HEALTH INSURANCE

CS/CS/SB 2534 — Health Insurance

by Health and Human Services Appropriations Committee; Banking and Insurance Committee; and Senators Peaden and Gaetz

The bill provides for two significant new programs designed to provide more affordable access to coverage for health care, primarily for individuals who are uninsured and small employers.

Cover Florida Health Access Program

Creates the "Cover Florida Health Access Program Act," which is designed to provide affordable health care options for uninsured residents. The program will allow insurers, HMOs, health-care-sponsored-organizations, or health care districts to offer consumers a choice of benefit plans at affordable prices. A Cover Florida plan entity must provide non-catastrophic coverage and may provide catastrophic coverage, supplemental insurance, and discount medical plan product options to enrollees.

Enrollment Eligibility Requirements:

- Resident of Florida;
- Ages 19 to 64;
- Not covered by private insurance or eligible for public insurance; and
- Uninsured for at least the prior 6 months, with exceptions for persons who lost coverage within the past 6 months under certain conditions.

Administration of the Cover Florida Health Access Program:
The Agency for Health Care Administration and the Office of Insurance Regulation are jointly responsible for establishing and administering the program. The agency and the office are required to issue an invitation to negotiate no later than July 1, 2008, to health insurers, health maintenance organizations, health care provider-sponsored organizations, and health care districts ("Cover Florida plan entities"). The agency and the office are required to approve at least one Cover Florida plan entity having an existing statewide provider network, and may approve at least one regional network plan in each Medicaid area.

Changes in plan benefits, premiums, and forms are subject to regulatory oversight by the agency and the office. The agency is required to ensure that the plans follow standardized grievance procedures. The office and the agency are required to submit an annual report to the Governor,

the President of the Senate, and the Speaker of the House of Representatives on the status of the program.

Health Flex Plan Program

The Health Flex Plan Program was established to offer basic affordable health care services to low income, uninsured residents. The amendment provides the following changes to the program:

- Expands the population eligible to purchase health flex plans by raising the family income limit from 200 to 300 percent of the federal poverty level (FPL).
- Allows a person who is covered under subsidized Medicaid or KidCare coverage and who lost eligibility due to the income limits to apply for coverage without a lapse in coverage if all other requirements are met. Under current law, these persons would be required to be uninsured for the prior 6 months prior to enrolling in a health flex plan.
- Expands the population eligible for health flex plans by allowing individuals who are covered under an individual contract issued by an HMO that has an approved health flex plan, as of October 1, 2008, to enroll in the HMO's health flex plan. These individuals would not be subject to the current requirement of being uninsured for the prior 6 months.
- Allows a person who is part of an employer group with at least 75 percent of the employees having income equal to or less than 300 percent of the FPL and not covered by private insurance during the last 6 months to be eligible for coverage. If the health flex plan is an insurer, only 50 percent of the employees must meet the income test.
- Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

Florida Health Choices Program

The bill creates the Florida Health Choices Program ("program"). The program is designed to be a single, centralized market for the sale and purchase of health care products including, but not limited to: health insurance plans, HMO plans, prepaid services, service contracts, and flexible spending accounts. Products sold as part of the program would be exempt from regulation under the Insurance Code and laws governing health maintenance organizations.

Authorized Vendors
The following entities are authorized to be eligible vendors of these products and plans: (1) insurers authorized under ch. 624, F.S., (2) HMOs authorized under ch. 641, F.S., (3) prepaid health clinics licensed under ch. 641, part II, F.S., (4) health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers, (5) provider organizations, including services networks, group practices, and professional associations, and (6) corporate entities providing specific health services. Vendors may not sell products that provide "risk-bearing coverage" unless those vendors are authorized

under a certification of authority issued by the Office of Insurance Regulation under the Florida Insurance Code. Vendors are required to make all risk-bearing products offered through the program guaranteed-issue policies, subject to preexisting condition exclusions established by the corporation.

Administration of the Program
The bill creates Florida Health Choice, Inc., as a not-for-profit corporation under ch. 617, F.S. The corporation will administer the program and function like a third-party administrator (TPA) for employers participating in the program. The corporation is responsible for certifying vendors and ensuring the validity of their offerings.

The corporation is governed by a fifteen member board, four members appointed by the Governor, four members appointed by the Senate President, four members appointed by the Speaker of the House of Representatives, and three ex-officio, non-voting members from the following agencies: Agency for Health Care Administration, Department of Management Services, and the Office of Insurance Regulation. The board members may not include insurers, health insurance agents, health care providers, HMOs, prepaid service providers, or any other entity or affiliate of eligible vendors.

The corporation is subject to the ethics (conflict of interest) requirements of part III of ch. 112, F.S., as well as the public records and public meetings requirements of chs. 119 and 287, F.S.

Board members are entitled to per diem and travel expenses but no other compensation is allowed. The board may secure staff and consultant services necessary to the operation of the program. A total of $1.5 million (the sum of 3 separate appropriation categories) in non-recurring funds is appropriated from the General Revenue Fund to fund the program.

Eligibility and Enrollment
The bill provides that small employers (1-50 employees), certain eligible individuals, cities (population less than 50,000), fiscally constrained counties, municipalities having a population of fewer than 50,000 residents, school districts in fiscally constrained counties, and statutory rural hospitals are eligible to enroll. Eligible individuals include individual employees of enrolled employers, state employees ineligible for the state group insurance plan, state retirees, and Medicaid reform participants who opt-out.

Pricing; Risk Pooling
Prices for products sold through the program must be based on age, gender, and location of participants. The corporation must develop a methodology for evaluating the actuarial soundness of the product, which methodology must be reviewed by the OIR. The corporation must use the methodology to compare the expected costs and benefits of the products, which must be reported to individuals participating in the program. Prices must remain in force for at least one year. The corporation must add a surcharge not to exceed 2.5 percent to generate funding for

administrative services provided by the corporation and payments to buyer's representatives (including insurance agents).

The program must utilize methods for pooling the risk of individual participants and preventing selection bias, including a postenrollment risk adjustment of the premium payments to the vendors. Monthly distributions of payments to the vendors must be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

OIR Recommendation on Risk-Bearing Products
Prior to making a risk-bearing product available through the program, the corporation must provide information on the product to the OIR. The OIR has 30 days to review the product and make a recommendation that it should, or should not, be made available through the program. If the OIR recommends that a risk-bearing product should not be made available, the product may be offered only if a majority of the board vote to include the product.

Florida KidCare Program

The Florida KidCare program is primarily targeted to uninsured children under age 19 whose family income is at or below 200 percent of the federal poverty level. The bill makes the following changes to the program:

- Expands eligibility and enrollment for the KidCare program by eliminating the 10 percent cap on enrollment for MediKids (ages 1-5) and Healthy Kids (ages 6-19) enrollees who have a family income of greater than 200 percent of the federal poverty level and pay full premiums. These enrollees must pay the full cost of the premium (unsubsidized).
- Requires Healthy Kids Corp. to submit a report to the Legislature and Governor, by February 1, 2009, on the premium impact to the subsidized portion of KidCare from the inclusion of the full pay program, and recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.

Dependent Coverage

The bill requires individual and group health insurers and HMOs to offer policyholders and certificate holders (parents) the option to continue coverage of their children on their family policy until age 30, if the child is: (1) unmarried with no dependents; (2) a resident of Florida or a full-time or part-time student; and (3) does not have insurance coverage under any private or public plan.

The bill maintains the current law that requires dependents to be covered until age 25 if the child is dependent upon the parent for support and who either lives in the household of the parent or is a full-time or part-time student. However, this requirement currently applies only to group health

insurance policies, which the bill applies to individual health insurance policies and to all HMO contracts.

Insurance Code Exemption for Certain Religious Organizations

The bill creates an exemption from the Florida Insurance Code for nonprofit religious organizations that qualify under Title 26, sec. 501 of the IRS Code. In order to meet this exemption, the nonprofit religious organization must:

- Limit its membership to members of the same religion;
- Act as an organizational clearinghouse for information between participants who have financial, physical, or medical needs and those with the ability to pay for the benefit of those members in need;
- Provide for medical or financial needs of participants through payments directly from one participant to another;
- Suggest amounts that participants may voluntarily give with no assumption of risk or promise to pay either among the participants or between the participants.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 40-0; House 118-1

CS/CS/CS/SB 2654 — Children with Disabilities

by Health and Human Services Appropriations Committee; Health Policy Committee; Banking and Insurance Committee; and Senators Geller, Ring, Bennett, Deutch, Villalobos, Rich, Fasano, Garcia, Wise, Atwater, Margolis, Crist, Joyner, Justice, Dockery, Dean, Dawson, Saunders, Pruitt, Webster, Alexander, Aronberg, Baker, Bullard, Carlton, Constantine, Diaz de la Portilla, Gaetz, Haridopolos, Hill, Jones, King, Lawson, Lynn, Oelrich, Peaden, Posey, Siplin, Storms, and Wilson

This bill authorizes the Agency for Health Care Administration (AHCA or Agency) to seek federal approval through a Medicaid waiver or state plan amendment for the provision of occupational therapy, speech therapy, physical therapy, behavior analysis, and behavior assistant services to individuals who are 5 years old and younger and have a diagnosed developmental disability, an autism spectrum disorder, or Down syndrome. Coverage for such services must be limited to $36,000 annually and $108,000 in total lifetime benefits. The agency must submit an annual report beginning on January 1, 2009 to the Legislature regarding progress on obtaining federal approval and recommendations for the implementation of services. The agency may not implement the provision of these services without prior legislative approval.

