HEALTH INSURANCE/HMO'S

CS/SB 836 — Health Insurers and Health Maintenance Organizations

by Banking & Insurance Committee and Senators Crist, Peaden, Wasserman Schultz, Dawson, Campbell, Saunders, and Geller

This committee substitute would prohibit health insurers and health maintenance organizations (HMOs) from requiring contracted health care practitioners to accept the terms of other health care practitioner contracts with the insurer, any other insurer, or any HMO, under common management and control with the insurer or HMO, as a condition of *continuation or renewal* of the contract. Any contract provision that would violate this provision is void. (However, this prohibition would not apply when an insurer or HMO is initially entering into a new contract with a physician.) This provision would apply to Medicare and Medicaid practitioner contracts as well as preferred provider (PPO), and exclusive provider (EPO) practitioner contracts. An exception is provided for a practitioner in a group practice who must accept the terms of a contract negotiated for the practitioner by the group. The bill provides that a violation of the above provision is not subject to the criminal penalty provision under s. 624.15, F.S. That criminal sanction makes any willful violation of the Insurance Code a second degree misdemeanor.

This bill is intended to prohibit the utilization of "all products clause" provisions contained in some insurance and HMO contracts, as a condition of continuation or renewal of a current contract. Health care practitioners object to insurers and HMOs using such clauses because these provisions require practitioners to participate in all of the health plan's current and future health plan products, as a condition of participating in any of the health plan's products.

If approved by the Governor, these provisions take effect July 1, 2001, and shall apply to contracts entered into or renewed on or after that date.
Vote: Senate 38-0; House 115-0

AUTO INSURANCE

CS/CS/SB 1092 — Motor Vehicle Insurance

by Criminal Justice Committee; Banking & Insurance Committee; and Senators Campbell, Crist and Garcia

Under the Florida Motor Vehicle No-Fault law, motor vehicle owners are required to maintain $10,000 of personal injury protection (PIP) coverage. Subject to co-payments and other restrictions, PIP insurance provides compensation for bodily injuries to the insured driver and

passengers regardless of who is at fault in an accident. This coverage also provides the policyholder with immunity from liability for economic damages up to the policy limits and for non-economic damages (pain and suffering) for non-permanent injuries. Property damage liability coverage of $10,000 is also required which pays for the property damage expenses caused by the insured to third parties in the accident.

In September 2000, the Fifteenth Statewide Grand Jury examined fraud relating to PIP insurance and found that PIP fraud consisted of: *1) the illegal solicitation of accident victims for the purpose of filing for PIP benefits and motor vehicle tort claims; 2) brokering patients between doctors, lawyers and diagnostic facilities, as well as attendant fraud, which can include the filing of false claims; 3) billing insurers for treatment not rendered; 4) using phony diagnostic tests or misusing legitimate tests; 5) inflating charges for diagnostic tests or procedures through brokers; and 6) filing fraudulent motor vehicle tort lawsuits.* According to the Grand Jury, "certain people have turned the $10,000 of personal injury protection coverage into their own personal slush fund." The Grand Jury made seven recommendations, five of which are addressed in this bill, while two of the recommendations are addressed in CS/HB 1805 (crash reports). In summary, the five recommendations provide for the following:

- Require regulation and licensure of medical facilities;
- Consider adopting a fee schedule for reimbursement under PIP similar to workers' compensation provisions;
- Provide insurers an additional 30 days to pay PIP claims, at least in instances where the insurer certifies that the claim be reviewed for fraud;
- Make all charges for magnetic resonance imaging (MRIs) unenforceable, unless such charges are billed/collected by 100 percent owner/lessee. This will remove incentives for brokering; and
- Provide that an insurer or PIP accident victim does not have to pay for services rendered by any provider or attorney who has solicited the victim.

This bill addresses the five recommendations in the Grand Jury report and related issues as follows:

- Requires certain clinics to register with the Department of Health and employ or contract with a physician as medical director or a specified health care practitioner as clinical director. Such directors must carry out and be legally responsible for specified responsibilities for the clinic and ensure compliance with record keeping, office surgery, and adverse incident reporting requirements as well as conduct systematic reviews of clinic billings to ensure the billings are not fraudulent or unlawful. Provides for exceptions to clinic registration for specified licensees and entities. Mandates penalties for unregistered clinics, for the disciplining of licensed health care practitioners who

violate certain provisions, and provides that it is a third degree felony for a person to operate or manage an unregistered clinic. Provides that charges or reimbursement claims made by an unregistered clinic are unlawful charges and are noncompensable and unenforceable. Authorizes $100,000 to be appropriated from registration fees collected from clinics to the Department of Health for the purpose of regulating clinics. These funds must be deposited into the Medical Quality Assurance Trust Fund.

- Adds five "medically necessary" diagnostic tests to be subject to the workers' compensation fee schedule (spinal ultrasounds, extremity ultrasounds, video fluoroscopy, surface electromyography, and nerve conduction testing). However, allowable amounts that may be charged to a PIP insurer or insured for medically necessary nerve conduction tests, done in conjunction with a needle electromyography procedure, and performed and billed solely by a specified physician who is especially certified, board recognized, or who holds diplomate status, shall not exceed 200 percent of the allowable amount under Medicare Part B.

- Limits the allowable amounts charged to PIP insurers and insureds after November 1, 2001, for magnetic resonance imaging (MRIs) services to 175 percent of the allowable amount under Medicare Part B, except that allowable amounts for MRIs provided in specified accredited facilities are limited to 200 percent of Medicare Part B. Provides that upon the effective date of the act and before November 1, 2001, allowable amounts that may be charged for MRIs are limited to 200 percent of Medicare Part B. Hospitals are excluded from this provision.

- Provides a definition of "broker" and states that insurance companies or insureds are not required to pay claims made by brokers or by persons making claims on behalf of brokers. Also defines "medically necessary" as used in the motor vehicle no-fault law.

- Provides that an insurer may, in good faith, request of a provider information or documentation as to why a PIP claim was reasonable in amount and medically necessary.

- Clarifies that insurers are not precluded or limited in asserting that a claim was unrelated, not medically necessary, or unreasonable in amount. Such assertion may be made at any time, including after payment of the claim.

- Authorizes that as a condition precedent to filing certain actions for an overdue claim for benefits, the insurer must receive a written notice of the intent to litigate (a "demand letter") containing specified information. This provision allows insurers 7 business days after receipt of a notice to pay the claim, with applicable interest and specified penalty, without being potentially subject to payment of attorney's fees.

