drug-free workplace and struck down the provision stating that it created an irrebuttable presumption which constituted a violation of an employee's constitutional right to due process.

The workers' compensation drug-free workplace provisions under ch. 440, F.S., were designed to accomplish the twin goals of discouraging drug abuse and maximizing a business's productivity by eliminating the costs and delays associated with work-related accidents resulting from drug abuse by employees.

The current (former) provisions as to drug-free workplaces state that if an employee is injured and is tested positive for drugs or alcohol, it is *presumed that the injury was occasioned primarily* by the drugs or alcohol, resulting in no workers' compensation benefits being paid. In a work-place which does not have a drug-free policy, the current law remains unchanged, providing that the presumption may be rebutted by *clear and convincing evidence* that the drugs or alcohol did *not* contribute to the injury.

If approved by the Governor, these provisions take effect July 1, 1998.
Vote: Senate 37-0; House 111-0

HEALTH INSURANCE

CS/SB 1584 — HMO Claims

by Banking & Insurance Committee and Senators Campbell, Forman and Silver

This bill creates s. 641.3155, F.S., and requires a health maintenance organization (HMO) to reimburse all claims or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO within 35 days after receipt of the claim by the HMO, unless the HMO contests or denies the claim. If the claim or a portion of a claim is contested by the HMO, the HMO is required to formally notify the contract provider within 35 days after receipt of the claim. Such notification must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Upon receipt of the additional information requested from the contract provider, the HMO must pay or deny the contested claim or portion of the contested claim within 45 days after receipt of the information.

In any event, an insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

If approved by the Governor, these provisions take effect October 1, 1998.
Vote: Senate 39-0; House 117-0

CS/CS/SB 1800 — Health Insurance

by Health Care Committee; Banking & Insurance Committee; and Senator Diaz-Balart

The committee substitute makes various changes to health insurance and HMO coverage requirements, as follows:

Persons Eligible for Guaranteed Availability of Individual Coverage

The bill expands eligibility for guaranteed availability of individual coverage to include persons with 18 months of prior coverage under an individual plan, if the prior insurance coverage is

terminated due to the insurer or health maintenance organization (HMO) becoming insolvent or discontinuing all policies in the state, or due to the individual no longer living in the service area of the insurer or HMO. (This is in addition to persons with 18 months of prior coverage, the most recent of which was under a group plan.)

The prior law provided that an individual is not eligible for guaranteed availability of individual coverage if the individual is eligible for a conversion policy under Florida law (since the conversion policy serves as the alternative mechanism for providing individual coverage). The bill provides that this alternative mechanism applies to an individual who is eligible for a conversion policy or contract offered to an individual who is no longer eligible for coverage under either an insured or self-insured plan. However, the conversion policy must be issued by an authorized Florida insurer or HMO and must conform to the requirements of s. 627.6675, F.S., (for group insurers) or s. 641.3921, F.S., (for HMOs), which requires the insurer or HMO to offer the standard benefit plan that must be offered to small employers and limits premiums for the conversion policy to 200 percent of the standard risk rate, as determined by the department.

Solvency Requirements for Health Maintenance Organizations (HMOs)

The bill increases the minimum surplus requirements for both new and existing HMOs. Under prior law, in order to obtain a certificate of authority as an HMO, an applicant was required to have a minimum surplus equal to the greater of: (a) $1.5 million, (b) 10 percent of total projected liabilities, or (c) $500,000 plus all startup losses projected to be incurred for 12 months. The bill increases the minimum requirement for certificates issued after October 1, 1998, to be the greater of: (a) 10 percent of total projected liabilities, (b) 2 percent of total projected premiums, or (c) $1.5 million plus all startup losses projected to be incurred for 12 months.

After an HMO obtains a certificate of authority, the prior law required the HMO to maintain a minimum surplus equal to $500,000 or 10 percent of total liabilities, whichever is greater. For HMOs obtaining a certificate of authority on or after October 1, 1998, the bill increases the minimum surplus requirement to the greater of $1.5 million, 10 percent of total liabilities, or 2 percent of total annualized premium. For HMOs that already have a certificate of authority as of October 1, 1998, the bill requires a scheduled increase in the minimum surplus requirement, as follows: by September 30, 1998, $800,000, 10 percent of liabilities, or 1 percent of annualized premium, whichever is greatest; by September 30, 1999, $1.15 million, 10 percent of liabilities, or 1.25 percent of annualized premium, whichever is greatest; and by September 30, 2000, the full requirement of $1.5 million, 10 percent of total liabilities, or 2 percent of annualized premium, whichever is greatest.