The bill creates the "Window of Opportunity Act" which requires the Office of Insurance Regulation (OIR or Office) to convene a workgroup by August 31, 2008, to negotiate a binding

compact agreement among participants relating to insurance and access to services for persons with developmental disabilities. The working group must include representatives from all licensed health insurers, all licensed health maintenance organizations, and employers with self-insured health benefit plans. No party must agree to the compact, but a party that does agree to the compact is bound to its terms and conditions. The compact agreement must include:

- A requirement to increase coverage for behavior analysis and behavior assistant services, speech therapy, physical therapy, and occupational therapy due to the presence of a developmental disability.
- Procedures for clear and specific notice to policyholders identifying the amount, scope, and conditions under which coverage is provided for such services.
- Penalties for documented cases of denial of claims for medically necessary services due to the presence of a developmental disability.
- Proposals for new product lines to be offered in conjunction with health insurance.

Once the compact agreement negations are completed, the OIR must report the results to the Governor, President of the Senate, and Speaker of the House of Representatives. Beginning February 15, 2009, the OIR must submit an annual report regarding the implementation of the compact agreement.

The bill also creates the "Steven A. Geller Autism Coverage Act" which requires insurer large group health insurance plans and HMO large group health maintenance contracts to provide coverage for diagnostic screening, intervention, and treatment of autism spectrum disorder in children through speech therapy, occupational therapy, physical therapy, and applied behavior analysis that is prescribed by the insured's treating physician in accordance with a treatment plan. All large group health insurance policies and HMO contracts issued or renewed on or after April 1, 2009, must provide the mandated autism spectrum coverage, except that the mandate is not enforceable against an insurer or HMO that is a signatory of the developmental disabilities compact for developmental disabilities, described above, as of April 1, 2009. However, the autism spectrum mandate is enforceable against a signatory of the developmental disabilities compact if the insurer or HMO has not complied with the terms of the compact by April 1, 2010.

The mandatory coverage for autism spectrum disorder is subject to a maximum benefit of $36,000 per year not to exceed $200,000 in total lifetime benefits. Beginning January 1, 2011, the maximum benefit is to be adjusted annually on that date to reflect annual changes in the medical inflation component of the Consumer Price Index. To be eligible for benefits and coverage, an individual must be diagnosed with an autism spectrum disorder at 8 years of age or younger. Benefits and coverage must be provided to eligible persons who are under 18 years of age or who are in high school. Coverage may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable than those applied to covered physical illnesses under the health plan or contract, except as allowed by the act. The coverage for autism may be

subject to other general exclusions and limitations of the insurer's or HMO's policy or plan. Benefits may not be denied on the basis that provided services are habilitative in nature.

Health insurance plans and HMOs may not deny, refuse to issue or reissue coverage, terminate, or restrict coverage because an individual is diagnosed with autism spectrum disorder.

If approved by the Governor, these provisions take effect July 1, 2008
Vote: Senate 40-0; House 117-0

CS/CS/SB 1012 — Health Insurance Claims Payments

by General Government Appropriations Committee; Banking and Insurance Committee; and Senators Gaetz, Baker, Fasano, Posey, Oelrich, Bennett, Ring, Lynn, and Storms

Senate Bill 1012 makes a number of changes to current law regarding assignment of benefits by policyholders or subscribers, third party access to provider networks, and recouping of certain overpayments to providers.

Assignment of Benefits

Committee Substitute for Senate Bill 1012 requires any insurer that contracts with a preferred provider to make payments directly to the preferred provider for such services to its insureds. The bill allows a health insurance policy insuring against loss or expense due to hospital confinement or medical and related services to provide direct payment to licensed ambulance providers, in addition to recognized hospitals and physicians to whom current law authorizes direct payment. Additionally, an insurance contract may not prohibit the direct payment of a licensed ambulance provider for emergency services provided pursuant to s. 395.1041, F.S., or medical transportation services provided pursuant to part III of chapter 401, F.S. Payment to the medical provider may not be greater than the payment the insurer would have paid without an assignment of benefits by the policyholder.

Health maintenance organizations (HMOs) are required to directly pay contracted hospitals, ambulance providers, physicians, and dentists for covered services if their subscribers make an assignment of benefits. An HMO contract may not prohibit the direct payment of benefits to a licensed hospital, ambulance provider, physician or dentist for covered services, for emergency services provided pursuant to s. 395.1041, F.S., or for ambulance transport and treatment provided pursuant to part III of chapter 401. Payment to the medical provider may not be more than the payment due in the absence of an assignment of benefits. These requirements do not affect the prohibition against balanced billing and other requirements in s. 641.3154, F.S., or the requirements for payment of emergency services in s. 641.31, F.S.

Third Party Access to Provider Networks

The bill establishes requirements for a contracting entity to lease, rent, or grant access to the health care services of a preferred provider or exclusive provider to a third party (sometimes referred to as a "silent Preferred Provider Organization") not involved in the original contract. The requirements apply if the participating provider is licensed under ch. 458, F.S., (physicians), ch. 459, F.S., (osteopaths), ch. 460, F.S., (chiropractors), ch. 461, F.S., (podiatrists), or ch. 466, F.S., (dentists). The bill also applies these requirements to group, blanket, and franchise health insurance. The requirements are that:

- The health care contract between the contracting entity and participating provider must expressly authorize granting access to provider's services to third parties. When the contract is entered into, the contracting entity must identify any third party it has granted access to the health care services of the participating provider.
- The contracting entity may sell, lease, rent or otherwise grant access to the participating provider's services only to the following third parties:
  - A payer or third-party administrator or other entity responsible for administering claims on the payer's behalf.
  - A preferred provider organization or network that is required to comply with all of the terms to which the originally contracted primary participating provider network is bound.
  - An entity that is engaged in the business of providing electronic claims transport.
- Upon request by a participating provider, a contracting entity must provide the identity of any third party that has been granted access. A contracting entity must also maintain an Internet website or a toll-free telephone number through which the provider may obtain a listing of the third parties that have been granted access.
- A contracting entity must ensure that an explanation is furnished to the participating provider that identifies the contractual source of any applicable discount.
- A contracting entity must ensure that all third parties given access comply with the physician contract, unless otherwise agreed by a participating provider.
- The right of a third party to exercise the rights and responsibilities of a contracting entity terminates on the day following the termination of the contract with the contracting entity, subject to applicable continuity-of-care laws.
- A health care contract may provide for arbitration of disputes under the section.

A contracting entity is deemed in compliance when the insured's identification card provides information, written or electronically, which identifies the preferred provider network(s) to be used to reimburse the provider for covered services.

The provisions regarding third party access to provider networks do not apply if the third party granted access is:

- An employer or other entity providing coverage and the employer or entity has a contract with the contracting entity for the administration or processing of claims for payment or services provided under the health care contract;
- An entity providing administrative services to, or receiving administrative services from, the contracting entity; or
- An affiliate or a subsidiary of a contracting entity, or other entity if operating under the same brand licensee program as the contracting entity (Blue Cross Blue Shield operates under a brand licensee program).

Claims for Overpayment and Underpayment

Reduces the maximum time period from 30 months to 12 months after payment is made to a provider for an insurer or HMO to make a claim for overpayment, or a provider to make a claim for underpayment if the provider is licensed under ch. 458, F.S., (physicians), ch. 459, F.S., (osteopaths), ch. 460, F.S., (chiropractors), ch. 461, F.S., (podiatrists), or ch. 466, F.S., (dentists). However, a 30-month period is available if the provider is convicted of fraud pursuant to s. 817.234, F.S.

Other Provisions:

- Revises the definition of small employer for group health insurance coverage to provide that companies that are affiliated groups as defined in s. 1504(a) of the Internal Revenue Code are considered one employer, for purposes of calculating the number of employees. Certain companies currently considered small employers will no longer be entitled to guarantee issue and modified community ratings since they will no longer be deemed small employers. The bill also exempts from the definition small employers formed primarily for the purpose of providing health insurance. This conforms Florida law to the current National Association of Insurance Commissioners Model Act.
- Allows the Office of Insurance Regulation to waive the requirement that a multiple employer welfare arrangement must have its principal place of business in Florida and maintain complete records of its assets, transactions and affairs at that locale if an arrangement has been operating in another state for at least 25 years, has been licensed in that state for at least 10 years, and has a minimum fund balance of at least $25 million at the time of licensure.