- Requires insurers to provide specified information to providers when paying only a portion of a claim or rejecting a claim.

- Creates a civil cause of action to allow insurers to sue a person who, in connection with a claim for PIP benefits, is found guilty of or plead guilty or nolo contendere to specified violations, regardless of adjudication of guilt.

- Provides for specified crimes (insurance fraud, solicitation of persons involved in motor vehicle accidents, and patient brokering) to be ranked under the Criminal Punishment Code so that judges will consider such crimes as to sentencing guidelines. Provides that it is a third degree felony for persons to willfully use accident reports to commercially solicit accident victims.

- Expands immunity from civil liability for individuals reporting insurance fraud to the Department of Insurance.

- Provides that the "spiritual healing" provision does not affect determinations of what other services or procedures are medically necessary.

- Eliminates the medical payments provision which currently requires that medical payment insurance fill the 20 percent PIP co-insurance.

- Changes the interest rate for overdue payments from a fixed rate to the rate established by the Comptroller under s. 55.03, F.S.

- Helps to remedy the current practice of insurers utilizing "paper" independent medical examinations (IMEs) by requiring "valid" reports by experienced physicians or a physical examination by a physician who meets certain active practice criteria. Also provides that such report may not be modified by anyone other than the physician.

- Allows providers up to 75 days under specified conditions to submit a statement of charges to insurance companies.

- Certain changes in the bill take effect as to PIP policies issued or renewed on or after October 1, 2001, which are referenced above. These include: "medically necessary" benefits; "spiritual healing" provision; a "valid" report by a physician; and the repeal of medical payments provision. Changes as to treatments rendered on or after October 1, 2001, which are noted above, include: information insurers must provide when they deny or reduce a claim; the provision that insurers are not limited in asserting the claim was unrelated, not medically necessary; claims made by or on behalf of brokers; the new fee schedules; the time limitations for providers to send in claims; discovery of information by an insurer; and the provision related to demand letters.

If approved by the Governor, these provisions take effect upon becoming law, except as otherwise provided above.
Vote: Senate 39-0; House 108-8

CS/HB 1805 — Public Records/Motor Vehicle Crashes

by Competitive Commerce Council; Insurance Committee; and Rep. Waters and others (CS/SB 1466 by Banking & Insurance Committee and Senators Sanderson and Holzendorf)

In September 2000, the Fifteenth Statewide Grand Jury, in a report on insurance fraud related to personal injury protection (PIP) benefits found that individuals called "runners" pick up copies of motor vehicle crash reports filed with law enforcement agencies and use them to solicit people involved in motor vehicle accidents. The Grand Jury found that access to crash reports provided the ability of such runners, who were employed by unscrupulous attorneys and medical providers, to contact large numbers of potential clients in violation of the prohibition of crash report use for commercial solicitation purposes. In the words of the Grand Jury, "the wholesale availability of these reports is a major contributing factor to this illegal activity and likely the single biggest factor contributing to the high level of illegal solicitation."

The Grand Jury examined crash report fraud and made two recommendations to the Legislature:

- Protect the victims of crimes or accidents by prohibiting the release of accident reports to anyone other than the victim, their insurance company, a radio or television station licensed by the FCC, or a professional journalist. The Grand Jury stated that this would "close the door" to access by solicitors with no legitimate need for the reports.

- Increase the penalty for persons who access crash reports by increasing the violation to a third degree felony.

This bill addresses the Grand Jury's concerns by providing an exemption from the public records requirements for motor vehicle crash reports that reveal personal information concerning parties involved in a vehicular accident. Specifically, the bill provides an exemption from public records provisions (s. 119.07(1), F. S., and s. 24(a), Art. I, State Constitution) for such crash reports which reveal the identity, home or employment telephone number or address, or other personal information of parties involved in an accident, for a period of 60 days from the date the report is filed. However, such reports may be made available to the following persons or entities: parties to the crash, their legal representatives, their insurance agents, their insurers or insurers to which they have applied for coverage, persons under contract with such insurers to provide claims or underwriting information, prosecutorial authorities, radio or television stations licensed by the Federal Communications Commission, newspapers qualified to publish legal notices, and free newspapers. Persons attempting to access crash reports within the 60-day period must present "legitimate credentials or identification" demonstrating their right to access such information. Further, any state or federal agency authorized by law to have access to crash reports must be granted access.

The bill provides that it is a third degree felony for employees of state or local agencies who knowingly disclose crash report information to persons not entitled to access such information as well as for persons who obtain, or attempt to obtain, confidential crash report information who

know they are not entitled to obtain such information. The bill provides a statement of public necessity.

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

WORKERS' COMPENSATION

SB 770 — Workers' Compensation/Law Enforcement

by Senator Crist

This bill amends s. 440.092, F.S., to broaden the circumstances in which law enforcement officers are considered to be acting within the course and scope of employment and, accordingly, covered by workers' compensation by creating an additional statutory exception to the "going and coming" rule. The bill provides that an injury to a law enforcement officer, as defined in s. 943.10(1), F.S., during the officer's work period or while going to or coming from work in an official law enforcement vehicle, shall be presumed to be an injury arising out of and in the course of employment unless the injury occurred during a distinct deviation for a non-essential personal errand. If however, the employer's policy or the collective bargaining agreement that applies to the officer permits such deviations for non-essential errands, the injury shall be presumed to arise out of and in the course of employment.

The bill provides that the Legislature declares that it is a proper and legitimate state purpose to provide workers' compensation coverage to law enforcement officers during work periods and while going to and coming from work in an official law enforcement vehicle. The bill also provides that the Legislature determines that the provisions of this act fulfill an important state interest.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 39-0; House 116-0

CS/HB 1803 — Workers' Compensation

by Competitive Commerce Council; Insurance Committee; and Rep. Waters and others (CS/SB 1926 by Banking & Insurance Committee and Senator King)

The bill eliminates certain reporting requirements for carriers, authorizes outsourcing of certain functions of the Division of Workers' Compensation (division), and provides other changes that are designed to streamline the dispute resolution process and increase the overall efficiency of the administration of the workers' compensation system.

General Provisions

Managed care for the provision of medical treatment for employees is optional, rather than mandatory, for employers and carriers. Carriers are required to give an employee the opportunity for one change of physician during the course of treatment for any one accident.

The bill reestablishes and authorizes carriers to provide a workers' compensation insurance credit for employers that institute a safety program in the workplace, pursuant to the provisions of the rating plan. In addition, the bill establishes specific requirements for public employers relating to the safety program discount. Previously, the Division of Safety was responsible for approving safety programs; however, the division was abolished in 2000.

