DEPARTMENT OF BANKING AND FINANCE

CS/HB 57 — Unlawful Sales of Securities

by Financial Services Committee, Rep. Green and others (SB 300 by Senator Sebesta)

This bill (Chapter 2000-123, L.O.F.) narrows the scope of violations by a securities dealer that would allow for purchasers to rescind the purchase. The bill limits the scope of violations to a violation of s. 517.12 (1), (4), (5), (9), (11), (13), (16), or (18), F.S. The bill provides that a sale made in violation of the provisions of s. 517.12(11), F.S., relating to the failure to renew a branch office registration or the failure of a securities dealer, investment advisor, associated person or branch office to file a change of address amendment pursuant to s. 517.12(13), F.S., would not be subject to recission by the purchaser.

Currently, any violation of s. 517.12, F.S., allows a purchaser to rescind the transaction. This includes a sale by a dealer or associated person who is not registered with the Department of Banking and Finance, but it also includes sale by a securities dealer who has failed to timely renew his or her registration and certain other violations of ministerial sections.

These provisions became law upon approval by the Governor on April 24, 2000.
Vote: Senate 39-0; House 116-0

SB 156 — Funeral and Cemetery Services

by Senator Klein

This bill revises provisions relating to the regulation of cemeteries and the sale of preneed funeral and burial contracts, by the Department of Banking and Finance and the Board of Funeral and Cemetery Services, pursuant to ch. 497, F.S.

The bill increases the annual renewal fees for cemetery licenses and for certificates of authority for persons selling preneed funeral and burial contracts, for those entities exceeding certain sales thresholds. However, the bill also eliminates examination fees for both such entities, other than for travel and per diem expenses incurred by the department for examinations outside the state. The increased annual revenue from licensure renewal fees, estimated to be $212,050, is offset by the decreased revenue of ($212,044) from

elimination of examination fees, resulting in a negligible impact on the Department of Banking and Finance Regulatory Trust Fund.

The bill also: (1) defines the term "religious institution" and substitutes that term for "church" and "synagogue" to provide consistent word usage in sections that provide exemptions from regulation; (2) allows the department or the board to adopt rules allowing for the electronic submission of documents or fees, and to accept a certification of compliance with the chapter, rather than submission of actual documents; (3) sets the application fee at $500 for an initial certificate of authority for selling preneed funeral contracts which currently may not exceed $500; and (4) increases from $5 to $10, the maximum per contract fee that may be set by the board that certificateholders must pay into the Regulatory Trust Fund, currently set at $4.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 39-0; House 110-0

CS/HB 439 — Public Records-Certified Capital Companies

by Governmental Operations Committee and Rep. Crow (CS/SB 1872 by Banking & Insurance Committee and Senator Sullivan)

Certified capital companies (CAPCOs) are statutorily authorized entities under s. 288.99, F.S., which are designed to provide venture capital for investment in new and expanding Florida businesses. The main function of a CAPCO requires the writing of investment contracts and complex structuring of investments with private sector businesses whose financial and tax records are generally not open to the public for competitive reasons. Additionally, the personal financial records of the principals of such companies are also generally protected under the private sector corporate veil.

This bill amends s. 288.99, F.S., to provide an exemption from public records requirements under s. 119.07, F.S., and s. 24(a), Art. I of the State Constitution, for any information relating to an investigation or review of a CAPCO by the Department of Banking and Finance, including consumer complaints, until the investigation or review is complete or ceases to be active. However, certain information remains confidential and exempt even after the investigation is complete or ceases to be active under specified circumstances. The provisions of the bill allow the department to provide this confidential information to law enforcement or administrative agencies in connection with their official duties. It exempts personal information relating to departmental investigatory personnel and their families under certain conditions. It also exempts the social security numbers of customers, complainants, and other persons involved in a CAPCO.

The bill provides broad authority for confidentiality of information provided to the department which is only given to the department on a confidential basis. It further

provides, with certain exceptions, that confidential information offered in evidence at any administrative, civil or criminal proceeding may remain confidential if the presiding officer makes such determination. The bill additionally grants a privilege against civil liability to persons in regard to information or evidence furnished to the department, unless such persons act in bad faith.

The bill provides that it is subject to the Open Government Sunset Review Act and shall stand repealed on October 2, 2005, unless reviewed and saved from repeal through reenactment by the Legislature. Finally, the bill provides a public necessity statement outlining the reasons for the exemptions and confidentiality.

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

HB 1139 — Consumer Finance

by Rep. Littlefield (CS/SB 2028 by Banking & Insurance Committee and Senator Grant)

This bill (Chapter 2000-127, L.O.F.) authorizes a consumer finance lender licensed under ch. 516, F.S., to charge a maximum fee of $10 for a consumer loan payment in default for not less than 10 days, if the charge is agreed upon, in writing, between the parties before imposing the charge.

The bill also transfers the disclosure requirement relating to the number and the amount of each payment and date of first payment from the separate itemized document to the written contract to conform to federal disclosure requirements.

The Department of Banking and Finance licenses and regulates consumer finance (ch. 516, F.S.) and retail installment sales (ch. 520, F.S.), which includes motor vehicle sales finance and installment sales finance. A late charge, or delinquent fee, is authorized for the late payment on a retail installment loan made under the provisions of ch. 520, F.S. Under current law, ch. 516, F.S., does not expressly provide for an assessment of a late charge for an account that is delinquent.

These provisions were approved by the Governor and take effect July 1, 2000.
Vote: Senate 39-0; House 115-1

DEPARTMENT OF INSURANCE/TREASURY

HB 1115 — Bail Bond Premiums

by Rep. Bense (CS/SB 1560 by Banking & Insurance Committee and Senator Horne)

This bill (Chapter 2000-126, L.O.F.) revises Florida's reporting requirements for bail bond insurers by requiring such insurers to report bail bond premiums on their financial statements net of premiums retained by bail bond agents. However, the direct written premiums for bail bonds cannot be less than 6.5 percent of the total consideration received by the agent for bail bonds written by the agent. As a result of the passage of this bill, Florida bail bond insurers will be able to write more bail bond insurance, similar to the limits imposed on insurers domiciled in other states.

Presently, Florida law requires insurers to submit financial statements with the Department of Insurance to aid the department in monitoring the solvency of insurers. The manner in which financial information is compiled and reported is determined by the state in which the insurer is domiciled. Therefore, foreign insurers writing business in Florida compile financial reports in accordance with the law of their home state.

Under current Florida law, insurers writing bail bond insurance are required to report to the department the gross amount of premiums written, including the premium retained by the bail bond agent, which can be as much as 90 percent of the premium collected on bail bonds. This is a reflection of the amount of risk retained and work performed by the bail bond agent in the transaction of bail bond business. Insurers writing bail bonds are not liable to pay the amount of a bail bond unless the defendant does not appear for judicial proceedings and the bail bond agent is unable to pay the bail amount.

Florida domestic bail bond insurers have been at a competitive disadvantage compared to some other states. Currently, a Florida insurer may report higher premiums than other insurers writing the same business. Florida insurers report premiums on a gross basis while foreign insurers in some other states are permitted to report premiums minus commissions retained by the bail bond agent. Domestic bail bond insurers, whether doing business in Florida or in other states, would exceed state premium-to-surplus ratio limits sooner than insurers from several other states. Therefore, Florida bail bond insurers presently are not able to write as much bail bond business as similarly situated insurers domiciled in other states.

This bill also specifies that the reporting or payment of insurance premium taxes under ss. 624.509, 624.5091, and 624.5092, F.S., and the insurance premium tax and related excise taxes would continue to be calculated using gross bail bond premiums. The bill requires domestic insurers writing premiums for bail bonds to disclose additional premium information, specifically, the amount of bail bond premiums included on the

surety line of the annual statement, in the notes to the financial statement of the insurer's annual statement filed with the department.

If approved by the Governor, these provisions take effect October 1, 2000, and apply to premiums written for calendar year 2000 and thereafter.
Vote: Senate 39-0; House 116-0

CS/SB 1956 — Viatical Settlements

by Banking & Insurance Committee and Senators Lee and Geller

In 1996, the Florida Legislature created the Viatical Settlement Act (ss. 626.991-626.993, F.S.) to establish the framework for regulating the viatical industry by the Department of Insurance. Under current law, a viatical settlement contract is a written agreement under which the owner of a life insurance policy who has a terminal illness ("viator") sells the policy to another person in exchange for a bargained-for payment, which is generally less than the expected death benefit under the policy. The amount paid to the policy owner depends on the person's life expectancy and market forces. The person who buys the policy from the original policy owner takes over premium payments, and, upon the death of the original policy owner, collects the death benefit under the policy.