If approved by the Governor, these provisions take effect November 1, 2008, and will apply to contracts entered into, issued, or renewed on or after that date. The amendments made to ss. 627.6131 and 641.3155, F.S., (overpayment or underpayment of claims) apply to claims payments made on or after November 1, 2008.
Vote: Senate 38-0; House 119-0

HB 461 — Health Flex Plans

by Rep. Patronis and others (SB 1022 by Senators Peaden, Gaetz, and Lynn)

The Health Flex Plan Program was established to offer basic affordable health care services to low-income, uninsured residents. The bill expands the population eligible to purchase health flex plans by raising the income limit from 200 to 300 percent of the federal poverty level. The bill also extends the expiration date of the program from July 1, 2008 to July 1, 2013.

If approved by the Governor, these provisions take effect July 1, 2008.
Vote: Senate 38-0; House 107-2

CS/HB 535 — Health Insurance

by Policy and Budget Council and Rep. Cretul and others (CS/SB 1968 by General Government Appropriations Committee and Senators Posey and Storms)

The bill requires health insurance companies and health maintenance organizations to provide policyholders and subscribers with identification cards that contain specified information that can be used to estimate the financial responsibility of the covered person, in compliance with the federal Health Insurance Portability and Accountability Act of 1996, and contact information for the insurer or health maintenance organization. This information will assist hospitals and other providers to determine coverage and the financial responsibility of the covered person.

This bill also expands the definition of bone marrow transplant for purposes of required health insurance coverage to include nonablative therapy and authorizes coverage for bone marrow transplants for life-prolonging intent, not just for curative purposes. These changes in the law would update coverage requirements to reflect current practice and advancements in the area of bone marrow transplants.

If approved by the Governor, these provisions take effect January 1, 2009.
Vote: Senate 39-0; House 111-0

PROPERTY INSURANCE

CS/CS/SB 2860 and 1196 — Insurance

by General Government Appropriations Committee; Banking and Insurance Committee; and Senators Atwater, Geller, Fasano, Garcia, Jones, Gaetz, and Wilson

Senate Bill 2860 is entitled the Homeowners Bill of Rights Act.

Rating Law for Property and Casualty Insurance (s. 627.062, F.S.)

Repeal of Arbitration - Repeals the option for an insurer, for any property and casualty insurance rate filing (or any other filing), to appeal a rate filing disapproved by the Office of Insurance Regulation (OIR) to an arbitration panel in lieu of an administrative hearing. Current law prohibits use of arbitration until January 1, 2009.

Extension of Prohibition on "Use and File"- Extends for one additional year, until December 31, 2009, the current prohibition on insurers using the "use and file" option for property insurance rate increases. This would continue to require that an insurer make a "file and use" filing that prohibits an insurer from increasing its rates prior to approval by the OIR, unless deemed approved by failure of the OIR to issue a notice of intent to disapprove within 90 days. Current law prohibits "use and file" rate increases until December 31, 2008.

Use of Approved Hurricane Loss Models - Requires that projected hurricane losses must be estimated using a model or method found to be accurate or reliable by the Florida Commission on Hurricane Loss Projection Methodology.

Profit Factor - Deletes the requirement that the OIR approve a profit factor in a rate filing for an insurer that is commensurate with the risk, for that portion of the rate covering hurricane losses for which the insurer has not purchased reinsurance. By striking this language, the law requires the OIR to consider "a reasonable margin for profit and contingencies."

Expedited Hearings on Rate Filings - Provides for an expedited hearing process for rate filings by:

- Requiring Division of Administrative Hearings to hold the hearing within 30 days after the request for the hearing.
- Requiring the hearing officer to issue the recommended order within 30 days after the hearing (or after receipt of the transcripts).
- Requiring parties to submit written exceptions within 10 days.
- Requiring the OIR to enter a final order within 30 days after the entry of the recommended order.

- Allowing timeframes to be waived upon agreement of all parties.
- Allowing an insurer to request an expedited appellate review of a final OIR rate order and providing legislative intent that the 1st DCA grant the insurer's request.

Transparency in Rate Regulation (creating s. 627.0621, F.S.)

For residential property insurance rate filings the OIR must provide information on an Internet website of all assumptions made by any OIR actuary; the overall rate change requested by the insurer; a statement describing any assumptions that deviate for actuarial standards of the Casualty Actuarial Society; and a certification by the office's actuary that based on the actuary's knowledge, that his or her recommendations are consistent with accepted actuarial principles.

In any administrative or judicial proceeding, the work-product and attorney-client privilege exemptions from public disclosure do not apply to communications with office attorneys or records prepared by or at the direction of an OIR attorney except when the communication or record reflects a mental impression, conclusion, litigation strategy, or legal theory of the attorney or the OIR that was prepared exclusively for civil or criminal litigation or adversarial administrative proceedings *and* the communication occurred or the record was prepared after the initiation of a court action, after issuance of a notice of intent to deny a rate, or after the filing by an insurer of a request for a hearing.

Administrative Proceedings in Rate Determinations

The bill allows an administrative law judge (ALJ) to make the certain findings of fact in an administrative hearing on a property insurance rate filing. The ALJ may find whether the factors used in a rate filing or applied by the office are consistent with standard actuarial techniques or practices or are otherwise based on reasonable actuarial judgment, whether a factor for underwriting profit and contingencies is reasonable or excessive, or whether the cost of reinsurance is reasonable or excessive. The administrative law judge may enter a recommended order that approves, modifies or rejects the requested change, as supported by the record.

Requirements for Trade Secret Documents (s. 624.4213, F.S.)

The bill specifies requirements for submission of a document to the OIR or the Department of Financial Services (DFS) in order for a person to claim that the document is a trade secret. Each page or portion that is a trade secret must be labeled as such and be separated from non-trade secret material. The submitting party must include an affidavit certifying certain information as to the trade secret status of the documents.

The OIR is authorized to release a document marked as trade secret to a requestor if the OIR provides the insurer with 30-days notice and opportunity to obtain a court order barring disclosure. The bill allows the OIR or DFS to disclose a trade secret to employees or officers of

another governmental agency whose use of the trade secret is within the scope of their employment.

Market Conduct Examinations—Required Filing of Claims Handling Practices (s. 624.3161, F.S.)

The bill authorizes the OIR to order an insurer to file its claims handling practices and procedures as a public record based on findings of a market conduct examination. The OIR findings must be that the insurer had a pattern or practice of willful violations of an unfair insurance trade practice related to claims-handling causing harm to policyholders, as prohibited by s. 626.9541(1)(i), F.S. The requirement applies to the claims-handling procedures for the line of insurance that was the subject of the market conduct exam. The filings must be held by the office for a 36-month period.

Administrative Fines for Violations of the Insurance Code (s. 624.4211, F.S.)

The bill doubles all current fines that may be imposed by the OIR upon an insurer for violation of the Insurance Code or any rule or order. A maximum fine of $40,000 (rather than $20,000) may be levied for a willful violation, not to exceed an amount equal to $200,000 (rather than $100,000), for all willful violations arising out of the same action. A maximum fine of $5,000 (rather than $2,500) for a nonwillful violation, not to exceed an amount of $20,000 (rather than $10,000) for all nonwillful violations arising out of the same action.

Administrative Fines for Unfair Insurance Trade Practices (s. 626.9521, F.S.)

The bill doubles all current fines that may be imposed by the OIR or the Department of Financial Services (within each agency's respective jurisdiction) upon a person who violates any unfair or deceptive act or practice related to insurance. A maximum fine of $40,000 (rather than $20,000) may be levied for a willful violation, not to exceed an amount equal to $200,000 (rather than $100,000), for all willful violations arising out of the same action. A maximum fine of $5,000 (rather than $2,500) for a nonwillful violation, not to exceed an amount of $20,000 (rather than $10,000) for all nonwillful violations arising out of the same action.

Unfair Insurance Trace Practices; Payment of Undisputed Claim Amount (s. 626.9541, F.S.)

The bill prohibits an insurer from failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance polices within 90 days after determining the amount and agreeing to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed. Violations are grounds for a private civil remedy action, due to the cross-reference in current s. 624.155, F.S.

Notice of Non-Renewal

The bill increases the required notice of nonrenewal of a personal or commercial residential insurance policy from 100 days to 180 days if the policy has been written for 5 years or more. Insurers that are planning to nonrenew more than 10,000 policies within a 12-month period must notify the OIR 90 days before issuing any notices of nonrenewal.

Required Use of Models Approved by Florida Commission on Hurricane Loss Projection Methodology (s. 627.0628, F.S.)

The bill requires that for purposes of a rate filing insurers must use, and may not modify or adjust, a model or method found to be accurate or reliable by the Commission on Hurricane Loss Projection Methodology. The bill deletes the current law that in order for an approved model to be admissible and relevant, the OIR must have access to all of the assumptions and factors used in developing the model.