The bill revises the security deposit requirements for individual self-insured employers by eliminating the use of certificates of deposit and Treasury notes. Currently authorized self-insured employers must comply with the revised qualifying security deposit requirements on or before December 31, 2001, or upon maturity of existing security deposits, whichever occurs later.

The bill amends ss. 489.114, 489.115, 489.510, and 489.515, F.S., to address the conflict in requirements for obtaining a contractor's licensure and an exemption from workers' compensation coverage. Under current law, any person engaged in the business of construction contracting in Florida is required as a *precedent* to the issuance of a certificate to provide to the department evidence of workers' compensation coverage. This creates a conflict since the Division of Workers' Compensation requires an individual engaged in the construction business to submit a copy of their contractor's certificate as a *precedent* to issuing an exemption from coverage. To resolve this conflict, the bill requires the Department of Business and Professional Regulation to issue initial licenses to individuals seeking to engage in the business of contracting if the applicant qualifies for an exemption from coverage and submits an affidavit attesting to the fact that the exemption will be obtained within 30 days of initial licensure. This will provide an exception to the current law's requirement that proof of workers' compensation coverage or an exemption from coverage be submitted prior to obtaining a contractor's license.

The bill also provides that a person who performs services as a sports official for an entity sponsoring interscholastic sports events is an independent contractor, rather than an employee. A person who serves as a sports official as required by a school district is exempted from this provision.

Dispute Resolution Process

The Office of the Judges of Compensation Claims is responsible for hearing and resolving disputed workers' compensation issues under the authority of ch. 440, F.S. The bill transfers the workers' compensation hearings function, as a unit, from the Department of Labor and Employment Security to the Division of Administrative Hearings within the Department of

Management Services. The current number and location of the judges, the mediators, and the district offices of the judges will be maintained. The judges of compensation claims and the Deputy Chief Judge (currently the Chief Judge) will continue to be appointed by the Governor. The Deputy Chief Judge will report to the director of the Division of Administrative Hearings.

The petition for benefits will be filed directly with the Office of the Judges of Compensation Claims. By eliminating the role of the Division of Workers' Compensation as the quasi-clerk for receiving and processing petitions for the Office of Judges of Compensation Claims, it is anticipated that the judges will receive the petitions in a more timely manner.

In addition, the bill provides the following changes to ch. 440, F.S., relating to the appointment and accountability of the judges of compensation claims:

- Authorizes the Director of the Division of Administrative Hearings to investigate complaints against the Deputy Chief Judge and the judges of compensation claims and recommend to the Governor whether a judge should be disciplined or removed.

- Requires the statewide nominating commission to consider certain statutory requirements in evaluating a judge's performance and requires the Office of the Judges of Compensation Claims to collect information from the judges of compensation claims necessary for the commission to conduct its review of the judges' performance.

- Requires the Deputy Chief Judge to submit to the Legislature an annual report regarding the formal dispute resolution process for the prior fiscal year, including workload statistics for the office and a summary of any statutory requirements that the judges are generally unable to meet. Additional reporting requirements relating to the formal dispute resolution process are transferred from the division to the Office of the Judges of Compensation Claims.

- Requires a nominee for a judge's positions to be a member of the Florida Bar for the prior 5 years and experienced in the practice of workers' compensation. In addition to this requirement, a nominee for the Deputy Chief Judge will be required to demonstrate 5 years of administrative experience.

The bill provides the following changes to ch. 440, F.S., relating to the workers' compensation hearings process that are designed to expedite the process:

- Authorizes the Governor to appoint a temporary judge of compensation claims in the event of a vacancy for a period not to exceed 120 successive days.

- Authorizes the judges of compensation claims to dismiss portions of petitions for benefits upon receipt of the petition for benefits if the petition does not specifically identify or itemize certain information required by s. 440.192, F.S. The dismissal of any petition or

any portion of such petition under this provision would be without prejudice and would not require a hearing.

- Requires the judges of compensation claims to issue final orders on the merits of disputed issues within 30 days or closure of the hearing record, unless otherwise agreed upon by the parties.

- Transfers 18 positions from the Division of Workers' Compensation to the Office of the Judges of Compensation Claims to assist the Office in establishing an agency clerk and custodian of records functions internally.

- Eliminates the docketing review by the judges of compensation claims.

- Clarifies when the 120-day investigatory period for payment of claims commences, either 14 days within the receipt of the notice of injury or 120 days from the receipt of the petition. The carrier has a 120-day period after this initial payment of benefits to investigate a claim and admit or deny benefits.

- Revises the 120-day requirement for lump sum settlements in order for the tolling of time to begin when the employer is notified of the injury rather than the date of the injury.

- Eliminates the requirement for a hearing on lump sum settlements under s. 440.20(11)(a), F.S., if legal counsel represents the claimant and all parties agree to forego a hearing.

- Requires the written consent of the client after the first continuance of a final hearing.

- Authorizes the judges of compensation claims to enter an abbreviated final order in cases where compensability is not disputed, with the parties having an option to request separate findings of fact and conclusions of law. This change would assist the judges in meeting the 30-day deadline for entering a final order, as required in s. 440.25(d), F.S.

- Authorizes a qualified rehabilitation provider to have access to a claimant's medical records.

If approved by the Governor, these provisions take effect October 1, 2001, except as otherwise provided.
Vote: Senate 39-0; House 110-5

FINANCIAL INSTITUTIONS

CS/SB 1260 — Financial Institutions

by Banking & Insurance Committee and Senator King

Capitalization Requirements for De Novo Banks and Other Provisions

The bill increases the minimum capitalization requirements for new state-charted banks from $4 million to $6 million for an institution located in a county with a metropolitan statistical area, and from $2 million to $4 million for an institution located elsewhere, and requires that organizing directors subscribe to at least 25 percent of capital stock. It also requires that at least two proposed directors have at least 1 year experience as an executive officer, regulator, or director of a financial institution within the previous 3 years. However, the department may allow only one director (as currently required) to have such experience.

The bill allows the Department of Banking and Finance ("department") to return a substantially incomplete application to an applicant and allows resubmission of the application within 30 days without payment of an additional fee.

The term "strong and well-managed" institution is eliminated and replaced with the term, "operating in a safe and sound manner." In this regard, the bill eliminates the filing fee for relocation of a bank's main office if it is operating in a safe and sound manner and provides that the application is deemed approved if it is not denied within 10 days of receipt.