Presently, there is no statutory authorization for the department to regulate what are termed "life settlement" agreements. These agreements involve the sale of life insurance policies for other insureds, usually senior citizens who no longer have a need for life insurance and who do not meet the definition of a viator under present law because they do not have a life threatening illness.

In February 2000, the Fifteenth Statewide Grand Jury released its report on the viatical industry. In its report, the Grand Jury identified various fraudulent activities occurring in the industry and made recommendations for legislative changes, many of which are included in this bill.

This bill amends numerous provisions of the Viatical Settlement Act to provide for the following:

- Expands viatical settlement regulation by the Department of Insurance to cover "life settlements" in that it provides for the sale of policies that insure individuals who do not have a catastrophic or life threatening illness or condition;
- Increases criminal penalties for specified unlawful acts which are based on the value of the life insurance policy;
- Provides timely written disclosures to viatical settlement purchasers (investors) by viatical settlement providers;

- Allows a viatical settlement purchaser to void a viatical settlement purchase agreement at anytime within 3 days after receipt of disclosures;
- Clarifies the regulation of viatical settlement agreements and contracts involving Florida residents and residents of other states;
- Allows for a 2-year contestability period for viaticated policies which provides that a viatical settlement contract would be void and unenforceable if it is entered into within the 2-year period from the date the policy was issued and provides for certain exceptions;
- Provides that during the 2-year contestability period, if a viatical settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider must notify the insured of such transfer or change within 20 days after the transfer in ownership of change in beneficiary. Alternatively, if the owner of the policy is not the insured, the provider shall notify the insured that the policy is the subject of a viatical settlement contract within 20 days after the transfer of rights under the contract. Further, the bill requires providers to notify insurance companies within 20 days of any agreement to viaticate the policy or 20 days after the viator transfers the policy, that a life insurance policy has or will become a viaticated policy;
- Requires licensees to maintain books and contracts at a specified location and requires such information to be made available to the department;
- Mandates that certain viatical transaction forms be submitted to the department for approval;
- Requires viatical settlement providers and brokers to file viatical anti-fraud plans with the Fraud Division within the department by December 1, 2000;
- Authorizes department regulation over viatical settlement transactions relating to administrative remedies, unauthorized insurers, and criminal investigations; and
- Provides a grace period for unlicensed viatical settlement providers or brokers to become licensed.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 40-0; House 113-0

CS/SB 2130 — Public Deposits

by Banking & Insurance Committee and Senator Rossin

The Treasurer is responsible for keeping all state funds and securities and investing excess funds in qualified public depositories. The Treasurer is also responsible for establishing qualifications in order to designate banks and savings and loan associations as qualified public depositories, pursuant to ch. 280, F.S. A qualified public depository is required to collateralize a specified portion of the public monies on deposit so that the designated portion of the public deposits is immediately available should the need arise. Effective October 1, 1998, legislation was enacted, relating to the Uniform Commercial Code, which affected the Treasurer's security interest in pledged collateral held.

The Department of Banking and Finance is responsible for regulating state banks or associations with trust departments and trust companies under the provisions of ch. 660, F.S. However, every trust company and every state or national bank or state or federal association having trust powers is required to provide the Treasurer with a security deposit or pledge of security.

The bill changes provisions relating to the qualified public depository program and security deposits by trust companies and banks and associations with trust powers as follows:

- Revises the qualified public deposit program to add specific language to the collateral agreements used in the program in order for the Treasurer to have a priority perfected security interest in the collateral pledged, in accordance with changes enacted in the Uniform Commercial Code. In addition, the bill identifies triggering events which allow the Treasurer to assert that a default has occurred under the collateral agreement and to direct the custodian to deposit or transfer the collateral.

- Provides two additional requirements designed to better protect the public deposit program. Each qualified public depository is required to have a minimum of $100,000 collateral. Also, 20 percent additional collateral is required if the qualified public depository, due to hardship reasons, cannot price their portfolio on the last day of the month. This provision allows the Treasury to have adequate collateral pledged without the qualified public depository having to incur the expense of an additional pricing.

- Eliminates Federal Home Loan Bank time deposits and negotiable certificates of deposit as acceptable collateral types. The Federal Home Loan Bank time deposits are eliminated because the Treasurer is unable to perfect the security interest. Negotiable certificates of deposit are eliminated because it is unused collateral type and causes confusion with the nonnegotiable certificates of deposit that are not eligible as collateral.

- Excludes Federal Reserve banks from the standard collateral agreement, due to unacceptable provisions (including liability for the state and the waiver of sovereign rights) and establishes the possibility of entering into a separate agreement, with the approval of the Treasurer, that may require terms that are not consistent with qualified public depository program.

- Requires a trust company, bank, or association to provide the Treasurer with the following written information: (1) the full legal name of the entity; (2) the employer identification number; (3) the principal place of business; and (4) the amount of capital stock and amount of required collateral.

- Limits the security deposit or pledge for each trust company, bank or association having trust powers to $500,000. Currently, if an entity with trust powers has its principal place of business in Florida the security requirement may not exceed $500,000. Generally, an entity that does not have its principal place of business in Florida must provide a security deposit or pledge in the amount of 25 percent of the issued and outstanding capital stock.

- Authorizes each trust company, bank, or association as pledgor, with the approval of the Treasurer to deposit eligible collateral with a custodian. The custodian must not be affiliated or related to the trust company, bank, or association.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 39-0; House 117-0

HEALTH INSURANCE/HEALTH MAINTENANCE ORGANIZATIONS

CS/CS/CS/SB 414 — State Group Health Insurance Program and Prescription Drug Program

by Fiscal Policy Committee; Governmental Oversight & Productivity Committee; Banking & Insurance Committee; and Senators Mitchell, Clary, Rossin, McKay, and Latvala

This bill provides that it is the Legislature's intent to expand the eligibility of state group health insurance and state employees' prescription drug coverage program to include small municipalities, small counties, and district school boards of small counties. A small county is defined to mean a county with a population of 100,000 or less and a small municipality is defined to mean a municipality with a population of 12,500 or less. Any costs or savings associated with the expansion of the state group health insurance program or the state employees' prescription drug coverage program would be passed on to the local government participants.

The Department of Management Services is required to contract with a third party to conduct an actuarial study to evaluate the costs of allowing such local governments to participate in the state group health insurance program and the prescription drug coverage program. The study will identify the costs based on the impact to the state, state officers and employees, and local government participants. The department is required to submit a report to the President of the Senate, Speaker of the House of Representatives, and the Governor by December 1, 2000. For purposes of conducting the study, a minimum

enrollment of 3 years and a minimum of 12 months notice prior to withdrawing from the program must be considered for the eligibility of local governments to enroll.

The Department of Management Services is also required to request from the Internal Revenue Service, by October 1, 2000, a written determination letter and a favorable private letter ruling stating that the State Group Self-Insurance Program is a facially qualified plan. The department is required to notify the President of the Senate and the Speaker of the House of Representatives within 30 days of receipt of a favorable or unfavorable ruling letter from the Internal Revenue Service.

The bill also revises the provisions relating to the state group health insurance dental program, to provide that any solicitation or contract made after July 1, 2001, must include a comprehensive indemnity dental plan option which offers enrollees an unrestricted choice of dentists.

If approved by the Governor, these provisions take effect upon becoming law, except that section 1 will take effect July 1, 2001.
Vote: Senate 37-0; House 119-0

SB 828 — Insurance/Medicare Supplement Policy

by Senator Grant

This bill redefines the term, "Medicare supplement policy," for purposes of the Florida Medicare Supplement Reform Act, (ss. 627.671 - 627.675, F.S.) to exclude from regulation under part VIII of ch. 627, F.S., a policy or plan of one or more labor organizations, or trustees of a fund established by labor organizations for employees or former employees, or members or former members. Policies issued in Florida are still subject to other provisions of the Insurance Code. Such policies or plans issued outside of Florida which cover Florida residents are exempt from any regulation by the Florida Department of Insurance. The bill changes the Florida definition of "Medicare supplement policy" to more closely follow the federal definition contained in 42 U.S.C. 1395ss, subpart (g)(1) and the National Association of Insurance Commissioners (NAIC) model law and regulations, except that federal law and the NAIC also exclude policies issued by employer groups from the definition of Medicare supplement policy.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 39-0; House 111-0

CS/SB 1300 — Employee Health Care Access Act

by Banking & Insurance Committee and Senator Holzendorf

The current Employee Health Care Access Act in s. 627.6699, F.S., requires insurers in the small group market to guarantee the issue of coverage to any small employer with 1 to 50 employees, including sole proprietors and self-employed individuals, regardless of their health condition. Rates for such policies must be established on a "modified community rating" basis, which prohibits consideration of health status or claims experience, and allows only age, gender, geographic location, tobacco usage, and family composition (size) to be used as rating factors.