The commission is required to adopt findings related to a model's probable maximum loss calculations. An insurer must use and may not modify or adjust models found by the commission to be accurate or reliable in determining probable maximum loss levels for rate filings made more than 60 days after the commission has made such findings.

The bill specifies that the processes, standards, and guidelines of the commission do not constitute final agency action or statements of general applicability that implement, interpret, or prescribe law and are exempt from chapter 120, F.S.

Use of Public Hurricane Loss Model

The bill allows insurance companies to use the Public Hurricane Loss Model to determine rate requests in advance of a filing, but requires the insurer to pay for use of the public model. It requires the Financial Services Commission to establish by rule, by January 1, 2009, a fee schedule for access and use of the model, reasonably calculated to cover only the actual costs.

Hurricane Mitigation Premium Credits Tied to Uniform Home Rating Scale (s. 627.0629, F.S.)

The OIR is required to develop, by February 1, 2011, a proposed method for insurers to establish windstorm mitigation premium credits (discounts) that correlate to the numerical rating of a structure pursuant to the uniform home rating scale. The Financial Services Commission must then adopt rules by October 1, 2011, requiring insurers to make rate filings which revise their credits pursuant to this method, consistent with generally accepted actuarial principles and wind loss mitigation studies. The rules must allow a period of at least two years after the effective date of the revised credits for a property owner to obtain an inspection or otherwise qualify for the revised credit, during which time the insurer must continue to apply the old mitigation credit.

Disclosure of Windstorm Mitigation Rating Upon Sale of Home (s. 689.262, F.S.)

The bill provides that, effective January 1, 2010, the potential purchaser of a residential property with an insured value of $500,000 or more, insured by Citizens, and located in the wind-borne debris region be informed of the structure's windstorm mitigation rating.

Effective January 1, 2011, a purchaser of residential property located in the wind-borne debris region must be informed of the windstorm mitigation rating of the structure, either in the contract for sale or as a separate document attached to the contract. The Financial Services Commission is authorized to adopt rules, including the form of the disclosure and the requirements for the inspection or report that is required.

Citizens Property Insurance Corporation (s. 627.351, F.S.)

Extension of Rate Freeze - Extends the freeze on rate increases in Citizens from January 1, 2009 to January 1, 2010. Requires Citizens to make an annual, actuarially sound rate filing beginning July 15, 2009, to be effective no earlier than January 1, 2010.

*Assessments for Citizens Defici*ts - Revises the required assessments to fund a deficit in *each* of Citizens' three accounts (high risk, personal lines, or commercial lines) to:

- Require up to a 15 percent of premium surcharge for 12 months on all Citizens' policies, collected upon issuance or renewal;
- If this is insufficient, require a regular assessment against insurers which may be recouped from their policyholders, of up to 6 percent (rather than 10 percent) of premium for most lines of property and casualty insurance or 6 percent of the deficit, whichever is greater;
- Require any remaining deficit to be funded by a bond issue, funded by multi-year emergency assessments on policyholders on most types of property and casualty insurance, of up to 10 percent of premium for most lines of property and casualty insurance, or 10 percent of the deficit, whichever is greater.

The bill grants the board of Citizens the discretion to apply the amount of any assessment or surcharge which exceeds the amount of the deficit to various business purposes.

Eligibility for Higher Value Homes - Provides that homes with a dwelling replacement cost of $2 million or more, rather than current law's $1 million or more, are ineligible for coverage, effective January 1, 2009, with limited exceptions for current policyholders who obtain rejections from three surplus lines insurers and one authorized insurer.

Eligibility for Properties Within 2,500 Feet of the Coast - Deletes the current law requiring that new properties constructed after January 1, 2009, within 2,500 feet of the coast must meet "Code Plus" requirements in order to be eligible for Citizens. By repealing this provision, the law would still require that any new home meet the Florida Building Code.

Forced Purchase of Bonds - Deletes current law requiring insurers to purchase bonds that remain unsold for 60 days.

Access to Claims and Underwriting Files - Provides that a policyholder who has filed suit against Citizens has the right to discover the contents of his or her claims file to the same extent that discovery would be available from a private insurer. Allows Citizens to release confidential underwriting and claims file information under certain circumstances.

Multi-Policy Discount

Allows an insurer to offer a multi-policy discount if the policyholder has wind-only coverage with Citizens or an insurer that has removed a policy from Citizens, provided that the same insurance agent services both policies.

Citizens Property Insurance Corporation Mission Review Task Force

The bill creates the Citizens Mission Review Task Force to analyze and report on changes needed to return Citizens to its former role as a state-created, noncompetitive residual market mechanism that provides property insurance coverage to risks that are otherwise entitled but unable to obtain such coverage in the private market. The task force must submit reports by January 31, 2009, to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The task force is composed of 11 members and must be funded by Citizens.

Insurance Capital Build-Up Incentive Program (s. 215.5595, F.S.)

The bill revises the requirements for the Program, which provides for surplus note loans to insurers of up to $25 million, repayable over 20 years at the 10-year Treasury bond rate, as approved by the State Board of Administration (SBA). Insurers that apply by September 1, 2008 are eligible for a surplus note loan equal to the amount of new capital that an insurer contributes. Insurers that apply after September 1, but before June 1, 2009, may apply for a surplus note equal to one-half of the amount of new capital that the insurer contributes. The bill revises the minimum premiums that the insurer must commit to write, by adding a minimum *gross* premium to surplus ratio requirement, as an alternative to the current *net* premium to surplus writing ratio requirement. The distinction is that net premiums deduct the reinsurance premiums that the insurer pays (cedes) to a reinsurer. An insurer must write at least 15 percent of its premiums for new policies for policies taken out of Citizens, for each of the first 3 years of the surplus note.

To fund the program, Citizens is to transfer $250 million from its personal lines account and commercial lines account to the General Revenue Fund on December 15, 2008, unless the estimated year-end surplus in the Personal Lines Account and the Commercial Lines Account is less than $1 billion. The State Board of Administration (SBA), beginning July 1, 2009, must make quarterly transfers to Citizens of interest and principal payments for surplus notes that were funded by appropriations from Citizens in FY 2008-09. Citizens is prohibited from using any of the amendments to the Insurance Capital Build-Up Program or any transfer of funds as justification or cause in seeking any rate or assessment increase. However, this provision does not limit the amount of an assessment that may be greater due to the transfer of these funds.

The bill requires the SBA to make annual reports to the Legislature on the results of the program and each insurer's compliance with the terms of its surplus note. The SBA must transfer to Citizens on January 15, 2009, uncommitted or unreserved funds, that were funded by transfers from Citizens.

Florida Hurricane Catastrophe Fund; $10 Million Coverage Option

The bill requires the FHCF to offer $10 million of additional coverage to limited apportionment companies (having $25 million in surplus or less and writing at least 25 percent of premiums in Florida), insurers approved to participate in the Insurance Capital Build-Up Incentive Program, and insurers that purchased the supplemental coverage in 2007. Similar coverage was offered in 2006 and 2007. This coverage would reimburse the insurer for up to $10 million in losses, for each of two hurricanes. The coverage will again be priced at a 50 percent rate on line (e.g., $5 million premium for $10 million in coverage) with a free reinstatement for a second storm. The insurer's retention for such coverage remains at 30 percent of the company's surplus. The coverage expires on May 31, 2009.

Annual Report by CFO

Requires the CFO to annually report to the Governor and Legislative presiding officers regarding the economic impact on Florida from a 1-in-100 year hurricane and the premium increase needed to fund such a hurricane.

If approved by the Governor, these provisions take effect July 1, 2008
Vote: Senate 33-5; House 117-0

HB 7103 — My Safe Florida Home Program

by Jobs and Entrepreneurship Council and Rep. Reagan (CS/SB 644 by Banking and Insurance Committee and Senators Justice, Rich, Gaetz, Storms, Dockery, and Joyner)

The bill makes several changes to the My Safe Florida Home Program (MSFHP) administered by the Department of Financial Services (DFS). The intent of the MSFHP is to provide free

home inspections for at least 400,000 site-built, single-family residential properties and provide grants to at least 35,000 applicants prior to June 30, 2009.

The bill provides that to qualify for selection by the DFS as a wind certification entity to provide hurricane mitigation inspections, an entity must use hurricane mitigation inspectors who are certified or licensed as building inspectors, general or residential contractors, professional engineers or architects, or individuals who have at least two years prior experience in residential construction or residential building inspection and who have received specialized training in hurricane mitigation procedures.

The legislation requires DFS to adopt a quality assurance program that includes a statistically valid number of reinspections. It also allows DFS to verify that mitigation improvements have been made to all openings, including exterior doors and garage doors, prior to issuing a reimbursement grant check to the homeowner. The bill eliminates a provision in current law which requires DFS to transfer $40 million to the Volunteer Florida Foundation to provide inspections and grants to low-income homeowners. This provision is removed due to concerns about the tax status of the Foundation. The DFS may provide the remaining $18.7 million that has not yet been transferred to the Foundation, directly to non-profit organizations to serve low-income homeowners.