The bill eliminates the current provision in s. 658.34(4), F.S., which requires the approval of the department for the issuance of previously un-issued stock to declare or pay dividends. However, the bill requires dividends declared or paid from previously un-issued stock to comply with provisions of s. 658.34, F.S., (shares of capital stock) and s. 658.37, F.S., (dividends and surplus).

The bill provides that the pay-on-death account provisions of s. 655.82, F.S., would apply to and govern deposits in trust, affecting only deposits made to an account created after December 31, 1994.

The bill requires each state bank and state trust company to pay the department $25 for each certificate of good standing certifying that a state-chartered financial institution is licensed to conduct business in this state under the financial institutions code.

The bill amends s. 655.50, F.S., relating to the Florida Control of Money Laundering in Financial Institutions Act, to conform state financial transaction reporting requirements to the federal reporting standards.

The bill allows "banker's banks" to provide specified services to financial institutions, including state and federal associations, banks, savings banks, trust companies, international bank agency, or credit union.

One-Bank Holding Companies

The bill increases the percent of capital stock a one-bank holding company may accept as collateral on a loan from any one borrower from 10 to 15 percent of the capital of the one-bank holding company, if the stock is listed and traded on a recognized exchange. If a loan is collateralized by capital stock that is not listed on a recognized exchange, the one-bank holding company would be permitted to accept loans with such collateral up to a maximum of 10 percent of the capital of the one-bank holding company. The bill permits a one-bank holding company to make a loan using its own stock as collateral, as long as the loan would not be used for the purchase of additional stock.

Confidentiality of Deposit Records

The bill amends s. 655.059, F.S., relating to confidentiality of depositor books and records. Current law requires books and records relating to deposit accounts and loans of depositors, borrowers, members and stockholders of financial institutions to be confidential and prohibits disclosure except upon express authorization of the account holder as to his or her own accounts. This is known as the "opt-in" provision. Information relating specifically to loans may be released without the borrower's authorization under specified circumstances. In addition, financial institutions, holding companies and their subsidiaries may furnish to one another information relating to their customers or members, subject to the requirement that each corporation maintain the confidentiality of such information and not disclose the information to any unaffiliated person or entity.

"Affiliates" of financial institutions would be allowed to furnish to other financial institutions, holding companies and their subsidiaries and affiliates information relating to their customers or members, subject to the confidentiality requirements noted above.

The bill also provides that notwithstanding the provisions relating to confidentiality (noted above), that nothing in this subsection shall prohibit a financial institution from disclosing financial information as permitted by Pub. L. 106-102 (1999), as set forth in 15 USCA, s. 6802, as amended. This refers to the Gramm-Leach-Bliley Act (GLB), also known as the "Financial Services Modernization Act."

The GLB was signed into law on November 12, 1999, and becomes effective on July 1, 2001. It allows banks, securities firms and insurance companies to merge, affiliate with each other, and engage in new business activities outside their traditional areas. These entities can share certain consumer information which they can ultimately provide to anyone they choose. However these third parties cannot share that information with anyone else. Also, under GLB, consumers must be offered the opportunity to refuse to allow their personal financial information to be shared by

signing and sending back disclosure information which has to be provided to the consumer on an annual basis by the financial institution. This is known as the "opt-out" provision. Thus, as a result of the implementation of this law, financial institutions would be able to adopt a less restrictive standard (opt-out provision) than current Florida law (opt-in provision) as to consumer financial disclosures.

Worthless Checks

The bill amends s. 68.065, F.S., relating to actions to collect worthless checks. It removes the requirement that a written demand must be delivered by "registered or certified mail," for recoveries of service charges on worthless checks, drafts or orders of payment. Current law would still require that a written demand be made.

If approved by the Governor, these provisions take effect upon becoming law, except as otherwise provided.
Vote: Senate 39-0; House 118-2

CS/CS/HB 107 — Unclaimed Property

by Competitive Commerce Council; Banking Committee; and Rep. Prieguez and others (CS/SB 1398 by Banking & Insurance Committee and Senator Carlton)

The bill (Chapter 2001-36, L.O.F.) substantially revises the Florida Disposition of Unclaimed Property Act, in ch. 717, F.S., as follows:

1. Changes references from abandoned property to unclaimed property;

2. Revises requirements for recovery services agreements between an owner's representative and an owner to include the option to disclose specified information or to limit fees to 15 percent for all contracts with a dollar value of $250 that are held by the Department of Banking and Finance for 24 months or less (25 percent for property held by the department for more than 24 months) or $25 for all contracts with a dollar value of less than $250;

3. Removes the one-time notification limitation imposed on the department for notifying owners of unclaimed property;

4. Revises reporting requirements for holders of unclaimed property;

5. Allows for direct payments to the owner of the unclaimed property after authorized fee deductions to the attorney, certified public accountant, or private investigative agency;

6. Places an affirmative duty on holders of unclaimed property to use reasonable and prudent efforts to locate apparent owners through at least one active search for the owner

within 180 days after an account becomes inactive (2 years from the date of specified activities);

7. Revises the procedure for the Department of Banking and Finance to resolve disputes and conflicts among claims;

8. Includes certified public accountants among persons authorized to file claims as owner's representatives;

9. Requires owners' representatives to maintain certain records and requires representatives to provide such records to the Department of Banking and Finance;

10. Exempts a licensed, Florida-certified public accountant who is acting within the scope of the practice of public accounting, as defined in ch. 473, F.S., from the regulatory provisions for private investigative agencies (recovery agencies) under ch 493, F.S.;

11. Increases the maximum aggregate amount of unclaimed property from $1,000 to $5,000 in small estate accounts in which heirs must now submit an affidavit stipulating to specified expenses in claiming property;

12. Clarifies that the 10-year statute of limitations period to claim property escheated to the state begins at the time the property is received by the state; and

13. Eliminates a claimant's entitlement to interest on amount of unclaimed property.

These provisions were approved by the Governor and take effect October 1, 2001.
Vote: Senate 38-0; House 116-0

CS/CS/CS/SB's 1526 & 314 — Money Transmitter's Code ("Payday Loans")

by Finance & Taxation Committee; Commerce & Economic Opportunities Committee; Banking & Insurance Committee; and Senators Constantine, Campbell, and Cowin

The committee substitute creates the Deferred Presentment Act in ch. 560, part IV, F.S. It provides for regulation of deferred presentment transactions, more commonly referred to as "payday loans," by which a business provides cash or currency in exchange for another person's check and agrees to hold that person's check for a period of time prior to depositing or redeeming the check.