This bill makes the following changes:

1. Eliminates the prohibition that rates not be based on the health status or claims experience of any individual or group and allows limited use of such factors. Small group carriers are allowed to adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium may be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these additional factors.

2. Deletes the guaranteed-issue requirements for employers with one employee, sole proprietors, and self-employed individuals and, instead, provides for an annual open enrollment period for such persons, during the month of August. Coverage would begin on October 1, unless the insurer and the policyholder agree to a different date. Any one-person small employer getting coverage must not be formed primarily for the purposes of buying health insurance and if an individual hires his or her spouse and dependent children as employees, the entire family unit would be considered a one-person group, unless both spouses are working full-time. (Although this bill provides for the 1-month open enrollment to begin in August 2000, another bill, CS/CS/HB 591, delays the implementation of this provision until August 2001, and continues to provide for guaranteed-issue of one life groups until such time.)

3. Allows small group carriers to provide a credit to reflect the administrative and acquisition expense savings resulting from the size of the group. This is expected to result in about a 3 to 5 percent credit for larger groups (for example, 25 to 50 employees), and be transferred as an overall cost increase to the smaller groups.

4. Prohibits small group carriers from using "composite rating" for employers with fewer than 10 employees, which would prohibit a premium statement to an employer that averages the rates for all employees and, instead, would require the

carrier to list the rate applicable to each employee based on that employee's age and gender. (But, the total premium remains unchanged.)

5. Specifies certain family-size categories that small group carriers may use.

6. Clarifies the applicability of additional rate filing procedures and standards for insurers and HMOs, respectively.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 40-0; House 112-5

CS/CS/CS/SB 1508 and CS/SB's 706 & 2234 — Managed Care Organizations

by Fiscal Policy Committee; Health, Aging & Long-Term Care Committee; Banking & Insurance Committee; and Senators Brown-Waite, Laurent, and Saunders

The 1999 Florida Legislature authorized the Director of the Agency for Health Care Administration (AHCA or "the agency") to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. The Advisory Group issued its report and recommendations on February 1, 2000. The bill makes the following changes, based on these recommendations and subsequent discussions among the bill sponsors and affected parties:

1. The bill requires health maintenance organizations (HMOs) to pay a claim for treatment if a provider follows the HMO's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider submitted information to the HMO with the intent to misinform the HMO. The bill also requires HMOs to pay a hospital-service claim or referral-service claim for treatment of an eligible subscriber which was authorized by a provider empowered by contract with the HMO to authorize or direct the patient's utilization of health care services and that was also authorized in accordance with the HMO's current and communicated procedures, unless the physician provided information to the HMO with the willful intention to misinform the HMO.

2. The Statewide Provider and Managed Care Organization Claim Dispute Resolution Program is created. The agency must contract with an independent third-party claims dispute resolution organization to recommend to the agency an appropriate resolution of disputes between a managed care organization and providers with regard to claim disputes in violation of the prompt payment statute, s. 641.3155, F.S., subject to a final agency.

The bill prohibits the claims dispute resolution organization from hearing any claim that is subject to a binding claims dispute resolution process provided by contract entered into prior to October 1, 2000, between the provider and the managed care organization. Contracts entered into or renewed on or after October 1, 2000, may require exhaustion of an internal dispute-resolution process as a prerequisite to the submission of a claim by a provider or HMO to the resolution organization. Other exclusions include claims related to interest payments, claims that do not meet the jurisdictional thresholds established by AHCA rule, disputes based on any action that is pending in state or federal court, and claims related to Medicare and Medicaid. A provider or HMO would not be permitted to file a claim dispute with the resolution organization more than 12 months after a final determination has been made on a claim by an HMO.

The agency would be required to adopt rules to establish a process for the consideration by the resolution organization of claims disputes, which must include the issuance of a written recommendation to AHCA, supported by findings of fact, within 60 days after receipt of the claims dispute submission. Within 30 days after receipt of the recommendation of the resolution organization, AHCA must issue a final order. The bill does not specify the allowable scope of the recommendations by the review organization, other than to recommend "an appropriate resolution of the dispute." The bill also does not specify what actions or penalties may be ordered by AHCA against either the managed care entity or the provider.

The entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule which must include an apportionment of the fee in those cases where both parties may prevail in part.

3. HMOs are required to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending by the HMO unless the requesting provider contractually agrees to take a pending or tracking number.

4. The bill clarifies the "balance billing" provisions, transferring related provisions from s. 641.315, F.S., to newly created s. 641.3154, F.S., and: (1) prohibiting a provider from collecting or attempting to collect from a subscriber any money for services authorized by an HMO when the provider in good faith knows or should know that the HMO is liable for payment of fees for services, (subject to the presumption in the paragraph, below); (2) prohibiting a provider from billing the subscriber during the pendency of any claim for payment and during any legal or dispute resolution process; (3) prohibiting a provider from reporting a subscriber to a credit agency for unpaid claims due from an HMO; (4) specifying that these

prohibitions apply to both contracted and noncontracted providers rendering covered services; and (5) requiring HMOs and the Department of Insurance to refer violations by physicians and facilities to the appropriate regulatory agency for final disciplinary action.

A presumption is created that a provider does not know and should not know that an organization is liable, *unless* one of the following three conditions exists: (1) the provider is informed by the HMO that it accepts liability; (2) a court determines that the HMO is liable; or (3) the Department of Insurance or AHCA makes a final determination that the HMO is required to pay for such services subsequent to a recommendation made by the Statewide Provider and Subscriber Assistance Panel.

5. The requirements of s. 641.3155, F.S., related to payment of provider claims by HMOs (often referred to as the "prompt pay" requirements) are applied to claims made by either contracted *or noncontracted* providers. The requirement for an HMO to pay claims within 35 days of receipt, would be limited to a "clean claim" or any portion of a clean claim filed by a provider. "Clean claim" is defined by reference to specific claim forms, which definition is repealed when a definition is adopted by rule by the Department of Insurance, which must be consistent with federal standards required by the federal Health Care Financing Administration.

   The bill clarifies that the current 10 percent annual simple interest penalty on a claim against an HMO begins to accrue on the 36th day after the clean claim has been received, and requires that the interest be payable with the payment of the claim. With regard to the current law requirement that an HMO pay or deny a claim within 120 days after receiving the claim, the bill provides that an HMO's failure to meet this deadline imposes an uncontestable obligation on the HMO to pay the claim.

   The bill amends s. 641.3155(5), F.S., to require an HMO to file a claim against a provider for an overpayment and prohibits the HMO from reducing payment to the provider, unless the provider agrees to the reduction or fails to respond to the HMO's claim within specified time frames. The time frames and requirements in subsection (5) that apply to HMO claims against providers, mirror the time frames and requirements that apply to provider claims against HMOs provided in subsections (2)-(4).

   Both provider claims and HMO claims for overpayment are deemed to be *received* when receipt is verified electronically, if the claim is electronically transmitted, or, if the claim is mailed to the address disclosed by the HMO, on the date indicated on the return receipt. An HMO and a provider may agree to other

methods of transmission and receipt of claims. Providers and HMOs are required to wait 45 days after receipt of a claim, by the other party, before submitting a duplicate claim. Providers who bill electronically are entitled to electronic acknowledgment of receipts of claims within 72 hours.

An HMO is prohibited from retroactively denying a claim due to subscriber ineligibility more than 1 year after the date of payment of the clean claim.

6. The bill prohibits as an unfair claim settlement practice, an HMO committing or performing with such frequency as to indicate a general business practice, systematic downcoding with the intent to deny reimbursement otherwise due.

7. The bill authorizes AHCA to impose fines against hospitals and other regulated facilities for a violation of the "balance billing" prohibitions of s. 641.3154, F.S., or a violation of s. 641.3155(5), F.S., related to payment of claims for overpayment made by an HMO, if sufficient claims do not exist to enable the take-back of an overpayment. Maximum fines are the same maximum fines that AHCA may impose against HMOs for violation of any provision of part III of ch. 641, F.S.