The bill amends s. 641.285, F.S., to increase the minimum deposit of cash or securities that HMOs must file with the Department of Insurance, from $100,000 or twice the HMO's estimated average monthly uncovered expenditures, whichever is greater, to a flat $300,000 deposit requirement. The bill eliminates all of the various exceptions to the deposit requirement that previously applied and authorizes the department to require additional deposits ranging from $100,000 to a maximum of $2 million, under certain conditions.

The bill amends s. 641.26, F.S., relating to annual reports that must be filed by HMOs. The bill requires that the annual audited financial statements filed by a certified public accountant (CPA) must include any material weaknesses in the HMO's internal control structure as noted by the CPA and a description of remedial actions taken by the HMO. The required annual filing of a certification by an actuary as to the actuarial soundness of the HMO. The bill authorizes the department to require updates of the annual actuarial certification of the HMO's actuarial soundness under certain conditions. The bill further authorizes the department to require an HMO, upon written request, to furnish such additional information as to its material transactions which, in the department's opinion, may have a material adverse effect on the HMO's financial condition.

Establishment of Standard Risk Rate

The bill requires the Department of Insurance, rather than the Florida Comprehensive Health Association (FCHA), to annually establish the standard risk premium which serves as the benchmark for establishing maximum premiums for the FCHA and for individual conversion policies that must be offered by group insurers and HMOs.

Notice of Conversion Policy Options

The bill requires insurers and HMOs to mail to individuals who are eligible for a conversion policy or contract, an election and premium notice form, including an outline of coverage, within 14 days of request or notice to the insurer that an individual is considering applying for a conversion policy.

Required Bonds for Fiscal Intermediary Organizations

The bill amends s. 641.316, F.S., to replace the $10 million fidelity bond requirement for all persons or entities engaged in the business of providing fiduciary or fiscal intermediary services to any contracted health care provider or provider panel. The bill deletes the $10 million fidelity bond requirement and replaces it with two separate, but lower, bond requirements. The fiscal intermediary service organization is required to obtain a fidelity bond in the minimum amount of 10 percent of the funds handled by the intermediary in connection with its fiscal services during the prior year, or $1 million, whichever is less, subject to a minimum bond amount of $50,000.

This fidelity bond must protect the intermediary from loss caused by the dishonesty of its employees. The organization is also required to maintain a surety bond on file with the department, with a penal sum of not less than 5 percent of the funds handled by the intermediary in connection with its fiscal services during the prior year, or $250,000, whichever is less, subject to a minimum bond amount of $10,000. The condition of the bond must be that the intermediary register with the department and not misappropriate funds within its control or custody.

Other Provisions

The bill makes the following additional changes: (1) conforming Florida law to the federal Mental Health Parity Act of 1996, thereby authorizing the Florida Department of Insurance to enforce such provisions under state law, which requires that lifetime and annual dollar limitations on mental health benefits (if provided) under group policies be the same as for other medical and surgical benefits under the policy, subject to certain exemptions; (2) providing that moneys paid into a Roth individual retirement account (IRA) or Medical Savings Account are protected from creditors; (3) revising minimum standards for Medicare supplement policies, to conform to federal law; (4) excluding supplemental plans provided under a separate policy or contract, designed to fill gaps in the underlying health plan, from the definition of "health benefit plan" as used in s. 627.6699, F.S., thereby exempting such plans from the guaranty-issue and modified community rating requirements of that section; (5) revising the requirements for an HMO to provide a 12-month extension of benefits for persons who are totally disabled, to apply the requirement to any termination of an HMO contract, including termination by a group contract holder, but limiting such requirement to group HMO contracts; (6) exempting disability income and accidental death policies from certain prohibited rating practices that apply to health insurance policies; (7) clarifying that in those situations where an insurer or HMO is discontinuing offering a particular policy form or is discontinuing all coverage in the state for a particular market, that the notice requirements must be provided to policyholders prior to *nonrenewal*, thereby eliminating a possible interpretation that an insurer may cancel policies mid-term, with appropriate notice; and (8) providing that if notice is given to an insurer or HMO by an insured within 60 days of the birth of a child (or placement, in the case of an adopted child), the insurer or HMO may not deny coverage of the child due to failure to timely notify the insurer (i.e., within 30 days).