The bill mandates that DFS implement a no-interest loan program by October 1, 2008, which is to be contingent upon the selection of a qualified vendor and the execution of a contract acceptable to DFS and the vendor. The DFS is directed to set aside $10 million from the MSFHP funds for the loan program.

The bill allows DFS to contract with third parties for the provision of information technology and contractor services for low-income homeowners, which shall be considered direct program costs, rather than administrative costs for purposes of administrative cost limitations.

The bill clarifies that policyholders may submit a uniform mitigation verification inspection form to their insurers for the purpose of determining premium discounts for wind insurance. Further, insurers must accept as valid the uniform mitigation verification forms certified by the DFS or signed by a hurricane mitigation inspector employed by an approved My Safe Florida Home wind certification entity, a building code inspector, a general or residential contractor or a professional engineer or architect so that homeowners can access insurance discounts or credits for which they are eligible.

If approved by the Governor, these provisions take effect July 1, 2008.
Vote: Senate 40-0; House 118-0

OTHER INSURANCE

CS/CS/SB 2082 — Insurance (Sale of Annuities)

by General Government Appropriations Committee; Banking and Insurance Committee; and Senators Bennett and Atwater

The bill increases penalties for specified unfair or deceptive insurance practices related to the sale of life insurance and annuity contracts and strengthens the standards for making recommendations involving annuities to senior consumers. The act is named the "John and Patricia Seibel Act."

Unfair or Deceptive Insurance Practices

The bill imposes increased fines and penalties for the unfair and deceptive insurance practices known as "twisting" and "churning," and adds a prohibited practice of willfully submitting to an insurer on behalf of a consumer a document bearing a false signature. "Twisting" and "churning" involves misleading representations in an attempt to induce a consumer to cash in funds from a current investment or insurance product in order to purchase another product. The bill classifies engaging in a pattern or practice of "twisting" and "churning" as a first degree misdemeanor. Willfully submitting a false signature is a third degree felony. The fines (administrative penalties) for these practices are increased to:

- $5,000 for each non-willful violation (currently $2,500), up to a maximum aggregate amount of $50,000 (currently $10,000).
- $30,000 for each willful violation (currently $20,000), up to a maximum aggregate amount of $250,000 (currently $100,000).

The bill also makes it an unfair or deceptive insurance practice for an agent to use designations or titles that falsely imply that he or she has special financial knowledge or training.

Sales of Annuities to Senior Consumers

The bill strengthens the standards that apply to recommendations to a senior consumer to purchase an annuity contract. Specifically, it:

- Requires that the insurer or insurance agent have an objectively reasonable basis for believing that an annuity recommendation to a senior consumer is suitable.
- Requires insurance agents, prior to recommending a product to a senior consumer, to obtain specified personal and financial information from the consumer relevant to the suitability of the recommendation, on a form adopted by the Department of Financial Services (department).

- Requires the insurer or agent to provide the consumer with specified information on a form adopted by the department concerning differences between the annuity being recommended for purchase and the existing annuity that would be surrendered or replaced.
- Authorizes the Office of Insurance Regulation (OIR) to order an insurer to rescind a life insurance policy or annuity and provide a full refund of the premiums paid or the accumulation value, whichever is greater, when a senior consumer is harmed by a violation of the suitability statute.
- Requires insurers, managing general agents, and insurance agencies to each maintain or make available to the department or the OIR records of information collected from senior consumers and other information for five years after the insurance transaction is completed.
- Deems that any person who is registered with a member of the federal Financial Industry Regulatory Authority, who is required to make a suitability determination and does so while documenting the determination, is deemed to satisfy the section's requirements.

"Free Look" Period; Annuity Regulation

The bill increases the "free look" period from 10 days to 14 days after purchase of a life insurance or fixed annuity, for the consumer to obtain a refund. The bill applies this requirement to all annuities, rather than "fixed" annuities.

The bill clarifies the regulatory jurisdiction of the agencies under the Department of Financial Services regarding the sale of annuities.

Other Provisions

- Requires applicants for agent licensure to provide their home and business telephone numbers and email address in the application and to notify the department within 60 days after any changes.
- Requires all licensees to complete three hours of department-approved continuing education on the subject of suitability in annuity and life insurance transactions. The hours may be used to satisfy the current ethics continuing education requirement.

If approved by the Governor, these provisions take effect January 1, 2009.
Vote: Senate 40-0; House 119-0

CS/CS/SB 2012 — Insurance Policies

by Health Policy Committee; Banking and Insurance Committee; and Senators Deutch, Crist, and Fasano

The bill amends various provisions of the Insurance Code to provide for the following:

Long-Term Care Insurance

The bill amends s. 627.94073, F.S., to require insurers to notify a long-term care insurance policyholder of the right to designate a secondary addressee annually, rather than every 2 years, and requires the form designating the secondary addressee to inform the policyholder to update any change made to the address of the secondary addressee. Notice of possible lapse in coverage due to nonpayment of premium must be made by the United States Postal Service proof of mailing or certified or registered mail to the policyholder and to the secondary designee at the address shown in the policy or at the last known address provided to the insurer. The bill changes the requirement for an insurer to allow a policyholder to reinstate a long term care policy that has been cancelled for non-payment of premium, to include persons whose failure to pay the premium was due to continuous confinement in a hospital, skilled nursing facility, or assisted living facility of longer than 60 days. These provisions are effective January 1, 2009.

Holocaust Victims

The bill amends s. 626.9543, F.S., to extend the statute of limitations for filing insurance claims under the Holocaust Victims Insurance Act, from July 1, 2008 to July 1, 2018.

Multiple Employer Welfare Arrangement (MEWA)

The bill amends s. 624.443, F.S., to allow the Office of Insurance Regulation to waive the requirement that each MEWA maintain its principal place of business in this state if the MEWA has been operating in another state for at least 25 years, has been licensed in such state for at least 10 years, and has a minimum fund balance of $25 million at the time of licensure.

Motor Vehicle Personal Injury Protection Insurance

The bill amends s. 627.736, F.S., to clarify that personal injury protection (PIP) reimbursement for medical services be based on 200 percent of the allowable amount under the "participating physicians" schedule of Medicare Part B for 2007. Participating physicians accept Medicare’s allowed charges as payment in full for their Medicare patients.

Hospital Self-Insurance Alliances

Under current law, any two or more hospitals may form a self-insurance alliance to pool and spread liabilities for property insurance coverage. If an alliance purchases excess insurance, it is subject to the premium tax. The bill amends s. 395.106, F.S., to allow such alliances to be considered insurers only for the purpose of purchasing reinsurance coverage which would not be subject to the premium tax. The bill clarifies that contracts of reinsurance issued to a hospital alliance shall receive the same tax treatment as reinsurance contracts issued to insurers.

Citizens Property Insurance Corporation (Citizens)

The bill amends s. 627.351, F.S., to provide that a policyholder (and his or her attorney) who has filed suit against Citizens may have access to his or her own claim file to the same extent that discovery would be available from a private insurer in litigation as provided by the Florida Rules of Civil Procedure. This same right of access to claim files is provided to a third party in litigation pursuant to subpoena. Access to such files is subject to any confidentiality protections requested by Citizens. The bill authorizes Citizens to release confidential underwriting and claims file contents as it deems necessary to underwrite or service insurance policies and claims, subject to confidentiality protections deemed necessary. It also allows Citizens to release confidential underwriting file records to other governmental agencies upon written request and demonstration of need, which records remain confidential.

The bill requires Citizens to electronically report claims data and histories to a consumer reporting agency upon the request of such agency. A consumer reporting agency, as defined by the federal Fair Credit Reporting Act, that is in compliance with the confidentiality requirements of the Act maintains claims data and histories for use in connection with the underwriting of insurance involving a consumer. Insurers are able to review the claims history of insureds using the service provided by a consumer reporting agency.

Public Housing Authority Self-Insurance Funds

Current law allows public housing authorities to form self-insurance funds to spread liabilities of their members for property and casualty insurance. The bill amends s. 624.46226, F.S., to provide criteria that such entities must follow in forming self-insurance funds which includes:

- Having annual premiums in excess of $5 million;
- Using a qualified actuary to determine rates and reserves;
- Maintaining excess insurance coverage and reserve evaluation to protect the financial stability of the fund;
- Submitting annual audited financial statements to the Office of Insurance Regulation (OIR);

- Having a governing body comprised of commissioners of public housing authorities;
- Using knowledgeable persons or business entities to service the fund; and
- Certifying to the OIR that the fund meets the above provisions.

Should a self-insurance fund not meet such requirements, the fund is subject to the requirements under general law for commercial self-insurance funds, or if the fund provides only workers' compensation coverage, the general law for group (employer) self-insurance funds. The bill clarifies that such funds are not covered by the insurance guaranty association, but are subject to the premium tax.