8. In addition to any other provision of law, systematic upcoding by a provider, with the intent to obtain reimbursement otherwise not due from an insurer is punishable by fines in the same amounts as the fines that may be imposed against an HMO for a violation of ch. 641, F.S.

9. The bill amends the current criminal fraud statute which currently makes it a second degree misdemeanor for a person to fraudulently obtain goods or services from a hospital, to also cover the fraudulent obtaining of goods or services from any "provider," as defined in the HMO laws in s. 641.19(15), F.S.

10. The amount of $38,928 is appropriated from the Health Care Trust Fund and one position to the Agency for Health Care Administration for the purposes of carrying out the provisions of the act during the FY 2000-2001.

If approved by the Governor, these provisions take effect October 1, 2000.
Vote: Senate 39-0; House 115-0

CS/SB 2086 — Small Employer Health Alliances

by Banking & Insurance Committee and Senator King

This bill repeals the laws that establish the Community Health Purchasing Alliances (CHPAs) in ss. 408.70-408.706, F.S. In 1993, the Florida Legislature established CHPAs as state-chartered, nonprofit private organizations, intended to pool purchasers of health care together in organizations that broker health plans. The number of persons insured through CHPAs has steadily decreased from about 94,000 at the end of 1998 to about 35,000 in February 2000. Only seven insurance carriers are currently actively participating in CHPAs, as compared to 25 carriers that participated in 1998.

This bill authorizes a health insurer to issue a group policy to a small employer health alliance organized as a not-for-profit corporation under chapter 617, F.S. This would include former CHPAs that continue to operate as a not-for-profit corporation, or any other alliance so organized. The alliance may be formed for purposes of obtaining insurance. Currently, s. 627.654, F.S., authorizes a group policy to be issued to an association or labor union, which has a constitution and bylaws, has at least 25 members, and which has been organized and maintained in good faith for a period of 1 year for purposes *other* than that of obtaining insurance.

The group policy issued to the alliance may insure a small employer, as defined in s. 627.6699, F.S., which is an employer with 1 to 50 employees, including sole proprietors and self-employed individuals. The policy may cover the employer's eligible employees and the spouses and dependents of such employees.

This bill amends s. 627.6699, F.S., to: (1) allow rates for a policy issued to an alliance or association to reflect a premium credit for expense savings attributable to administrative activities being performed by the group association; (2) allow an insurer to modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers; and (3) delete the provision that allows carriers that participate in CHPAs to apply a different community rate to business written in that program.

An insurer issuing a group health insurance policy to an alliance or other group association must allow any of its licensed and appointed agents to sell that policy and to pay the agent the insurer's usual and customary commission paid to any agent selling the policy.

If approved by the Governor, these provisions take effect October 1, 2000.
Vote: Senate 40-0; House 118-0

CS/HB 2339 — Comprehensive Health Care (Patient Protection Act of 2000)

by General Appropriations Committee, Rep. Feeney and others (CS/CS/CS/SB 2154, CS/SB 1900, and SB 282 by Fiscal Policy Committee; Health, Aging & Long-Term Care Committee; Banking & Insurance Committee; and Senators Latvala, Brown-Waite, Silver, Geller, Kurth, Dawson, Klein, and Cowin)

This bill is designated the Patient Protection Act of 2000 (in Section 1) and contains the following provisions:

Certificate of Need (Sections 2-15 and 59)

The bill amends the Certificate of Need (CON) statutes by identifying additional types of projects subject to *expedited* rather than *competitive* CON review. These projects include conversion of mental health services beds or hospital-based distinct part skilled nursing unit beds to acute care beds, conversion between or among the categories of mental health services beds, and conversion of acute care beds to mental health services beds.

Additionally, certain projects that are currently subject to expedited review are made subject to the minimal level of review under CON regulation, that is, *exemption* review. These include combination within one nursing home of the beds authorized by two or more CONs within the same planning subdistrict; division into two or more nursing homes in the same planning subdistrict of the beds authorized by a CON. The bill, also, creates some new exemption-level review projects:

1. Addition of hospital beds in a number not to exceed 10 beds or 10 percent of the licensed capacity of the service being expanded, except beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, and provided there was a prior 12-month occupancy of at least 80 percent in that service or at least 96 percent for hospital-based distinct part skilled nursing units.

2. Addition of temporary acute care hospital beds, as authorized by AHCA's administrative rules that are consistent with the hospital licensure law, in a number not exceeding 10 beds or 10 percent of the licensed bed capacity, whichever is greater, in a hospital that has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.

3. Addition of nursing home beds in a number not exceeding 10 beds or 10 percent of the licensed capacity of beds at the nursing home, whichever is greater, provided that the facility has been designated a Gold Seal nursing home, pursuant

to s. 400.235, F.S., and there was a prior 12-month occupancy of at least 96 percent.

4. Establishment of a specialty hospital offering a range of medical service restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county. (However, see section 69 of CS/HB 591, passed by the Legislature after this bill, which provides that notwithstanding any provision to the contrary contained in CS/HB 2339, the establishment of a specialty hospital offering a range of medical services restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county, is not exempt from the provisions of s. 408.036(1), F.S.)

CON oversight is eliminated by this bill for provision of respite care, expenditure for outpatient services, Medicare certified home health agencies, acquisitions, and cost overruns. The bill also provides a significant reduction and clarification of the review criteria used to evaluate applications for a CON and removes other obsolete provisions.

The bill creates a CON workgroup consisting of 30 members appointed by the Governor, the President of the Senate, and the Speaker of the House of Representatives, to include representatives from health care provider organizations, health care facilities, individual health care practitioners, local health councils, consumer organizations, and persons with health care market expertise as a private-sector consultant. The workgroup is to study issues pertaining to the CON program, including the impact of trends in health care delivery and financing. The workgroup is to submit an interim report by December 31, 2001, and a final report by December 31, 2002. The workgroup is abolished on July 1, 2003.

Public Medical Assistance Trust Fund (Sections 16-17 and 20-22)

The bill reduces from 1.5 percent to 1.0 percent the assessment on the portion of hospitals' net operating revenues generated by outpatient services, and for the assessment on ambulatory surgical centers, clinical laboratories, and diagnostic imaging centers. In order to prevent the loss of federal matching funds, the bill requires the Legislature to appropriate in each fiscal year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Fund sufficient funds to replace the revenue lost from reducing these assessments. This bill appropriates $28.3 million from the General Revenue Fund to the Agency for Health Care Administration to implement

the provisions relating to the Public Medical Assistance Trust Fund; provided however, that no portion of the appropriation shall become effective if a duplicative appropriation in another bill becomes law.

Medicaid and MedAccess (Sections 18-19 and 47-59)

The bill addresses a number of different Medicaid topics and related budget issues, including increasing the annual adult hospital outpatient services cap from $1,000 to $1,500; providing for a children's hospital disproportionate share program; authorizing the Department of Children and Family Services to transfer funds to the Agency for Health Care Administration (AHCA) to cover state match requirements exceeding the amount specified in the General Appropriations Act for targeted case management services; providing greater authority to AHCA to deny a Medicaid provider agreement and to set surety bond requirements for Medicaid providers; directing AHCA to submit a Medicaid waiver request for a pilot project specific to adult ventilator dependent patients; authorizing developmental research schools to participate in the Medicaid certified school match program; designating the Department of Children and Family Services as the agency responsible for Medicaid eligibility determinations for Supplemental Security Income recipients, including rulemaking authority; providing for the ongoing adjustment in optional state supplementation based on the federal benefits rate, rather than re-authorizing such adjustments in each year's General Appropriations Act; and providing that funds that are appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver and are not expended shall be transferred to AHCA to fund Medicaid-reimbursed nursing home care.

The bill repeals s. 409.912(4)(b), F.S., relating to AHCA's ability to contract for prepaid health care services with entities that provide only Medicaid services on a prepaid basis, and which are exempt from ch. 641, part I, F.S.

The bill increases the annual reimbursement limit from $1,000 to $1,500 on hospital outpatient services for persons receiving health care services through the MedAccess Program.

The bill provides authority for the Agency for Health Care Administration to contract with an entity in Pasco or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases, in order to test the cost-effectiveness of enhanced home-based medical care. The reimbursement for such services must be at a rate not less than comparable Medicare rates. The agency is authorized to apply for any federal waivers necessary to implement the program. The program will be repealed on July 1, 2002.