If approved by the Governor, these provisions take effect January 1, 1999.
Vote: Senate 37-0; House 114-0

AUTO INSURANCE

HB 3889 — Motor Vehicle Insurance

by Financial Services Committee, Rep. Safley and others (CS/SB 2052 by Banking & Insurance Committee and Senator Diaz-Balart)

This bill amends provisions in the Florida Motor Vehicle No-Fault Law, primarily affecting personal injury protection (PIP) benefits. In general, every owner or registrant of a four-wheeled motor vehicle is required to maintain $10,000 of PIP insurance, also known as no-fault insurance. Subject to copayments and other restrictions, PIP insurance provides compensation for injuries to the insured driver and passengers regardless of who is at fault in an accident. In particular, this legislation:

- Allows an insurance agent to charge an applicant a fee to cover the agent's actual costs of obtaining motor vehicle records, to the extent that those costs are not otherwise compensated pursuant to s. 627.7295, F.S. Defines the term "actual costs" to be the cost of obtaining the report or the pro rata cost per driver when the report is obtained on more than one driver.

- Requires health care providers to submit medical bills directly to the insurer within 30 days of treatment or service under s. 627.736, F.S. Alternatively, if the provider furnishes the insurer with 21 days notice of initiation of treatment, the provider may submit medical bills within 60 days of the service date. Neither the insurer nor the injured person is required to pay medical bills untimely submitted and any agreement to the contrary is unenforceable. The bill provides for an exception for medical services billed by a hospital for services rendered at a hospital-owned facility, for emergency services rendered by a hospital emergency department, or for the transport and treatment rendered by an ambulance provider.

- Specifies a method to determine who is the "prevailing party" entitled to attorneys fees and costs when a dispute between an insurer and a medical provider is arbitrated. Requires that the amount of the offer or claim at arbitration is the amount of the last written offer made up to 30 days before arbitration. Issues to be considered are to be submitted up to 30 days prior to arbitration.

- Provides that all statements and bills for medical services are to be submitted to the insurer on specified forms with specified procedural codes.

- Extends the time period within which payment is due for a claim for PIP insurance benefits under circumstances when an insurer makes a discovery request to a provider.

- Provides that an insurer's independent medical examination may be conducted within the municipality where the injured person is being treated, within the municipality where the injured person resides, or within 10 miles of the injured person's home, provided the location is within the insured's county of residence.

If approved by the Governor, these provisions take effect on October 1, 1998, except as otherwise provided.
Vote: Senate 30-1; House 116-0

BANKING

HB 4501 — Credit Unions/Conversions

by Financial Services Committee, Rep. Safley and others (CS/SB 2300 by Banking & Insurance Committee and Senator Laurent)

The bill provides that the Department of Banking and Finance may not approve an application by a federally-chartered credit union for conversion to a state charter unless a completed application for conversion is on file with the department on February 25, 1998. The prohibition on conversion will terminate on July 1, 1999, unless the Comptroller determines before such date by an order of general application that it is in the public interest to accept and approve such conversion applications and identifies a procedure for the acceptance and processing of such conversion applications. The Comptroller will consider certain specified factors and such other factors deemed relevant to the maintenance of a fair and competitive financial system in this state in making such a determination.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 39-0; House 115-0

OTHER

CS/SB 1372 — Insurance

by Banking & Insurance Committee and Senators Williams and Grant

This bill contains various insurance law changes, some of which were the substance of other bills, as noted below. The bill makes the following changes:

Insurance Agents and Related Provisions

The bill makes various changes to the laws affecting insurance agents and other individuals licensed by the Department of Insurance. In particular, the bill: (1) conforms various provisions to the requirement that agents be appointed (rather than licensed) by each insurer that they represent; (2) applies various requirements that currently apply to agents to customer representatives; (3) increases maximum administrative fines from $2,500 to $3,500 for agents and other licensees for each willful violation, specifies that fines may be in addition to probation or suspension, and authorizes the department to require an agent to make restitution to an injured party in addition to other penalties; (4) authorizes individuals holding a limited license for credit insurance to hold certain additional licenses; (5) requires life agents to pass an examination relating to variable annuity contracts in order to sell such contracts; (6) eliminates references to "claims investigators" which is a licensure classification no longer provided; (7) authorizes nonresidents to be licensed as a customer representative under certain conditions; (8) requires individuals holding a Florida nonresident agent's license to become licensed as a resident agent with 90 days after the individual becomes a resident of Florida; (9) expands the options for applicants for a title insurance agent's license to meet prior education or experience requirements; (10) applies certain requirements for individual title insurance agents to title insurance agencies; (11) specifies the purpose of the deposit or bond for title agents; (12) requires law enforcement agencies and the state attorney's office to notify the department of any insurance agent or other licensee who has been found guilty of a felony; (13) increases the required surety bond for surplus lines agents from $5,000 to $50,000; (14) specifies conditions under which a surplus lines agent may delegate to a producing agent the requirement to provide documentation of coverage to an insured; (15) requires insurance agencies to notify the department of a re-designation of the primary agent; (16) provides for the licensure of non-resident public adjuster and non-resident independent adjusters; (17) provides for responsibility and accountability of sales representatives of warranty associations; and (18) repeals obsolete statutes relating to the licensing of claims investigators and insurance vending machine licenses.

Workers' Compensation for Employee Leasing Firms

The bill includes provisions originally contained in SB 1946 by Senator Williams, which requires employers and employee leasing companies to obtain workers' compensation coverage for leased employees and pay premiums commensurate with the exposure and claims experience of the employer. The bill requires employee leasing companies to provide certain information to the insurer or the residual market when obtaining workers' compensation coverage. Insurers are required to conduct annual audits of payroll and classifications of employee leasing companies and may conduct more frequent audits. The bill: (1) defines the terms, employee leasing, experience rating modification, leased employee, lessee, lessor, and premium subject to dispute;

(2) authorizes an employee leasing company/lessor to obtain coverage in the voluntary market on leased employees through a workers' compensation policy issued to the lessor; (3) authorizes the insurer of the lessor to request specific information from the lessor to ascertain the exposure under the policy and to collect the appropriate premium; (4) requires the lessor that applies for coverage or is covered through the voluntary market to furnish certain information to the insurer, on an annual basis, to permit the calculation of an experience modification for each lessee upon termination of the leasing arrangement; (5) requires the information accrued during the term of a leasing arrangement which is used to calculate the experience modification rating for a lessee upon the termination of the arrangement to be used in the future experience ratings of the employee leasing company; (6) provides for the cancellation or nonrenewal of an employee leasing company's policy if there is an uncured violation of this section; (7) requires the insurer to assign an experience modification factor to a lessee/employer after a leasing arrangement is terminated, including the experience incurred for any leased employees during the leasing arrangement; (8) requires the employee leasing company to notify its insurer within 5 working days following actual termination of the leasing arrangement; (9) provides that this section does not affect the requirement that a lessee provide workers' compensation coverage for a non-leased employee; (10) provides that an employer shall not enter into an employee leasing relationship or be eligible for workers' compensation coverage in the voluntary market, if the employer owes its current or previous insurer any premium or if the lessee owes any amounts under a current or previous employee leasing arrangement; and (11) requires an insurer to conduct annual audits of payroll and classifications of employee leasing companies.

Privatization of the Special Disability Trust Fund

The bill provides a mechanism to create a financing corporation for the purpose of transferring and privatizing the liabilities of the Workers' Compensation Special Disability Trust Fund to a qualified entity. This financing mechanism would be used if the Special Disability Trust Fund Commission determined that the state could realize savings by privatizing the responsibilities and liabilities of the fund. The bill would create a Special Disability Trust Fund Privatization Commission comprised of the following officials or their designees: Governor, Insurance Commissioner, and the Comptroller that would be charged with the responsibility of evaluating the feasibility of privatizing the fund as well as selecting and contracting with an administrator to review, allow, deny, compromise, controvert, and litigate claims, if it is determined to be more cost efficient than the current administration of the fund. The commission may adopt rules necessary for the performance of its assigned duties and responsibilities. If the fund is privatized, a financing corporation would be created to issue the debt in order to use the proceeds to privatize the fund. The corporation (but not the commission) is exempt from the provisions of ch. 287, F.S., relating to procurement of goods and services. The corporation, under the control of a three-member board comprised of the following officials or their designees: Governor, Treasurer, and

Comptroller, is authorized to issue notes, bonds, and other forms of indebtedness and has all of the powers of a corporation authorized by law.