The committee substitute provides for regulation of this industry by the Department of Banking and Finance (department). In order to engage in a deferred presentment transaction, a person or business must be registered under part II of the chapter (which regulates persons who sell or issue payment instruments or who transmit funds) or part III of the chapter (which regulates persons who are in the business of cashing checks or other payment instruments or the

exchanging of foreign currency). Such persons must file with the department a declaration of intent to engage in deferred presentment transactions, accompanied by a $1,000 filing fee.

Deferred presentment agreements would be subject to the following requirements:

- Requires every deferred presentment transaction agreement to be written and signed by both the deferred presentment provider (provider) and the "drawer" (consumer) and executed on the same day that the currency is provided, and to include specified information regarding the terms of the agreement;

- Sets a maximum limit of $500 on the face amount of a check taken for deferred presentment, exclusive of allowable fees;

- Establishes a maximum fee of 10 percent of the amount paid to the consumer, plus a verification fee set by department rule (currently, $5);

- Requires the provider to immediately provide the consumer with the full amount of the check, less the allowable fee, upon receipt of the consumer's check (the provider may not actually collect the fee before the drawer's check is presented or redeemed).

- Prohibits the term of a deferred presentment agreement from being in excess of 31 days or less than 7 days;

- Requires the provider to comply with, and provide the consumer with a copy of, the disclosure requirements of the federal Truth-in-Lending Act and Regulation Z of the Board of Governors of the Federal Reserve Board;

- Allows the payment to the consumer to be in the form of the provider's payment instrument if the provider is registered under part II of the chapter, but no additional fee may be charged and the provider is prohibited from requiring the drawer to accept a payment instrument in lieu of currency;

- Prohibits "rollovers" which extend a deferred presentment agreement;

- Prohibits a deferred presentment provider ("provider") from entering into an agreement if an individual has an outstanding agreement with any provider or if a previous transaction has been closed for less than 24 hours. To verify this information, the provider must access a centralized database implemented by the department. Until such time as this database is implemented, the provider must obtain a signed statement from the individual that he or she does not have an outstanding agreement and has not terminated an agreement within the past 24 hours;

- Requires a 60-day grace period extension, without any additional charge, if an individual is unable to pay the amount due at the end of the deferment period, if the individual

agrees to make an appointment with a consumer credit counseling agency and complete the counseling by the end of the grace period; the consumer may agree to comply with, and adhere to, a repayment plan approved by the counseling agency;

- Allows the consumer to redeem his or her check prior to the presentation date; and
- Allows the provider to seek collection of a returned check pursuant to s. 68.065, F.S., (but without the provision for treble damages).

The committee substitute also amends ch. 560, F.S., the Money Transmitters' Code, which provides for the regulation of the money transmitter industry by the Department of Banking and Finance. This industry includes wire transmitters, check cashers, and foreign money exchangers. The committee substitute makes the following changes to ch. 560, F.S.:

- Deletes examination fees and uses registration fees to fund the regulatory program;
- Adds an initial $50 application fee for each vendor or branch of a part II (payment instruments and funds transmission) or part III (check cashing and foreign currency) registrant;
- Authorizes the department to assess a registrant a $500 late filing fee if the renewal application is submitted within 60 days after the expiration of the license;
- Increases the cap on renewal fees for registrants with multiple locations from $5,000 to $20,000; and
- Requires registrants to notify the department of any newly established locations within 60 days.

If approved by the Governor, these provisions take effect October 1, 2001.
Vote: Senate 39-0; House 120-0

HB 625 — Security for Public Deposits

by Rep. Bean and others (CS/SB 1670 by Banking & Insurance Committee and Senator Constantine)

The bill eliminates the advisory committee to the qualified public deposit program and establishes the Qualified Public Depository Oversight Board comprised of six members. The board would represent the interests of all qualified public depositories in safeguarding the integrity of the program and preventing the realization of loss assessments. The Treasurer will select two members that represent public depositories in each of the three asset groups. Any additional expenses of the public deposit program not covered by the resources of the program

will be paid in the same manner as loss assessments on qualified public depositories, as provided in s. 280.08, F.S.

The bill authorizes the Treasurer to establish special requirements for a qualified public depository in order to protect the integrity of the public deposit program. The Treasurer will be required to notify the custodian of collateral of any change in the Uniform Commercial Code in Florida which affects the requirements for a perfected security interest in collateral. The custodian has 180 days from such notice to withdraw, if the required collateral services cannot be provided. The bill authorizes the use of Federal Home Loan Bank letters of credit as eligible collateral, if certain requirements are met.

The bill also requires a qualified public depository to pledge, deposit, or issue additional eligible collateral between filing periods of monthly reports within 2 business days when notified by the Treasurer that the current market value of the collateral does not meet the required collateral. A qualified public depository is prohibited from acting as its own custodian.

Violations subject to administrative penalties are revised to include failure to maintain required collateral rather than failure to pledge sufficient collateral and the Treasurer is authorized to issue a cease and desist order if a qualified public depository deposits or arranges for the issuance of unacceptable collateral.

If approved by the Governor, these provisions take effect October 1, 2001, except as otherwise provided.
Vote: Senate 38-0; House 115-0

CS/HB 455 — Mortgage Brokers and Lenders

by Banking Committee and Rep. Detert (CS/SB 1896 by Banking & Insurance Committee and Senator Constantine)

The bill establishes education requirements for those seeking initial licensure under ch. 494, part III, F.S. (mortgage lending), and establishes continuing education requirements as a condition of renewal of licenses under part II (mortgage broker) and part III (mortgage lending) of the chapter.

An applicant for an initial mortgage lender license will be required to document 24 hours of classroom instruction in primary and subordinate financing transactions and in the provisions of ch. 494, F.S., and rules adopted under that chapter. An applicant for an initial mortgage lender's license, or the applicant's principal representative, will be required to pass a written test prescribed by the Department of Banking and Finance ("department") to determine competency in primary and subordinate financing transactions and the provisions of ch. 494, F.S., and rules adopted under that chapter. Mortgage brokers, mortgage lenders, and correspondent mortgage lenders will be required to complete at least 14 hours of professional education courses in

primary and subordinate mortgage financing transaction biennially as a condition for license renewal.