Hospitalists (Sections 23-25)

The bill amends ss. 641.31, 641.315, and 641.3155, F.S., to address the use of "hospitalists" by health maintenance organizations (HMOs):

- Provides that an HMO contract may not prohibit or restrict a subscriber from receiving in-patient services in a contracted hospital from a contracted primary care or admitting physician.

- Prohibits a contract between an HMO and a contracted primary care or admitting physician from containing any provision prohibiting such physician from providing inpatient services in a contracted hospital to a subscriber.

- Requires an HMO to pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted hospital to a subscriber.

In order for these provisions to apply, inpatient services must be determined by the HMO to be medically necessary and covered services under the organization's contract with the contract holder. These provisions apply to provider contracts entered into or renewed on or after July 1, 2000.

Adverse Determinations by Health Maintenance Organizations (Section 26)

The bill requires health maintenance organizations (HMOs) to ensure that only a medical or osteopathic physician licensed in Florida or who has an active, unencumbered license in another state with similar licensing requirements, may render an adverse determination regarding services provided by a Florida-licensed physician.

The HMO must submit to the treating provider and the subscriber written notification regarding the HMO's adverse determination within 2 working days after the subscriber or provider is notified of the adverse determination. The written notification must: (1) identify the physician making the adverse determination, (2) include the utilization review criteria or benefits provisions on which the adverse determination is based, (3) be signed by either the physician who renders the adverse determination or by an authorized representative of the HMO, and (4) include information about the appeal process for challenging adverse determinations.

Reducing Racial and Ethnic Health Disparities (Sections 27-32)

The bill creates s. 381.7351, F.S., creating the "Reducing Racial and Ethnic Health Disparities: Closing the Gap Act," consisting of newly created ss. 381.7351-381.7356, F.S. The bill provides legislative findings and intent that recognizes that certain racial and ethnic populations in Florida continue to have significantly poor health outcomes, and acknowledges that local governments and communities are best equipped to identify the health education, health promotion, and disease prevention needs of the racial and ethnic populations in those communities, and to mobilize the community to address these disparities and evaluate the effectiveness of the outcomes. The bill provides for administration of a grant program (program) by the Department of Health and authorizes the appointment of an ad hoc advisory committee. The bill provides criteria and procedures for awarding grants to local individuals, entities, and organizations to address the disparities in racial and ethnic health outcomes. It requires local matching funds, allows for in-kind contributions based on county population, and provides for dissemination of 1-year grant awards beginning no later than January 1, 2001, subject to specific appropriation and annual applications for grant renewal.

Florida Commission on Excellence in Health Care (Sections 33 and 61)

This bill creates the Florida Commission on Excellence in Health Care based on the proposal by the Department of Health and the Agency for Health Care Administration to facilitate the development of a comprehensive statewide strategy for improving health care delivery systems through meaningful reporting standards, data collection and review, and quality measurement. The Commission will also study whether the current practitioner and facility regulatory systems are effective in promoting patient safety. A report to the Legislature is due no later than February 1, 2001.

The Commission will be jointly chaired by the Secretary of the Department of Health and the Executive Director of the Agency for Health Care Administration. Membership on the Commission includes representatives from all facets of health care, including the regulatory boards and agencies, health care practitioner trade associations, health facility trade organizations, managed care organizations, risk management organizations, health care lawyer organizations, professional liability insurance industry, consumer advocacy organizations, and the Legislature. The Commission will be staffed by employees of the Department of Health and the Agency for Health Care Administration. The Commission is terminated June 1, 2001.

The bill appropriates $91,000 in nonrecurring general revenue from the General Revenue Fund to the Department of Health to cover the costs of the Commission relating to travel, consultants, and reproduction and dissemination of documents; provided that no duplicate appropriation becomes law.

Small Employer Health Alliance (Sections 34-43, 46, and 60)

The bill repeals the laws that establish the Community Health Purchasing Alliances (CHPAs) in ss. 408.70-408.706, F.S. In 1993, the Florida Legislature established CHPAs as state-chartered, nonprofit private organizations, intended to pool purchasers of health care together in organizations that broker health plans. The number of persons insured through CHPAs has steadily decreased from about 94,000 at the end of 1998 to about 35,000 in February 2000. Only seven insurance carriers are currently actively participating in CHPAs, as compared to 25 carriers that participated in 1998.

The bill authorizes a health insurer to issue a group policy to a small employer health alliance organized as a not-for-profit corporation under ch. 617, F.S. This would include former CHPAs that continue to operate as a not-for-profit corporation, or any other alliance so organized. The alliance may be formed for purposes of obtaining insurance. Currently, s. 627.654, F.S., authorizes a group policy to be issued to an association or labor union, which has a constitution and bylaws, has at least 25 members, and which has been organized and maintained in good faith for a period of 1 year for purposes *other* than that of obtaining insurance.

The group policy issued to the alliance may insure a small employer, as defined in s. 627.6699, F.S., which is an employer with 1 to 50 employees, including sole proprietors and self-employed individuals. The policy may cover the employer's eligible employees and the spouses and dependents of such employees.

The bill amends s. 627.6699, F.S., to: (1) allow rates for a policy issued to an alliance or association to reflect a premium credit for expense savings attributable to administrative activities being performed by the group association; (2) allow an insurer to modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers; (3) delete the provision that allows carriers that participate in CHPAs to apply a different community rate to business written in that program; and (4) requires a carrier issuing a group health insurance policy to an alliance or other group association to allow any of its licensed and appointed agents to sell that policy and to pay the agent the insurer's usual and customary commission paid to any agent selling the policy.

Conforming changes are made to s. 240.2995, F.S., relating to university health services support organizations, s. 240.2996, F.S., providing for confidentiality of information held by university health services support organizations, s. 240.512, F.S., establishing the H. Lee Moffitt Cancer Center and Research Institute, s. 381.0406, F.S., providing for rural health networks, s. 395.3035, F.S., relating to confidentiality of certain hospital records and meetings, and s. 627.4301, F.S., relating to genetic information for insurance purposes, to delete cross-references to sections that are repealed by section 60 of the bill.

The bill amends s. 408.7056, F.S., relating to the Statewide Provider and Subscriber Assistance Program, to move the definitions of the terms "agency," "department," "grievance procedure," and "health care provider" from s. 408.701, F.S., which is repealed. Additionally, ss. 240.2996, 240.512, and 395.3035, F.S., providing for exemptions from the public records laws, are amended to add a definition of *managed care*, which is the same definition that is in s. 408.701, F.S., which is repealed.

HMO Subscriber Protections and Consumer Assistance Notice (Sections 44- 45)

The bill creates s. 641.185, F.S., to provide standards to be followed by the Department of Insurance and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules relating to health maintenance organizations. For this purpose, the bill summarizes various statutory requirements that apply to HMOs related to ensuring that subscribers are rendered quality care from a broad panel of providers, including referrals and emergency care; assurance that the HMO has been independently accredited by a national review organization and is financially secure; that a subscriber should receive continuity of health care after the provider is no longer with the HMO; that a subscriber should receive information regarding reimbursement to providers; that a subscriber should have the flexibility to transfer to another HMO regardless of health status; and various other subscriber protections afforded by current statutes. The bill specifies that this section does not create a cause of action against a health maintenance organization by a patient or health care provider.

The bill creates s. 641.511(11), F.S., to require health care providers who contract with health maintenance organizations to post a consumer notice in the reception area of the provider which provides the addresses and telephone numbers of the Agency for Health Care Administration, the Statewide Provider and Subscriber Assistance Program, and the Department of Insurance. The bill requires the provider to include in the notice that the addresses and telephone numbers of the grievance department of the organization will be provided upon request. Rulemaking authority is granted to the Agency for Health Care Administration to implement this section.

Employee Health Care Access Act (Small Group Rating and Guarantee-Issue) (Section 46)

The current Employee Health Care Access Act in s. 627.6699, F.S., requires insurers in the small group market to guarantee the issue of coverage to any small employer with 1 to 50 employees, including sole proprietors and self-employed individuals, regardless of their health condition. Rates for such policies must be established on a "modified community rating" basis, which prohibits consideration of health status or claims

experience, and allows only age, gender, geographic location, tobacco usage, and family composition (size) to be used as rating factors.

The bill makes the following changes:

- Eliminates the prohibition that rates not be based on the health status or claims experience of any individual or group and allows limited use of such factors. Small group carriers would be allowed to adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium could be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these additional factors.