Public Adjusters

The bill contains the substance of CS/SB 1098, as revised, and is the product of recommendations pertaining to public adjusters from the Task Force on Citizens Claims Handling and Resolution. The Task Force found that while the services of public adjusters can be beneficial to policyholders who have suffered a loss, the current laws do not adequately protect consumers from unscrupulous public adjusters.

The bill amends various provisions of the Insurance Code to provide for the following changes:

- Requires the Department of Financial Services to create a specific examination for public adjusters and mandates continuing education requirements for such adjusters;
- Prohibits public adjusters from contacting an insured or claimant until 48 hours after the occurrence of an event that may be the subject of a claim under a policy;
- Prohibits public adjusters from soliciting an insured or claimant except on Monday through Saturday and only between the hours of 8 a.m. and 8 p.m.;
- Prohibits public adjusters from charging a fee unless a written contract was executed prior to the payment of a claim;
- Prohibits public adjusters from charging more than:
  - 20 percent of the insurance claims payment on non-hurricane claims;
  - 10 percent of the insurance claims payment on hurricane claims for claims made during the first year after the declaration of emergency;
- Provides for no cap on re-opened or supplemental hurricane claims; however, the fee cannot be based on any payments made by the insurer to the insured prior to the time of the public adjuster contract;
- Allows insureds or claimants to have 5 business days after the date on which the contract is executed to cancel a public adjuster's contract during a state of emergency declared by

the Governor; insureds or claimants have 3 business days to cancel a contract as to claims involving non-emergencies;

- Creates a public adjuster apprentice license and examination;
- Requires public adjuster contracts to be in writing and to display an anti-fraud statement; and
- Provides for nonresident public adjuster qualifications.

Title Insurance (UCC Personal Property Insurance)

The bill allows a title insurer to petition the OIR for a rate deviation under s. 627.783, F.S., for personal property title insurance, a Uniform Commercial Code insurance product. The bill requires that the OIR, in determining whether to approve a rate deviation for a personal property title insurance product, must be guided by "standards for national rates for the product being offered in other states."

Florida Hurricane Catastrophe Fund

The bill amends s. 215.555, F.S. to require the Florida Hurricane Catastrophe Fund to offer $10 million of additional coverage to qualified insurers in 2008, as was required in 2006 and 2007. This coverage would again be made available to limited apportionment companies (each having $25 million or less in surplus and writing at least 25 percent of its premiums in Florida), insurers approved to participate in the Insurance Capital Build Up Incentive Program, and insurers that purchased the supplemental coverage in 2007. This coverage would reimburse the insurer for up to $10 million in losses, for each of two hurricanes. The coverage will again be priced at a 50 percent rate on line (e.g., $5 million premium for $10 million in coverage) with a free reinstatement for a second storm. The insurer's retention for such coverage remains at 30 percent of the company's surplus. The bill would provide that the coverage expires on May 31, 2009.

Insurance Agents and Other Insurance Representatives

The bill amends several sections of the Insurance Code pertaining to insurance agents and other insurance representatives and provides for the following:

- Allows applicants to be exempt from the customer representative licensing examination if they have earned a specified degree and have completed at least nine academic hours in property and casualty insurance;
- Prohibits insurers, including Citizens, from requiring appointees (insurance agents) to complete specified continuing education (CE) courses offered by such insurers or by Citizens, in order for the appointment to be issued or renewed;

- Allows insurers, including Citizens, to require appointees to attend non-CE training and education programs offered by such insurers or by Citizens, in order for the appointment to be issued or renewed;
- Allows Citizens to require its employees to take training relevant to their employment and to require appointees to take CE courses which pertain solely to Citizens' internal procedures or products; and
- Authorizes independent study programs offering CE courses through correspondence to allow students to take a final closed book examination without being monitored provided that the student submits a sworn affidavit attesting he or she did not receive assistance while taking the exam.

Except as otherwise provided in this act, this act shall take effect July 1, 2008.
Vote: Senate 39-0; House 118-1

CS/SB 648 — Insurable Interest in Insurance Contracts

by Judiciary Committee and Senator Posey

This bill is expressly intended to clarify current Florida law relating to insurable interests and the purchase of life insurance. Florida case law has interpreted Florida law as prohibiting the issuance of a life insurance policy to someone who does not have an insurable interest in the insured.

The bill states that a person may purchase insurance on his or her own life or body for payment to any beneficiary. However, no person may purchase an insurance contract on the life or body of another individual unless the benefits under the insurance are payable to the individual insured, the insured's personal representatives, or a person who had an "insurable interest" in the life of the insured when the contract was entered into. The bill defines the various circumstances that constitute an insurable interest for purposes of life, health, or disability insurance. An insurable interest exists that allows such insurance to be purchased on:

- *Yourself*: an individual has an insurable interest in his or her own life, health and body.
- *Family members and loved ones*: an individual has an insurable interest in another person who is a close relation by blood or law and in whom the individual has a substantial interest engendered by love and affection.
- *Persons whose health and life is of substantial benefit to you financially*: an individual has an insurable interest in another person if there is a substantial pecuniary advantage in the continued life, health, and safety of that other person and the individual will have a substantial pecuniary loss upon the death, illness, or disability of that other person.

- *Other parties to a contract for the sale of a business*: an individual party to a contract for the purchase or sale in a business entity has an insurable interest in the life of the other parties for purposes of that contract.
- *Grantors of trusts, their relations, and others*: A trust or trustee acting in its fiduciary capacity has an insurable interest in the life of the trust grantor, persons closely related by blood or law to the grantor, or individuals in whom the grantor has an insurable interest. The insurable interest only exists if the life insurance proceeds are primarily for the benefit of trust beneficiaries who have an insurable interest in the life of the insured. *Beneficiaries*: a guardian, trustee, or fiduciary who acts in a fiduciary capacity has an insurable interest in a beneficiary and in any person for which the beneficiary has an insurable interest.
- *Persons who consent in writing to a charity*: a charitable organization has an insurable interest in the life of any person who consents in writing to the charity's ownership or purchase of insurance on that person. This provision is the substance of current s. 627.404(2), F.S.
- *Participants in a retirement or deferred compensation plan who consent in writing*: a trustee or custodian of a retirement or deferred compensation plan has an insurable interest in the life of participants in the plan who consent in writing to the plan's ownership of a life insurance policy on that person. The bill prohibits an employer, trustee, or custodian from taking adverse action against a plan participant who refuses to give consent.
- *Owners, directors, officers, partners, managers, and key employees of a business*: a business entity has an insurable interest in its owners, directors, officers, partners, and managers, and in key employees if their loss will result in a substantial pecuniary loss.

The bill requires the written consent of the insured as a prerequisite to the issuance of a contract of insurance on the insured, with exceptions for group life insurance or group or blanket accident, health or disability insurance. The signature of the proposed insured on the application for insurance constitutes written consent.

The bill provides a right of recovery against persons who receive insurance policy benefits if they did not have an insurable interest in the insured when the insurance contract was entered into.

If approved by the Governor, these provisions take effect July 1, 2008
Vote: Senate 38-0; House 112-0

CS/HB 937 — Title Insurance

by Jobs and Entrepreneurship Council and Rep. Ambler and Galvano (CS/CS/CS/SB 1684 by General Government Appropriations Committee; Governmental Operations Committee; Banking and Insurance Committee; and Senators Baker and Gaetz)

This bill creates the Florida 2008 Title Insurance Study Advisory Council (Council) which will undertake a comprehensive examination of the title insurance system in Florida and make findings and recommendations in its final report to the Governor, Speaker of the House of Representatives and President of the Senate on or before December 31, 2009. The final report must be approved by at least two-thirds of the Council's membership with the chair voting to approve. The Council will terminate after submitting its final report, but no later than December 31, 2009.

The Council is composed of 21 members including the Governor or designee serving as chair; the Chief Financial Officer or designee serving as vice chair; one member of the Senate appointed by the President; one member of the House of Representatives appointed by the Speaker; the Insurance Consumer Advocate; the Commissioners of Insurance Regulation and Financial Regulation or their designees; three representatives of title insurers and two independent title agents appointed by the Senate President; four representatives of title insurers and one independent title agent appointed by the Speaker of the House of Representatives; two members designated by the Real Property, Probate and Trust Law Section of the Florida Bar; one member of the banking industry appointed by the Commissioner of Financial Regulation, and one member of the real estate industry appointed by the Chief Financial Officer.

The Council will be administratively supported by the staff of the Executive Office of the Governor (EOG) with specified agencies and applicable legislative committees supplying information, assistance and facilities. The Legislature's Office of Program Policy Analysis and Governmental Accountability will conduct an independent historical analysis of title insurance and report its findings to the Council by September 30, 2008. The Council must hold its first meeting by August 1, 2008, with all meetings to be held in Tallahassee.

The legislation provides the sum of $242,003 in nonrecurring funds to be appropriated from the Insurance Regulatory Trust Fund in the Department of Financial Services for transfer to the EOG for FY 2008-2009 for the purpose of implementing the activities of the Council. The legislation authorizes two full-time equivalent positions to support the Council's activities.