An applicant for an initial mortgage lender license will be required to designate a "principal representative" within the mortgage lender business, which is comparable to the "principal broker" within a mortgage broker business, who has responsibility for exercising operational control of the licensee's business. The bill also requires that a mortgage broker be licensed for at least 1 year prior to being designated as a "principal broker" within the brokerage, or demonstrate to the department that he or she has been actively engaged in mortgage-related business for at least 1 year prior to being designated as a principal broker.

Licensees will be required to maintain records documenting compliance with the education requirements for a period of 4 years.

If approved by the Governor, these provisions take effect October 1, 2001, except as otherwise provided.
Vote: Senate 36-0; House 112-4

MISCELLANEOUS

CS/CS/SB 108 — Structured Settlements/Transfers

by Judiciary Committee; Banking & Insurance Committee; and Senators Geller and Dawson

Structured Settlements

Structured settlements are increasingly being used as means to settle personal injury claims. The structured settlement provides periodic payments for future medical expenses and wage replacement. As an alternative to continuing to receive these long-term payments, some individuals may assign or sell their settlement payments to a factoring company for a discounted, lump-sum payment. The bill would require court review and approval for all such transfers of structured settlements for the resolution of tort claims. In addition, the bill would require such transfer agreements to contain specific disclosures regarding the costs of the transactions and a comparison of the amount to be received in the transfer in comparison to the amount to be received through the structured settlement.

Since s. 440.22, F.S., prohibits the assignment, release, or commutation of compensation or benefits due or payable under this chapter, this bill would not apply to workers' compensation structured settlements.

Viatical Settlements

In 1996, Florida established the framework for regulation of the viatical industry by the Department of Insurance. In general, a viatical settlement is an agreement under which the owner of a life insurance policy, the "viator," sells the policy to another person, the "viatical settlement provider," in exchange for an up-front payment, which is generally less than the expected death benefit under the policy. The viatical settlement provider buying 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. The amount paid to the viator could depend on the viator's life expectancy and on market forces.

In the 2000 Regular Session, substantial changes were enacted expanding viatical settlement regulation by the department to cover any person who sells a life insurance policy, not just individuals with a "life threatening" illness. The legislation also provided disclosures to be made by viatical settlement providers to viatical settlement purchasers, the requirement for licensees to maintain certain records, and increased penalties for specified unlawful acts.

This bill provides for disclosures, form filings, and other protections, which are currently afforded to consumers engaged in viatical settlement transactions in the primary market to apply to such persons in the secondary market. Secondary market viatical settlement transactions pertain to those purchases made from any person or entity other than the viatical settlement provider who effectuated the viatical settlement contract, that is, who originally viaticated the policy.

The bill provides that viatical settlement sales agents be responsible for disclosures to purchasers in the secondary market, that viatical settlement purchase transactions in the secondary market be completed only through the use of escrow agents or third-party trustees, that all funds paid by purchasers be deposited with such trustees or agents, and that the funds must not be released to the seller until after a 3-day voidable period has expired. Also, the bill provides requirements that the viatical settlement provider who initially purchased the policy from the viator be responsible for monitoring the insured as to the insured's whereabouts and health status, premium payments, and submission of the death claim. This responsibility may be contracted out to a third party. The bill expands certain terms relating to trusts, financing and special purpose entities, purchasers, and purchase agreements. Finally, the bill clarifies that viatical settlement providers doing business from this state, and who transact business with viators or viatical settlement purchasers outside of the state, must be licensed in Florida.

If approved by the Governor, these provisions take effect October 1, 2001.
Vote: Senate 39-0; House 118-0

SB 218 — Mortgage Guaranty Insurance

by Senator Horne

This bill (Chapter 2001-37, L.O.F.) revises how a mortgage guaranty insurer's contingency reserve is calculated when determining whether the insurer meets the minimum surplus requirement.

Mortgage guaranty insurance protects a lender, usually a bank or mortgage company, against loss upon the default of a mortgage loan. Florida law requires a mortgage guaranty insurer to establish a contingency reserve equal to 50 percent of earned premiums on each policy it writes, which must be maintained for a 10-year period. This is a solvency-related requirement to protect against adverse economic conditions which could trigger mortgage guaranty insurance claims payments.

Florida law also requires that a mortgage guaranty insurer maintain a minimum surplus equal to the greater of $4 million, or 10 percent of the insurer's liabilities, but not more than $100 million. The contingency reserve has been considered a liability in calculating the surplus for a mortgage guaranty insurer and, therefore, in determining whether the minimum surplus requirement is met. Although the contingency reserve (and counting it as a liability) is a common requirement for mortgage guaranty insurers among the states, Florida's minimum surplus requirement that is based upon a percentage of the insurer's liabilities is not. The combined effect of these two requirements significantly increases the amount of the minimum surplus requirement to a greater amount than is typically required in other states.

Under the new law, each mortgage guaranty insurer will continue to report its contingency reserve as a liability in its financial statements, except that the contingency reserve will not be considered a liability for the purpose of determining whether the mortgage guaranty insurer meets the minimum surplus requirements.

The bill also clarifies provisions of current law by providing that a mortgage guaranty insurer may not have a total outstanding aggregate exposure (net of reinsurance) that exceeds 25 times the insurer's paid-in capital, surplus, and contingency reserve combined.

These provisions were approved by the Governor and take effect July 1, 2001.
Vote: Senate 39-0; House 118-0

CS/SB 658 — Insurance (Surplus Lines Insurance; Statutory Accounting)

by Banking & Insurance Committee and Senator Holzendorf

Surplus Lines Insurance

This bill authorizes the Florida Surplus Lines Service Office ("Service Office") to have access to records of surplus lines insurance agents related to the surplus lines insurance policies they write,

as currently authorized for the Department of Insurance. The bill also requires surplus lines agents to report certain information on policies written to the Service Office, that in most respects codifies what were already current practices of the Service Office pursuant to operational procedures approved by the Department of Insurance. Similarly, the bill clarifies the responsibilities of the Service Office relative to those of the department with regard to monitoring the surplus lines business and collecting the 5 percent premium tax imposed on surplus lines policies and the 0.3 percent service fee that funds the operations of the Service Office. Current fines and penalties that apply to late payment of the premium tax will now also apply to late payment of the service fee. The bill also deletes the requirement that insurers and adjusters notify the Service Office of each claim that is filed.

The bill increases maximum per-policy fee that may be charged by a surplus lines agent to a policyholder from $25 to $35.