- Deletes the guaranteed-issue requirements for employers with one employee, sole proprietors, and self-employed individuals and, instead, provides for an annual open enrollment period for such persons, during the month of August. Coverage would begin on October 1, unless the insurer and the policyholder agree to a different date. Any one-person small employer getting coverage must not be formed primarily for the purposes of buying health insurance and if an individual hires his or her spouse and dependent children as employees, the entire family unit would be considered a one-person group, unless both spouses are working full-time. (See, CS/HB 591, passed by the Legislature subsequent to this bill, which continues guarantee-issue for one-life groups through July 2001 and begins the 30-day annual open enrollment in August 2001.)

- Allows small group carriers to provide a credit to reflect the administrative and acquisition expense savings resulting from the size of the group. This is expected to result in about a 3 to 5 percent credit for larger groups (for example, 25 to 50 employees), and be transferred as an overall cost increase to the smaller groups.

- Prohibits small group carriers from using "composite rating" for employers with fewer than 10 employees, which would prohibit a premium statement to an employer that averages the rates for all employees and, instead, would require the carrier to list the rate applicable to each employee based on that employee's age and gender. (But, the total premium remains unchanged.)

- Specifies certain family-size categories that a small group carriers may use.

- Clarifies the applicability of additional rate filing procedure and standards for insurers and HMOs, respectively.

(See additional changes to s. 627.6699, F.S., related to the Small Employer Health Alliance, above.)

Mandated Benefits Study (Section 62)

The bill appropriates $200,000 from the Insurance Commissioner's Regulatory Trust Fund to the Office of Legislative Services for the purpose of implementing the legislative intent expressed in s. 624.215(1) for a systematic review of current mandated health coverages. The review would consist of an assessment of the impact of current mandated coverages using the guidelines provided in s. 624.215(2), F.S. The assessment shall also establish the aggregate cost of mandated health coverages. (See, CS/HB 591, passed by the Legislature subsequent to this bill, which specifies that notwithstanding any other provision of law, the $200,000 appropriation is for a review of proposed, rather than current, mandated benefits, and which specifies that the term "mandated coverage" does not include health care providers.)

Appropriation to AHCA (Section 63)

The bill provides that the General Appropriations Act for FY 2000-2001 shall be reduced by 4 full-time equivalent positions and $260,719 from the Health Care Trust Fund in the Agency for Health Care Administration for purposes of implementing the provisions of this act; provided however, that the reductions shall not be effective if duplicate or similar reductions also become law.

If approved by the Governor, these provisions take effect July 1, 2000, except as otherwise provided.
Vote: Senate 23-15; House 108-8

INSURANCE AGENTS/ADJUSTERS

CS/SB 106 — Insurance Policy Sales and Delivery Procedures

by Banking & Insurance Committee and Senator Mitchell

This bill amends several sections of the Insurance Code which relate to the resident agent and countersignature provisions (s. 624.426, F.S.), the use of a credit card under the unfair competition and deceptive acts law (s. 626.9541, F.S.), and the provisions relating to motor vehicle insurance contracts (s. 627.7295, F.S.).

Resident Agent and Countersignature Law

The bill provides an exception to the current requirement that any policy of property, casualty, or surety insurance covering a subject of insurance located or to be performed in Florida, must be countersigned by a licensed agent who is a Florida resident. Under the exception, insurance policies could be issued by insurers whose agents represent, as to

property, casualty, and surety insurance, only one company or group of companies under common ownership and for which a Florida resident agent is the agent of record and the application has been lawfully submitted to the insurer. Therefore, this exception to the countersignature law would not apply to policies sold by insurers that use independent agents who sell policies for various companies.

Unfair Methods of Competition and Unfair or Deceptive Acts

The bill revises the criteria under which property and casualty insurance may be sold through the use of a credit card. Under the unfair competition and deceptive acts law, there is a general prohibition against any person soliciting any insurance, accepting any applications for insurance, or receiving any premiums for insurance relative to a subject of insurance resident, located, or to be performed in Florida through a credit card facility or organization, for the purpose of insuring credit card holders. However, the current law also has certain exceptions. One exception is that this prohibition does not apply as to health insurance or to credit life, credit disability, or credit property insurance. Another exception is that such insurance may be sold through a credit facility if: (a) the insurance is noncancelable by any person other than the named insured, the policyholder, or the insurer; (b) any refund or unearned premium is made directly to the credit card holder; and (c) the credit card transaction is authorized by the signature of the credit card holder or other person authorized to sign on the credit card account.

This bill provides that the condition specified in (c), above, does not apply to property and casualty insurance so long as the transaction is authorized by the insured. This would allow for verbal authorization (over the telephone, for example) rather than written authorization as currently required.

Motor Vehicle Insurance Contracts

The bill provides an exception to the requirement of making a down payment equal to at least 2 months' premium for motor vehicle insurance. The exception would apply if an insured or family member has previously purchased and has in effect a policy of private passenger motor vehicle insurance, and purchases either additional coverage or adds coverage for an additional vehicle, with such coverage written by the same insurer or a member of the same insurer group.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 40-0; House 115-3

CS/HB 785 — Insurance Commission Sharing

by Insurance Committee and Rep. Sublette (CS/SB 314 by Banking & Insurance Committee and Senator Rossin)

This bill amends s. 320.771, F.S., which would prohibit a recreational vehicle dealer or broker who is not a licensed insurance agent from sharing insurance commissions on recreational vehicle insurance by forming a foreign corporation, partnership, or entity which is controlled by a person who is not licensed as an insurance agent. The effect of this bill would create a prohibition against nonresident agents sharing commissions with Florida recreational vehicle dealers or brokers by forming a foreign corporation, partnership, or entity which is controlled by a person not licensed as an insurance agent. The provisions of the bill would be enforced by the Department of Insurance.

Under current law, insurance agents are prohibited from sharing commissions "with any corporation unless such corporation is an insurance agency" (s. 626.753, F.S.).

If approved by the Governor, these provisions take effect October 1, 2000.
Vote: Senate 39-0; House 103-0

SB 2150 — Insurance Agents-Continuing Education

by Senator Holzendorf

This bill amends s. 626.2815, F.S., and provides that licensed insurance agents who earn continuing education (CE) requirements by completing an independent study program that is presented through interactive, on-line technology would not be required to take a monitored examination. Specifically, subject to the approval by the Department of Insurance, if the on-line independent study course has "sufficient internal testing" to judge the comprehension of the student, the exam would not be required to be monitored. Under this provision, licensed agents would have the opportunity to complete education requirements at a time convenient to them, without having to arrange time to sit for a monitored examination.

Under current law, most licensed insurance agents are required to complete 28 hours of continuing education (CE) courses every 2 years as a requirement for retaining their state license. Continuing education courses are subject to approval by the Department of Insurance and may be completed either through classroom instruction or independent study. Any CE course that is completed through an independent study program must conclude with a monitored examination.

If approved by the Governor, these provisions take effect July 1, 2000.
Vote: Senate 39-0; House 117-0

INSURANCE/GENERAL

CS/HB 215 — Stock and Mutual Insurance Companies

by Insurance Committee and Rep. Tullis (CS/SB 182 by Banking & Insurance Committee and Senator Diaz-Balart)

This bill prescribes the factors that directors of a domestic insurance company and a domestic mutual insurance holding company may consider in carrying out their duties. It also authorizes a mutual insurance holding company to merge or consolidate with a foreign mutual insurance company and with other entities. Each of these provisions is described in more detail, below.

The bill amends s. 628.231, F.S., relating to directors of a domestic insurance company, to prescribe the factors that the directors may consider in carrying out their duties. Some of the standards that are listed are substantially the same as the standards that currently apply to the directors of a for-profit Florida corporation, as specified in s. 607.0830(3), F.S. These standards allow the directors to consider such factors as they consider to be relevant, including the long-term prospects and interests of the corporation and its shareholders and the social, economic, legal, or other effects of any action on the employees, suppliers, or policyholders of the corporation or its subsidiaries, the communities and society in which the corporation or its subsidiaries operate, and the economy of the state and nation. The bill makes these standards applicable to the directors of domestic nonprofit mutual insurers, as well as domestic (for profit) stock insurers. The bill also amends s. 628.723, F.S., to prescribe that these same factors may be considered by the directors of a mutual insurance holding company in carrying out their duties.