Florida Hurricane Catastrophe Fund

The bill provides that the board of the Florida Hurricane Catastrophe Fund may reimburse a limited apportionment company in advance if the board determines that the fund's assets are sufficiently liquid to permit an advance. A limited apportionment company is defined as an insurer having a surplus of $20 million or less and writing 25 percent or more of its premiums in Florida. The Florida Hurricane Catastrophe Fund (Cat Fund) normally reimburses insurers after the end of the calendar year when an accounting is made of all claims for that year. However, the law previously provided that the Cat Fund may reimburse a limited apportionment company (same definition) the lesser of 90 percent of the board's estimate of the reimbursement due, or 90 percent of the company's share of the total fund premiums applied to the fund's currently available liquid assets, if the company demonstrates immediate receipt is essential to permit it to pay claims and the board determines that the fund's assets are sufficiently liquid to permit an advance.

Premium Tax and Assessment Exemption for Minority-Owned Insurers

The bill provides a 5-year exemption from premium taxation and regular assessments from the Residential Property and Casualty Joint Underwriting Association and the Florida Windstorm Underwriting Association for residential property insurance policies issued by a minority-owned insurer that obtains its certificate of authority after May 1, 1998. The bill requires that the insurer write at least 10 percent of its policies in enterprise zones designated pursuant to s. 290.0065, F.S.

Reinsurance

The bill revises s. 624.610, F.S., which specifies the types of reinsurance for which an insurer may obtain credit under its financial statements. Currently, three of the types of approved or permissible reinsurance arrangement require the establishment of a trust fund that meets certain requirements: a group of individual alien insurers which maintains at least $50 million in trust, such as Lloyds of London (fund for a specific contract (s. 624.610(2)(b)2., F.S.); and an individual reinsurer that maintains a trust fund covering its U.S. obligations plus a $20 million surplus, such as Zurich Re or CNA Re (s. 624.610(2)(b)4., F.S.). The current law applies additional trust fund requirements to the last two of these three types of reinsurance, including a requirement that the assets of the trust be distributed in accordance with the insurance laws of the state in which the trust is domiciled and requiring the reinsurer to waive any right otherwise available to it under U.S. (bankruptcy) law. The bill changes the cross-reference to the types of reinsurance trust fund arrangements that must meet these additional conditions. By doing so, the amendment applies

these additional requirements to the type of reinsurance provided by a group of alien insurers with $50 million in trust (Lloyds), but deletes the requirements for reinsurance obtained from an individual reinsurer that maintains a trust fund covering its U.S. obligations. (It appears that this deletion is an inadvertent error.) The bill also repeals s. 624.22, F.S., related to the purpose of ch. 624, F.S., which provides legislative intent to ensure adequate regulation of reinsurers, to require adequate security to fund U.S. obligations of a non-U.S. reinsurer, and that the assets be distributed in accordance with the insurance laws of the state in which the trust is domiciled. This language is transferred to the reinsurance statute, s. 624.610, F.S.

Financial Requirements for Surplus Lines Insurers

The bill includes provisions originally contained in SB 1316 by Senator Holzendorf which provides that only those surplus lines insurers that have an application on file with the Department of Insurance before February 28, 1998, may elect to be subject to the lower, alternative surplus requirements previously authorized by 1997 legislation. The 1997 legislation authorized surplus lines insurers meeting certain criteria to have and maintain a $4 million surplus, rather than be subject to the general requirement of having a $15 million surplus or, for insurers licensed on or before December 31, 1993, a $4.5 million surplus at the end of 1997 and specified annual increases reaching $15 million at the end of 2004. The 1997 act applied only to those surplus lines insurers that (1) are a member of an insurance holding company that also owns a Florida domestic insurer and (2) are in compliance with the requirements of ch. 625, F.S., relating to accounting and investment restrictions of authorized insurers. The department reports that one surplus lines insurer has filed an application for election of the lower surplus requirements by the date specified in the bill, February 28, 1998.