The bill requires persons who independently obtain coverage from a surplus lines insurer (rather than through a surplus lines agent) to report and pay the 5 percent premium tax to the Service Office, rather than to the department. The bill would also impose the 0.3 percent service fee that currently applies to surplus lines policies on independently procured coverage, payable to the Service Office.

Statutory Accounting

The bill adopts uniform, statutory accounting principles, as defined in the National Association of Insurance Commissioners' (NAIC) Accounting Practices and Procedures Manual, effective January 1, 2001, and makes conforming changes to the accounting provisions of the Insurance Code for insurers and health maintenance organizations.

Statutory accounting principles are the accounting principles or practices prescribed or permitted by an insurer's state of domicile. Statutory accounting principles attempt to determine at the financial statement date an insurer's ability to meet its obligations to its policyholders and creditors. Statutory accounting principles are designed to address the concerns of regulators and are established on a relatively conservative basis. In contrast, generally accepted accounting principles (GAAP) are designed to meet the varying needs of different users of financial statements and emphasize the measurement of emerging earnings of a business from period to period. The purpose of NAIC's Codification of Statutory Accounting Principles project was to produce a comprehensive guide to statutory accounting for use by insurance departments, insurers, and auditors. By adopting the latest NAIC manual, Florida joins 44 other states that reference the manual in either their statutes or rules.

Health maintenance organizations (HMOs) authorized in Florida on January 1, 2001, are given two options with regard to complying with the new statutory accounting principles. An HMO may either report all assets in accordance with the new statutory accounting principles (the NAIC Accounting Practices and Procedures Manual, effective January 1, 2001), or the HMO may report assets acquired prior to June 30, 2001, in accordance with the 2000 version of s. 641.35,

F.S., through December 31, 2005. Assets acquired on or after June 30, 2001 must be accounted for in accordance with the new statutory accounting principles.

If approved by the Governor, these provisions take effect upon becoming law and section 24 (requiring any quarterly or annual statement filed after the effective date of the act to be prepared in accordance with the act) shall apply retroactively to January 1, 2001.
Vote: Senate 34-0; House 118-0

CS/SB 788 — Unfair Discrimination/Insurance

by Banking & Insurance Committee and Senator Silver

The committee substitute amends s. 626.9541, F. S., to add disability, property and casualty, and automobile insurance companies to the list of insurers (health and life insurers and managed care providers) that are currently prohibited from refusing to issue a policy or deny a claim to applicants or insureds who have been, or are likely to become, victims of domestic abuse by a family or household member. Specifically, the bill declares that it is an unfair or deceptive act for disability, property and casualty, and automobile insurers to underwrite a policy, refuse to issue or renew a policy, refuse to pay a claim, terminate a policy or increase rates based on the fact that the insured or applicant who is also the proposed insured, has made a claim or sought medical or psychological treatment in the past for abuse, or that a claim might occur as a result of any future abuse, by a family or household member upon another family or household member. It clarifies that a health insurer, life insurer, disability insurer, or managed care provider may refuse to underwrite, issue, or renew a policy based on the applicant's medical condition, but the company shall not consider whether such condition was caused by an act of abuse. The current law defines "abuse" to mean assault, battery, sexual assault, placing another in fear of serious bodily injury, false imprisonment, physically or sexually abusing a minor child, or an act of domestic violence.

The bill further clarifies that the above provision does not prohibit a property and casualty insurer or automobile insurer from excluding coverage for intentional acts by the insured if such exclusion does not constitute an act of unfair discrimination. The "intentional act" exclusion is a standard provision in property and casualty contracts. The exclusion provides that the insurance company is not required to pay any claim resulting from an intentional act by the insured as to covered property. For example, if a battered woman's spouse burns down their house, the insurer would not cover the loss since if it was an intentional act by the co-insured. However, the bill would prohibit an insurer from canceling or refusing to renew coverage of the wife, or refusing to issue new coverage to the wife, based on the past act of domestic violence.

The bill also deletes the term "solely" as that term applies to facts insurers consider as to domestic violence. This would clarify that an insurer could not base its decision to deny a claim or policy based on the fact that the insured made a claim as a result of domestic violence.

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 38-0; House 119-0

CS/SB 806 — Insurance Examination/Exemptions

by Banking & Insurance Committee and Senator Laurent

This committee substitute would exempt applicants for licensure as a customer representative or adjuster from examination requirements under certain circumstances. Specifically, a customer representative applicant would be exempt from taking and passing an examination approved by the Department of Insurance if the applicant obtains a designation as a Certified Customer Service Representative (CCSR) from the Florida Association of Insurance Agents, or the designation of Registered Customer Service Representative (RCSR) from a regionally accredited postsecondary institution in Florida. Similarly, an applicant for licensure as an adjuster would be exempt from examination requirements if the applicant obtains a designation as an Accredited Claims Adjuster (ACA) from a regionally accredited postsecondary institution in the state. The curriculum for all three designations must be approved by the department and include comprehensive analysis of basic property and casualty lines of insurance and testing at least equal to that of standard department testing for customer representative and all-lines adjuster licenses. The bill provides that the department shall adopt rules establishing standards for the approval of the curriculum.

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 39-0; House 118-0

CS/SB 938 — Credit Insurance

by Banking & Insurance Committee and Senator Peaden

This committee substitute authorizes the issuance of a credit life or disability insurance license to a creditor or a lending or financial institution, e.g., state or federal banks, associations, savings banks, or credit unions, and provides that such licensees may also sell credit insurance and credit property insurance. The bill requires that officers and directors of the entity applying for credit life or disability licensure with the Department of Insurance must submit fingerprints with an application.

The bill also provides that in lieu of written acknowledgments for credit life insurance, that if credit life insurance is solicited or consummated by telephone, the creditor agent or agent must provide written disclosures to the borrower within 30 days from the date the coverage takes effect. Further, the borrower must be notified that he or she has 30 days from the date the disclosures are received to rescind the credit life insurance coverage.

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 38-0; House 118-1

HB 405 — Public Records/Surplus Lines Insurance Records

by State Administration Committee and Rep. Brummer (CS/SB 1026 by Banking & Insurance Committee)

This bill reenacts and expands the current public records exemption and confidentiality for certain surplus lines insurance records submitted by surplus lines insurance agents to the Department of Insurance, as provided by s. 626.921(8), F.S. The exemption was scheduled for repeal on October 2, 2001, unless reviewed and reenacted by the Legislature, pursuant to the criteria specified in the Open Government Sunset Review Act, s. 119.15, F.S.