The bill *adds* standards for directors of a domestic insurer and for directors of a domestic mutual insurance holding company that are *not* standards that currently apply to Florida corporations in s. 627.080, F.S. These added standards allow the directors to also consider the short-term and long-term interests of the insurer, including benefits that may accrue to the insurer from its long-term plans, and the possibility that these interests may be best served by the continued independence of the insurer; the resources, intent, and conduct, past, stated, and potential, of any person seeking to acquire control of the insurer; and any other relevant factors. Since these standards do not apply to Florida corporations generally, they would be uniquely applied to the directors of Florida domestic insurance companies, both stock and mutual, and to directors of a Florida domestic mutual insurance holding company.

The broad nature of the factors may enable the directors to reject an offer by an outside party to acquire the insurer. The directors would be less likely to be liable to stockholders (or policyholders, in the case of a mutual insurer), by rejecting an offer that may be in the best interests of the stockholders (or policyholders), based on other factors that the law would allow the directors to consider.

In 1997, Florida law authorized a new form of domestic insurance corporate organization known as a "mutual insurance holding company." The creation of this corporate form provided an alternative method for a domestic mutual (policyholder-owned) insurance company to convert into a stock (stockholder-owned) insurance company. (ss. 628.701-628.733, F.S.)

At this time, one former mutual insurance company has converted into a mutual insurance holding company, the FCCI Mutual Insurance Holding Company, which has a stock insurance company subsidiary, the FCCI Insurance Company (and an intermediate holding company between these two companies). This domestic insurer is the state's leading writer of workers' compensation insurance.

Converting into a stock insurer significantly enhances an insurer's ability to raise capital, issue debt, and engage in mergers and acquisitions. Prior to 1997, the law allowed a domestic mutual insurance company to convert into a stock insurance company, which remains an option under current law. (s. 628.441, F.S.) This requires approval by the Department of Insurance and requires that the policyholders receive a distribution of cash or stock upon the conversion of the mutual insurer into a stock insurer. A mutual insurance company may alternatively convert into a mutual insurance holding company with a stock insurance company subsidiary, subject to the approval of the department. The policyholders of the former domestic mutual insurance company are not entitled to any distribution of cash or stock upon the conversion, but they become owner-members of the mutual holding company and are insured by the subsidiary stock insurer (and are entitled to a distribution of cash or stock upon liquidation of the holding company).

The bill amends s. 628.715, F.S., relating to mergers and acquisitions involving mutual insurance holding companies. The bill would allow a *mutual insurance holding company* to merge or consolidate with, or acquire the assets of, a *foreign mutual insurance company* which redomesticates to Florida pursuant to s. 628.520, F.S. The members of the foreign mutual insurance company would be authorized to approve in a contemporaneous vote both the redomestication plan and the agreement for merger and reorganization.

The current law allows a mutual insurance holding company to "acquire the assets" of a foreign or domestic mutual insurance company. But, acquiring the assets of a mutual insurer is legally different than a merger or consolidation. Acquiring the assets involves a

purchase or buy-out of another insurer, while a merger or consolidation involves shared ownership and restructuring of the ownership interest of the two entities, which in the case of two mutual insurers are the ownership interests of the policyholders.

The bill also allows a mutual insurance holding company to merge or consolidate with, or acquire the assets of, a domestic or foreign reciprocal insurance company, a group self-insurance fund, or any other similar entity.

The bill authorizes the Department of Insurance to retain outside consultants to evaluate each merger, for which the domestic mutual insurance holding company would be required to pay reasonable costs. The department must approve the merger unless it finds that the merger would be inequitable to the policyholders of any domestic insurance company involved in the merger or to the members of any domestic mutual holding company involved in the merger, or if the merger would substantially reduce the security of and service to be rendered to policyholders of a domestic insurance company.

The bill creates s. 628.730, F.S., to also allow a mutual insurance holding company to merge into its intermediate holding company, subject to approval by the department. The surviving intermediate holding company must assume all of the assets and liabilities of the mutual insurance holding company. All of the stock of the intermediate holding company owned by the mutual insurance holding company must be distributed to existing persons who were members of the mutual insurance holding company at any time within the 3-year period preceding the date of the merger. The mutual insurance holding company may, immediately prior to the merger, sell or cause the intermediate holding company to sell to the public up to 25 percent of the voting stock of the intermediate holding company.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 38-0; House 117-0

CS/HB 311 — Industrial Insured Captive Insurers

by Insurance Committee and Rep. Waters (CS/SB 930 by Banking & Insurance Committee and Senator Grant)

This bill (Chapter 2000-124, L.O.F.) lowers the thresholds required to qualify as an industrial insured of an industrial insured captive insurer that is licensed in the state prior to December 31, 1999, or a subsidiary formed by that industrial insured captive insurer after December 31, 1999. For such industrial insureds, the required gross assets would be lowered from $50 million to $10 million; the required number of employees for the industrial insured would be lowered from 100 to 25 full-time employees; and the amount of premiums required to be paid by the industrial insured would be lowered from $200,000 to $100,000 aggregate annual premiums paid for all insurance risks. The

industrial insureds of industrial insured captive insurers that are licensed after December 31, 1999, would be required to meet the higher thresholds that are set forth in current law.

Regardless of the date of licensure, an industrial insured captive insurer would be required to maintain unimpaired capital and surplus of at least $20 million.

"Industrial insured captive insurers" are captive insurers which have as their members or stockholders only those industrial insureds which they insure. An "industrial insured" is an insured which has gross assets in excess of $50 million, procures insurance through a full-time employee of the insured who acts as insurance manager, has at least 100 full-time employees, and pays annual insurance premiums of at least $200,000 for each line of insurance or at least $75,000 for any line of coverage in excess of $25 million.

These provisions became law upon approval by the Governor on April 24, 2000.
Vote: Senate 39-0; House 115-0

CS/HB 313 — Payment of Insurance Claims

by Insurance Committee; Rep. Waters and others (SB 892 by Senator King)

This bill (Chapter 2000-113, L.O.F.) amends s. 627.4035, F.S., permitting insurance companies to pay claims through the use of a debit card account or other electronic transfer when the recipient or the recipient's representative approves such a payment in writing. Any fees charged to the recipient for payment by debit card or other form of electronic transfer would be required to be disclosed in writing to the recipient or the recipient's representative at the time of written authorization.

Under present law, insurers are required to pay all claims in cash and electronic transfers and debit card transactions are not expressly included in the class of items considered "cash" within s. 627.4035(3), F.S.

Under this bill, consumers could benefit from the added convenience of receiving claim payments in electronic form. Furthermore, by utilizing the debit card or other electronic transfer system, insurance companies should realize cost savings in the claims payment process through a reduction in the amount of paper that must be used as well as from a reduced incidence of check fraud.

These provisions became law upon approval by the Governor on April 11, 2000.
Vote: Senate 36-0; House 117-0

CS/SB 1226 — Insurance

by Banking & Insurance Committee and Senator Holzendorf

This bill restricts current provisions that require insurers to guarantee the issuance of an individual health insurance policy. In 1997, to comply with the federal Health Insurance Portability and Accountability Act, Florida enacted several provisions, including s. 627.6487, F.S., which guarantees the availability of individual health insurance coverage to individuals with 18 months of certain prior creditable coverage, the most recent of which was group coverage. In 1998, this provision was expanded to include persons whose most recent coverage was under an individual policy, under certain circumstances. The bill specifies that the most recent prior creditable coverage under an individual plan must have been provided in Florida to qualify as creditable coverage for purposes of guaranteed availability of s. 627.6487, F.S.

The bill provides the following changes to the Insurance Code relating to life insurance:

- Modifying the method of calculating the deficiency reserve for renewable term life insurance policies;
- Updating the buyer's guide required to be used by insurers soliciting life insurance business; and
- Authorizing the Department of Insurance to adopt by rule the model rules for the valuation of life insurance policies adopted by the National Association of Insurance Commissioners in March 1999.

In addition, the maximum service charge a general lines agent, insurer, or subsidiary of an insurer may charge to finance insurance premiums on policies is revised to authorize a service charge not exceeding $12 per year for any balance greater than $220. Currently, an agent is authorized to charge $1 per installment for a maximum of $12 per year. If the total premium financing charge or rate of interest exceeds this amount per year, the agent, insurer, or subsidiary of the insurer would be subject to the provisions of part XV, ch. 627, F.S., which authorizes the Department of Insurance to impose penalties for excessive premium finance charges.

The bill authorizes the Division of Risk Management within the Department of Insurance to directly purchase annuities through a structured settlement consulting firm for the purpose of entering into structured settlements and exempts the purchase from the competitive sealed bidding process and proposal requirements.