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

CS/SB 2462 — Group Self-Insurance Funds

by Banking and Insurance Committee and Senator Gaetz

Section 624.4621, F.S., allows two or more employers to pool their liabilities under the workers' compensation act and form a group self-insurance fund (fund). The Office of Insurance Regulation (office) regulates these funds, which are subject to requirements primarily intended to address solvency and financial ability to pay claims.

The bill amends current law relating to the process by which group self-insurance funds pay dividends to members. The bill allows the trustees of a fund, established prior to June 1, 2008, to distribute dividends to fund members without prior approval of the office; however, the fund must notify the office within 10 days after the dividend distribution and provide certain information to support the dividend payment. The bill limits the amount of the dividend and prohibits the distribution of dividends if it jeopardizes the financial condition of the fund. Group self-insurance funds established after June 1, 2008 are required to obtain prior approval of the office for the distribution of dividends for the first 7 years of operation.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 40-0; House 117-0

FINANCIAL MATTERS

CS/CS/CS/SB 2158 — Money Services Businesses

by General Government Appropriations Committee; Finance and Tax Committee; and Banking and Insurance Committee)

Money services businesses (MSBs), also known as money transmitters, offer financial services, such as check cashing, money transmittals (wire transfers), sales of monetary instruments, and currency exchange outside the traditional banking environment. This bill incorporates recommendations from a recently released statewide grand jury report, *Check Cashers: A Call for Enforcement* and from the Senate Interim Project 2008-101, *Regulation of Money Services Businesses* designed to enhance the regulation of money services businesses in Florida. The bill provides the following changes.

General Provisions

- Reduces application and renewal fees for part II (money transmitters) and part III (check cashers) licensees by 25 percent.
- Caps branch location and vendor application fees associated with a change in control at $20,000.

- Expands prohibited acts to include violations under 18 U.S.C., sec. 1957, which pertains to engaging in monetary transactions in property derived from specified unlawful activity. This violation would be punishable as a third-degree felony.
- Makes it a violation of state law, subject to administrative sanctions, for a licensee to fail to comply with federal regulations relating to the prevention of money laundering such as maintaining records and preparing reports.
- Authorizes the office to immediately suspend or revoke a license if a licensee fails to provide requested records at the time of an exam.
- Requires licensees to incur the costs of an examination. An examination of a licensee is required at least once every five years. A new licensee is required to be examined within 6 months of licensure. Currently, there is not a statutory schedule and less than 40 percent of licensees have been examined in the last 5 years.
- Requires the office to make referrals of violations of law that may be a felony to the appropriate criminal investigatory agency having jurisdiction.
- Requires the office to adopt disciplinary rules concerning violations of the law.
- Requires the office to submit an annual report to the Legislature summarizing its activities relating to the regulation of ch. 560, F.S., entities, including examinations, investigations, referrals and the disposition of such referrals.

Money Transmitter Provisions

- Requires a money transmitter to be organized as a limited liability company, limited liability partnership, or a corporation to assist in the determination of net worth requirements.
- Creates a definition for net worth and increases the maximum net worth requirements to $2 million. The net worth requirement per location is reduced from $50,000 to $10,000.
- Requires all licensees to submit annual audited financial reports that are used to determine whether net worth and other safety and soundness requirements are met.

Check Casher Provisions

- Exempts from licensure a check casher that engages in a check cashing transaction that is less than $2,000 per person per day and for whom the check cashing compensation at each location does not exceed 5 percent of the total gross income of the retail business for the prior 60 days. Currently, the law provides that a person is engaged in check cashing which is incidental to its retail business if the check cashing compensation at each location does not exceed 5 percent of the total gross income of the retail business for the prior year.

- Requires a customer to present an acceptable identification and provide a thumbprint for checks greater than $1,000.
- Increases security at licensed check cashing locations by requiring the installation of security cameras or bullet-proof glass.
- Requires check cashers subject to licensure to submit suspicious activity reports (SARs) to the federal government, when applicable.

Deferred Presentment Provider Provisions:

- Requires a deferred presentment provider to notify the office within 15 business days after ceasing operations. The bill authorizes the Financial Services Commission to adopt rules regarding the reconciliation of open transactions.
- Prohibits a deferred presentment provider from accepting more than one check to collect on a deferred presentment transaction for a single transaction.
- Prohibits a deferred presentment provider from assessing the costs of collection, other than charges for insufficient funds as allowed by law, without a judgment from a court of competent jurisdiction. This same provision is also added to s. 560.309, F.S., relating to check cashers.

If approved by the Governor, these provisions take effect January 1, 2009.
Vote: Senate 39-0; House 119-0

CS/CSHB 343 — Financial Services

by Policy and Budget Council; Jobs and Entrepreneurship Council; and Rep. Carroll and others (CS/CS/SB 818 by General Government Appropriations Committee; Banking and Insurance Committee; and Senator Bennett)

The bill addresses a number of issues related to banking, insurance, and financial instruments, as follows.

- Authorizes the sale of optional guaranteed asset protection (GAP) products by motor vehicle installment sellers, sales finance companies, retail lessors and their assignees, and establishes requirements for the sale of such products. The creditor selling the GAP product agrees to waive the customer's liability for some or all of the amount by which the debt exceeds the value of the collateral. The seller of GAP coverage may not require its purchase as a condition for making a loan. In order to offer a GAP product, the seller of the GAP product must comply with specified statutory consumer protection requirements.

- Defines "debt cancellation product," specifies that such products may be sold by financial institutions (banks, credit unions, etc.) and their subsidiaries and other business entities authorized by law, and states that it is not insurance for purposes of the Florida Insurance Code. A creditor selling a debt cancellation product agrees to cancel or suspend all or part of a customer's obligation to make payments upon the occurrence of specified events, including guaranteed asset protection contracts and other debt cancellation or suspension agreements. Financial institutions are required to manage risks associated with debt cancellation products prudently, and to establish and maintain effective risk management and control programs regarding such products. A financial institution may not require the purchase of a debt cancellation product as a condition for making the loan, line of credit, or loan extension.
- Defines insurance purchased by a creditor for its financial debt cancellation products as a form of casualty insurance.
- Eliminates the $50,000 limit on insurance that may be procured on the life of a debtor under a debtor group contract, or pursuant to a credit life insurance policy. Instead, the limit is the amount of the person's indebtedness to the creditor. The bill also allows the term of credit disability insurance to extend for the term of the indebtedness, rather than the current 10-year time limitation.
- Specifies that a deposit or account made in the name of two persons who are husband and wife is considered a tenancy by the entirety unless otherwise specified in writing.
- Raises the minimum proposed capitalization for any proposed bank to $8 million and deletes the differing capitalization for banks in metropolitan areas and those in rural counties. The bill also raises the minimum total capital accounts at opening for a trust company from $2 million to $3 million and sets differing capitalization standards for banks owned by single-bank holding companies and banks owned by multi-bank holding companies.
- Eliminates the need for a bank or trust company to obtain approval from the Office of Financial Regulation (OFR) in order to increase its capital. However, a state bank or trust company must notify the OFR in writing 15 days before increasing its capital stock. The bill deletes the prohibition against a bank or trust company issuing capital stock with over a $100 par value. It states a financial institution may not issue or sell stock of the same class which creates different rights, options, warrants, or benefits among the purchasers or stockholders of that class of stock. However, the financial institution may create uniform restrictions on the transfer of stock as permitted in s. 607.0627, F.S.
- Deletes the current prohibition against a bank or trust company issuing capital stock that has a par value greater than $100, thus giving these institutions more flexibility.
- Clarifies who can assert dissenter's rights pursuant to the approval of the sale of stock by a state bank or trust company. The fair value of the shares of stock will be determined

using the procedures in s. 607.1326, F.S., and s. 607.1331, F.S. – the same as is applied to corporations.

- Allows state-mandated endowments that are funded by a general appropriation act prior to 1990 to maintain funds in trust accounts in financial institutions.

If approved by the Governor, these provisions take effect October 1, 2008.
Vote: Senate 40-0; House 115-0

CS/HB 643 — Foreclosure Fraud

by Jobs and Entrepreneurial Council and Rep. Ford and others (CS/CS/SB 992 by Judiciary Committee; Banking and Insurance Committee; and Senators Fasano, Gaetz, Atwater, Lynn, and Baker)

With the increasing number of foreclosures in Florida and nationwide, a significant number of schemes have appeared that are allegedly designed to rescue or save a homeowner from foreclosure. Unscrupulous businesses have targeted and defrauded homeowners of the equity in their homes. Often the specific details of these arrangements are not explained or adequately disclosed to the homeowner.

The bill provides additional protections to such homeowners facing foreclosure. The bill defines and addresses transactions involving foreclosure-rescue consultants and equity purchasers-two of the main types of foreclosure-rescue schemes.