Health Insurance Sold to Foreigners in Airports

The bill includes the provisions originally contained in SB 1416 by Senator Gutman (which also passed) which provides that health insurance policies delivered or issued for delivery in Florida to residents of foreign countries would not be subject to regulation by the Department of Insurance as to policy terms or premiums.

Other Provisions

The bill includes the provisions of CS/SB 994 by Banking and Insurance Committee and Senator Grant, which: (1) deletes the requirement that the Department of Insurance promulgate rules to establish criteria for determining if an insurer has demonstrated sufficient compliance with the various provisions of the Insurance Code; (2) allows insurers to provide motor vehicle policyholders credit for prepaid premiums that they may otherwise lose under certain

circumstances; (3) removes the countersignature requirement by the agent of record when an insurance policy is transferred from one company in an insurance company group to another company in the same group; (4) provides that the Department of Insurance may, rather than shall, annually conduct a sampling of claims or actions for damages as to personal injury or property damage reports which are maintained by liability insurers; and (5) provides that the Department of Insurance may, rather than shall, annually require that an insurer report certain information relating to product liability insurance.

If approved by the Governor, these provisions take effect October 1, 1998.
Vote: Senate 36-0; House 117-0

CS/HB 1575 — Certified Capital Companies

by Financial Services Committee, Rep. Feeney and others (CS/CS/SB 1512 by Ways & Means Committee; Banking & Insurance Committee; and Senators Latvala and Forman)

Venture capital is typically the major source of funding for start-up companies. In recent years, there have been concerns regarding the availability of venture capital for such companies in Florida. This bill establishes a mechanism to provide financing, via certified capital companies, for qualified small businesses. Insurance companies are provided a premium tax credit to invest in certified capital companies which, in turn, will make investments in qualified small businesses.

A corporation, partnership, or limited liability company may file for certification as a certified capital company (CAPCO) under the bill on or before December 1, 1998. CAPCOs certified by the Department of Banking and Finance may receive contributions of capital from insurers (and other investors), and the insurers receive a credit against state premium taxes for each dollar contributed to a certified capital company, at the rate of 10 percent a year for 10 years, beginning with premium tax filings for the year 2000. The total amount of tax credits may not exceed $15 million annually, subject to an aggregate cap of $150 million. To be certified, a CAPCO must have net capital of at least $500,000 and at least two of its principals must demonstrate 5 years experience in making venture capital investments.

To remain certified, CAPCOs are required to meet investment benchmarks. At least 50 percent of CAPCO funds must be invested in "qualified businesses" by December 31, 2003, defined as small businesses (determined by rules of the U.S. Small Business Administration) headquartered in Florida and with their principal business operations in Florida. A qualified business must certify that it is unable to obtain conventional financing and that it has fewer than 200 employees, at least 75 percent of whom are employed in Florida. At least 50 percent of the CAPCO's investments in qualified businesses must be in "early stage technology businesses" involved in activities related to developing initial product or service offerings. A qualified business does not include a business

predominantly engaged in retail sales, real estate development, insurance, banking, lending, oil and gas exploration or engaged in professional services provided by accountants, lawyers, or physicians.

Before a CAPCO may make any distribution to its equity holders, other than a "qualified distribution," the CAPCO must have invested 100 percent of its certified capital in qualified investments. A "qualified distribution" of up to 2.5 percent of the CAPCO's capital may be made to equity holders for the costs and expenses of forming, managing, and operating the company, plus reasonable and necessary fees for professional services, such as legal and accounting services. Payments of principal and interest to debt holders may be made without restriction.

A CAPCO is required to pay to the Department of Revenue 10 percent of the portion of distributions to all certified investors (insurers) and equity holders that exceeds the sum of the CAPCO's original certified capital (which includes both equity and debt investments) and any additional capital contributions to the CAPCO.

The Office of Tourism, Trade, and Economic Development is responsible for allocating premium tax credits to insurers who apply and submit specified documentation. A CAPCO must annually file a report with the Office and the Department of Banking and Finance detailing the investments the CAPCO has received from insurers and the investments it has made in qualified businesses, including the number of jobs created or retained and the average wages of such jobs. The Department of Banking and Finance must conduct an annual review of each CAPCO to determine if it is abiding by the requirements of certification and the Department of Revenue may audit and examine the records of CAPCOs and insurer investors.

If approved by the Governor, these provisions take effect upon becoming law, except as otherwise provided.
Vote: Senate 39-0; House 118-1