The bill also creates the Commission for Health Care for the Employee Leasing Industry. The purpose of the commission is to study the availability and affordability of health care and the delivery methods for providing health care. The commission is required to submit a report to the Legislature and the Governor by January 1, 2001. The commission will be

comprised of 2 members of the Senate appointed by the Senate President; 2 members of the House of Representatives appointed by the Speaker of the House of Representatives; 3 members of the employee leasing company industry appointed by the President of the Senate, 3 members of the employee leasing company industry appointed by the Speaker of the House of Representatives; the Treasurer or his designee; and the Secretary of the Department of Business and Professional Regulation or his designee. Staff support will be provided by the Senate Banking and Insurance Committee and the House Insurance Committee.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 38-0; House 117-0

CS/SB 2304 — Reinsurance Credit

by Banking & Insurance Committee and Senator Holzendorf

This bill amends s. 215.555, F.S., relating to the Florida Hurricane Catastrophe Fund and s. 624.610, F.S., relating to credit for reinsurance.

The following changes are made to the Florida Hurricane Catastrophe Fund ("Fund"): (1) The bill corrects an error in the changes that were enacted in 1999 to the method for determining each insurer's recovery from the Fund. The 1999 changes to the law were intended to limit each insurer's maximum recovery, in any 1 year, to its proportionate share of Fund premiums for that year, multiplied by the Fund's claims-paying capacity. However, the language actually provided that this limitation applied if the Fund determines that it will not be able to raise sufficient funds to pay all insurers in full. The bill specifies that this limitation on each insurer's recovery applies in all cases, even if sufficient funds are available to pay all insurers in full. (2) The bill also clarifies that the Fund may provide coverage to insurers assuming liabilities for policies in the Florida Windstorm Underwriting Association or the Florida Residential Property and Casualty Joint Underwriting Association. This clarifies that such coverage is not contrary to the current law's provision that excludes from the definition of "covered policy" any "reinsurance agreement."

The bill amends s. 624.610, F.S., relating to the types of reinsurance that are approved and reinsurers "accredited" in order for an insurer to obtain credit as an asset or a deduction from liability on its accounting and financial statements. These changes bring the Florida statute into closer conformity with the current National Association of Insurance Commissioners Model Act on Credit for Reinsurance. The changes create uniform trust fund language for the three classes of trusts authorized and make consistent the regulatory authority with regard to these trusts. The changes also generally reinforce state action to compel security from alien reinsurers and to enforce state requirements that the claims against insolvent alien insurers be valued and paid in accordance with state

law. It also conforms state law governing Lloyd's of London reinsurance trust funds to the actual operation of the New York trusts as restructured by agreement between the New York Insurance Department and Lloyds in 1995.

If approved by the Governor, these provisions take effect June 1, 2000.
Vote: Senate 39-0; House 117-0

WORKERS' COMPENSATION

SB 2084 — Rulemaking Authority of the Division of Workers' Compensation
by Senator King

This bill revises the Division of Workers' Compensation's (of the Department of Labor and Employment Security) rulemaking authority relating to the financial requirements for self-insured employers and the authority to suspend or revoke authorization for self-insured employers for good cause. The division is authorized to specify by rule the amount of the qualifying security deposit required prior to authorizing an employer to self-insure and the amount of net worth required for an employer to qualify for authorization to self-insure. The bill also authorizes the division to suspend or revoke any authorization to a self-insurer for good cause, as defined by rule by the division.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 37-0; House 117-0

CS/SB 2532 — Workers' Compensation
by Banking & Insurance Committee and Senator Thomas

For purposes of determining the assessment base for the Workers' Compensation Administration Trust Fund (which primarily funds the Division of Workers' Compensation) and the Special Disability Trust Fund (which reimburses carriers for second injuries), the bill clarifies legislative intent for the terms, "net premiums," and "net premiums collected" by stating that the terms have meant and continue to mean premiums arising from workers' compensation policies issued by an insurer in Florida as the primary insurance carrier without a deduction for ceded reinsurance premiums transferred to another carrier for reinsurance purchased or any premium expense attributable to purchasing reinsurance.

The division is required to notify carriers and self-insurers of the Workers' Compensation Administrative Trust Fund assessment rate by July 1 of each year. The calculation for the assessment base is determined based upon the anticipated expenses of the Division of

Workers' Compensation for the next calendar year, instead of the prior fiscal year, effective January 1, 2001. The assessment rate is effective January 1 of the next calendar year and will be included in the workers' compensation rate filings approved by the Department of Insurance which become effective on or after January 1 of the next calendar year.

The bill lowers the maximum assessment rate for the Workers' Compensation Administration Trust Fund from 4 percent to 2.75 percent, effective January 1, 2001. However, during the interim period of July 1, 2000, through December 31, 2000, such assessments cannot exceed 4 percent. For the purpose of calculating the assessment levied after July 1, 2001, carriers are required to use the full premium policy reported prior to the application of deductible discounts or credits. If a carrier excluded ceded reinsurance premiums from its assessments prior to January 1, 2000, the division cannot recover any past underpayments of assessments related to ceded reinsurance premiums prior to January 1, 2001, against such carriers. The division may permit a carrier to remit any underpayment of assessments for assessments levied after January 1, 2001.

For purposes of determining the assessment base for the Special Disability Trust Fund and calculating the assessment due, ceded reinsurance premiums are required to be included. In the event a carrier excluded ceded reinsurance premiums from their Special Disability Trust Fund assessments on or before January 1, 2000, the carrier is not required to pay assessments until the Division of Workers' Compensation notifies the carriers of the impact of including ceded insurance premium on the assessment. The division is not authorized to recover any past underpayments of assessments levied against any carrier that on or before January 1, 2000, excluded ceded reinsurance premiums in the assessments prior to the point in time that the division advises the carrier of the appropriate assessment that should have been paid.

The bill creates a Task Force on Workers' Compensation Administration for the purpose of evaluating the method in which the workers' compensation system is funded and administered. The Task Force is comprised of 3 members appointed by the Governor (including one member serving as the chair), 2 members appointed by the President of Senate, and 2 members appointed by the Speaker of the House of Representatives. A sum of $250,000 is appropriated from the Workers' Compensation Administration Trust Fund to the Executive Office of the Governor to conduct a financial and operational analysis of the Division of Workers' Compensation that is required to be submitted to the Task Force. The Task Force is required to submit their recommendations to the Governor, President of the Senate, and the Speaker of the House of Representatives by January 15, 2001.

The bill also provides that any insurance carrier claiming a deduction for the Workers' Compensation Administration Trust Fund assessment against the amount of any other tax levied by the state upon the premiums, assessments, or policies is not required to pay any

additional retaliatory tax levied pursuant to s. 624.5091, F.S., as a result of claiming such a deduction. Because deductions under this provision are available to carriers, s. 624.5091, F.S., will not limit such deductions in any manner.

The Florida Workers' Compensation Joint Underwriting Association, Inc., (FWCJUA) is the insurer of last resort, or residual market for workers' compensation coverage in Florida. The FWCJUA provides coverage to applicants who are unable to obtain coverage through the voluntary market. Many smaller employers and employers that have experienced a high incident of workplace injuries obtain insurance through the FWCJUA. The bill provides that, if the plan's gross written premiums reported to the Division of Workers' Compensation are less than $30 million, the division is required to transfer to the plan, subject to appropriation by the Legislature, an amount not to exceed the plan's fixed administrative expenses for the preceding year. Fixed administrative expenses are defined to mean the expenses of the plan, not to exceed $750,000, which are directly related to the plan's administration but which do not vary in direct relationship to the amount of premium written by the plan and which do not include loss adjustment premiums. The bill also authorizes the FWCJUA to use policyholder surplus attributable to any year to fund a deficit in the plan.

The bill also provides that, as one of the conditions to become self-insured, an employer is required to provide proof to the Division of Workers' Compensation of the entity's ability to pay compensation individually and on behalf of its subsidiary and affiliated companies with employees in this state. According to the division's application for self-insured employers, currently an employer is required to identify the businesses that will be self-insured. Any wholly-owned subsidiaries may be included and majority-owned businesses may be included if an indemnity agreement is executed. The term, affiliate, does not appear to be used or defined in the application instructions, rules, or ch. 440, F.S.

If approved by the Governor, these provisions take effect July 1, 2000, except as otherwise expressly provided in the act.
Vote: Senate 35-0; House 109-0