Foreclosure-Rescue Consultants

- Defines the term, "foreclosure-rescue consultant" as a person who directly or indirectly makes a solicitation, representation, or offer to a homeowner to provide or perform, in return for payment of money or other valuable consideration, foreclosure related rescue services. The bill provides exceptions.
- Requires a foreclosure-rescue consultant to have a signed agreement before initiating or engaging in any services. Certain disclosures are required to be in the agreement. A homeowner is allowed one business day to review the agreement before signing, and a homeowner must receive a copy of the signed agreement within three hours of signing the agreement.
- Prohibits a foreclosure rescue-consultant from soliciting, charging, or receiving fees for such services until all services contained in the agreement have been completely performed.
- Allows the homeowner the right to cancel an agreement within three business days of signing without penalty. This right may not be waived by either party. In the event of

cancellation, any payments made to a consultant are returned to the homeowner within 10 business days of cancellation notice.

Equity Purchasers

- Defines the term "equity purchaser," as any person who acquires title to any residential real property as a result of a foreclosure-rescue transaction.
- Requires a foreclosure-rescue transaction written agreement to contain certain disclosures including any option or right to repurchase the property in foreclosure.
- Requires at the time the written agreement is signed, the purchaser must give a homeowner a notice of the homeowner's right to cancel the transaction. A homeowner may cancel a transaction within 3 business days without penalty. This right to cancel may not be waived or limited by either party.
- Requires that, in the event of cancellation, any payments made by an equity purchaser to the homeowner or by the homeowner to the equity purchaser must be returned at cancellation.
- Provides that the homeowner has a 30-day right to cure any default of the contract with the purchaser, and this right may be exercised on at least three separate occasions during the life of the agreement.
- Requires that, if the homeowner has the right to repurchase the property, the purchaser must verify and demonstrate that the homeowner has a reasonable ability to make the repurchase payment. A rebuttable presumption arises that the homeowner has a reasonable ability to make the payments if the monthly payments and interest payments on other personal debt do not exceed 60 percent of the homeowner's monthly gross income.
- Provides that the price the homeowner pays may not be unconscionable. A rebuttable presumption arises that the transaction was unconscionable if the repurchase price is greater than 17 percent per annum more than the total amount paid by the equity purchaser to acquire, improve, and maintain the property.
- Provides that any foreclosure-rescue transaction involving a lease option or other repurchase agreement creates a rebuttable presumption that the transaction is a loan transaction and the conveyance from the homeowner to the equity purchaser is a mortgage under s. 697.01, F.S.
- Provides that a violation of any provision of this act is an unfair and deceptive trade practice. Violators are subject to the penalties and remedies provided in ch. 501, part II, F.S., including a monetary penalty not to exceed $15,000 per violation.

If approved by the Governor, these provisions take effect October 1, 2008.
Vote: Senate 38-0; House 113-0

CS/SB 966 — Automated Teller Machine Transactions

by Commerce Committee and Senators Alexander and Lynn

The bill authorizes an owner or operator of an automated teller machine (ATM) in Florida to charge a fee or surcharge to a customer who is accessing funds from that ATM. The fee or surcharge must be disclosed in compliance with federal Regulation E. The bill provides that an agreement to operate or share an ATM may not "prohibit, limit, or restrict" the right of the owner or operator to charge an access fee or surcharge not otherwise prohibited under state or federal law to a customer conducting a transaction using an account from an international banking corporation.

If approved by the Governor, these provisions take effect July 1, 2008.
Vote: Senate 37-0; House 118-0

SB 874 — Title Loans/Regulation/Consumers

by Senator Fasano

In 2000, the Legislature enacted the Florida Title Loan Act, which established a regulatory framework for title loan transactions. A title loan is a transaction in which a loan of money is made with the title to a motor vehicle offered as security. Physical possession of the motor vehicle is maintained by the borrower, and the motor vehicle title is held by the lender. This legislation was in response to title loan lenders making high interest loans to consumers.

In recent years, litigation has arisen regarding the application of the Florida Title Loan Act to commercial transactions, such as financing floor planning or inventory purchases for independent used car dealers. This bill amends the scope of the act by providing that this act applies to the regulation of title loans made to consumers. The term "consumer" is defined to mean an individual borrowing money for personal, family, or household purposes.

If approved by the Governor, these provisions take effect July 1, 2008.
Vote: Senate 39-0; House 115-0

MISCELLANEOUS

CS/HB 727 — Firesafety/Structure Markings

By the Jobs and Entrepreneurship Council and Rep. Gibson and others (SB 1554 by Senators Wise and Lynn)

This bill provides that the act may be cited as the "Aldridge/Benge Firefighter Safety Act." The bill requires that structures using light-frame truss-type construction must be marked to warn

persons conducting fire control and other emergency operations of the existence of such construction, due to danger of collapse. The State Fire Marshal is provided with rulemaking authority, and local fire officials and the State Fire Marshal are authorized to enforce the signage provision.

The State Fire Marshal is directed to study the use of managed, facilities-based voice over Internet protocol telephone service for monitoring fire alarm signals. If the study determines that the voice over Internet protocol telephone service provides a level of protection equal to that required in the National Fire Alarm Code, the State Fire Marshal must begin rulemaking by December 1, 2008, to allow the use of the technology as an additional method of monitoring fire alarm systems.

The bill further provides that notwithstanding other provisions of law to the contrary, nursing homes licensed under ch. 400, part II, F.S., must be protected throughout by approved automatic sprinkler systems by December 31, 2010. The bill eliminates the requirements that an approved system be installed in each hazardous area of a nursing home by December 31, 2008. After July 1, 2009, the State Fire Marshal may not accept applications for participation in the State Fire Marshal Nursing Home Fire Protection Loan Guarantee Program. A nursing home licensee must submit complete sprinkler construction documents to the Agency for Health Care Administration for review by December 31, 2008, and the licensee must have final agency approval by June 30, 2009, to begin construction. Exceptions are provided for nursing home licensees if the construction documents are contingent upon approval of an application for the loan guarantee program.

If approved by the Governor, these provisions take effect July 1, 2008.
Vote: Senate 38-0; House 118-0

CS/CS/SB 2264 — Motor Vehicle Warranty Associations

by Banking and Insurance Committee; Commerce Committee; and Senator Lawson

The bill makes several changes to ch. 634, F.S., which governs the regulation of warranty associations, including motor vehicle service agreement companies and service warranty associations.

- Creates a definition of "motor vehicle manufacturer" that includes the subsidiaries and affiliates of an automobile manufacturer. It further defines "subsidiary" as used in this context.
- Exempts motor vehicle manufacturers from complying with certain financial solvency requirements that are required of other companies selling automobile service warranties. However, motor vehicle manufacturers still would be required to file forms and rates, comply with the unfair trade practices statutes, and be subject to other provisions in this chapter and regulation by the Office of Insurance Regulation (OIR).

- Exempts motor vehicle manufacturers from submitting fingerprinting or background information for anyone except those serving as officers or directors of the applicant entity.
- Gives the OIR the authority to develop by rule an abbreviated form for statistical reporting of sales of service agreements sold by motor vehicle manufacturers. Therefore, motor vehicle manufacturers will be required to file the abbreviated form instead of submitting the detailed financial report required by current Florida law.
- Specifies that the warranty register required in s. 634.4165, F.S., of warranty associations selling service warranties for consumer products (which are not motor vehicle service agreements or home warranties) must include the name and address of warranty holders, to the extent that the warranty holders provide that information.
- Requires that service warranty companies provide an alternate means for consumers to submit their name and address such as online registration, postcard remittance, or other methods acceptable to the OIR.
- Adds to the existing list of what constitutes an unfair or deceptive claim settlement practice by a service warranty association. The bill prohibits a service warranty association from denying a claim solely because it was unable to confirm that a customer in fact purchased a warranty, because the association did not collect the customer's name and address.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 39-0; House 117-0

HB 1037 — Escrow Agents

by Jobs and Entrepreneurship Council and Rep. Poppell and others (SB 2272 by Banking and Insurance Committee and Senator Posey)

The bill restricts unauthorized individuals from transacting business using the term "escrow" unless authorized under state law. The parties who are authorized to act as an "escrow agent," and are thus exempt from the requirements of this bill include:

- A financial institution as defined in s. 655.005, F.S.;
- An attorney who is a member of The Florida Bar or his or her law firm;
- A real estate broker who is licensed pursuant to chapter 475, F.S., or his or her brokerage firm; or
- A title insurance agent who is licensed pursuant to s. 626.8417, F.S., a title insurance agency that is licensed pursuant to s. 626.8418, F.S., or a title insurer who is authorized to transact business in this state pursuant to s. 624.401, F.S.

A willful violation is a first degree misdemeanor. The bill creates a cause of action for a person aggrieved by violation of the section. The bill provides for recovery of actual damages plus attorney fees and court costs.

If approved by the Governor, these provisions take effect July 1, 2008
Vote: Senate 40-0; House 117-0