Presently, if requested by the department, surplus lines agents are required to submit copies of policies, applications, and other specified information related to surplus lines policies that are written. The information must be maintained for 5 years and available for inspection by the department. Any information obtained by the department that reveals a trade secret, as defined in s. 688.002, F.S., is exempt from the public records law and confidential. As currently interpreted, any information that is specific to an individual policy or policyholder is considered a trade secret. The bill clarifies this by revising the exemption to apply to information that reveals information specific to a particular policy or policyholder, rather than information that reveals a trade secret.

The bill also expands the exemption by applying it to information furnished to the Florida Surplus Lines Service Office ("Service Office") under the Surplus Lines Law (ss. 626.913-626.937, F.S.), if the disclosure would reveal information specific to a particular policy or policyholder. The Service Office was created by the Legislature in 1997 and is authorized by s. 626.921, F.S., to require surplus lines agents to submit such information as required by the association's plan of operation, approved by department rule. The plan requires surplus lines agents to submit detailed information about each surplus lines policy written. By referring to information furnished to the Service Office "under the Surplus Lines Law," this bill also conforms to CS/SB 658, that amends ss. 626.923, 626.930, and 626.931, F.S., to authorize the Service Office to have the same access to records of surplus lines agents as currently provided to the Department of Insurance and to require surplus lines agents to report specified information.

If approved by the Governor, these provisions take effect October 1, 2001.
Vote: Senate 39-0; House 117-0

SB 1428 — State Group Health Insurance

by Senators Posey, Clary, and Mitchell

The bill provides that the Department of Management Services and the Division of State Group Insurance shall not prohibit or limit any properly licensed insurer, health maintenance organization, prepaid limited health services organization, or insurance agent from competing for any insurance product or plan purchased, provided, or endorsed by the department or the division on the basis of the compensation arrangement used by the insurer or organization for its agents.

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

CS/SB 1530 — Financial Settlements

by Banking & Insurance Committee and Senator Geller

This bill is identical to CS/CS/SB 108. Please see the summary of that bill.

If approved by the Governor, these provisions take effect October 1, 2001.
Vote: Senate 38-0; House 119-0

CS/SB 1610 — Funeral and Cemetery Services

by Banking & Insurance Committee and Senators Latvala, Wasserman Schultz, Lee, Sullivan, Mitchell, Miller, Lawson, Peaden, Posey, and Cowin

The bill makes significant changes to the statutes regulating funeral and cemetery services in ch. 497, F.S.

The bill gradually phases out the authority for funeral and cemetery businesses to purchase surety "payment" bonds as security for funds they have collected on contracts for future or preneed funeral and cemetery services and merchandise. The revision allows certain certificateholders to continue to use these payment-type surety funds authorized under s. 497.425, F.S., to secure funds by bond rather than by trust, but only on contracts written before July 1, 2001, and only as to funds not held in trust as of July 1, 2001. A specific provision is made for a certificateholder that is authorized to do business in Florida and that currently has $100,000,000 secured by bonds. This particular certificateholder is allowed to use the payment-type surety bond alternative of securing funds, on contracts written prior to December 31, 2004, but relates only to those funds not held in trust as of July 1, 2001. In summary, this provision provides two cutoff dates after which the payment-type surety bonding alternative in s. 497.425 can no longer be used, holds harmless the bonding arrangements currently utilized by certificateholders, and does not allow those certificateholders to secure any other funds currently

being held in trust as of the effective date of the bill. The other financing arrangements available under current law remain: letters of credit, performance surety bonds, and trust accounts.

In addition, the bill makes the following changes:

- Expands the list of financial institutions to include federal or state savings and loan associations authorized to handle trust accounts for funeral and cemetery preneed funds, as well as funds collected for cemetery care and maintenance.

- Eliminates the requirement for the Department of Banking and Finance to establish the need for a new cemetery before issuing a license for it to operate.

- Raises the acreage requirement for new cemeteries from 15 to 30 contiguous acres and increases the number of years from 1 to 3 for cemetery management experience required for managers of new cemeteries.

- Expands the statutory definitions of "cemetery" and "preneed contracts" and adds definitions of "ossuary" and "scattering gardens" to reflect current funeral and cemetery practices.

- Amends s. 470.002, F.S., to revise the definition of *legally authorized person*, to exclude a spouse who has been arrested for committing against the deceased an act of violence. This would provide that in such circumstances, the spouse would not be authorized to direct a funeral director or direct disposer how the deceased body should be disposed.

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 37-0; House 109-0

CS/SB 1722 — Surety Bonds/Reserve Amount

by Banking & Insurance Committee and Senator Horne

The bill amends s. 625.071, F.S., to revise the special reserve that surety insurers must establish for bail bonds from the current 25 percent of the total consideration (premium) paid for the bail bond, to the lesser of 35 percent of the bail premiums in force or $7 per $1,000 of bail liability. The bail premiums would not include amounts retained by licensed bail bond agents, but may not be less than 6.5 percent of the total consideration received for all bail bonds in force.

The bill benefits Florida domestic surety insurers which will have lower special reserve requirements which, in turn, will increase their surplus and increase the bail bond premiums that they may legally write. The amount of the special reserve, as amended, is still considered to be an adequate protection of the financial health of surety insurers and will be the same as that required by the U.S. Treasury for all insurers who issue bonds for federal agencies.

If approved by the Governor, these provisions take effect July 1, 2001
Vote: Senate 39-0; House 118-0

CS/SB 2174 — Insurance Agents

by Banking & Insurance Committee and Senator Holzendorf

This committee substitute makes a variety of changes relating to the licensure of insurance company representatives, mostly in ch. 626, F.S. Major changes include:

- Requiring licensed insurance agents marketing other products to maintain separate records relating to insurance products and transactions.
- Allowing the Department of Insurance access to insurance agent records maintained at a third party location.
- Specifying the activities constituting the "solicitation of insurance" and requiring licensure.
- Authorizing employee leasing companies to carry out specified insurance-type activities under limited circumstances.
- Eliminating the collection of certain information by the Department of Insurance.
- Expanding the amount of time specified licensees would have to obtain an appointment after the termination of their appointment, licensure, or the filing of the original license application.
- Mandating the fingerprinting of officers or directors to be filed with the Department of Insurance under certain circumstances.
- Removing the ability of licensees to waive confidentiality as to investigative information.
- Allowing the Department of Insurance to revoke or suspend the license of a licensee selling securities not registered as required under ch. 517, F.S.
- Clarifying that a nonresident license is limited to the specific lines of authority granted in the license issued by the agent's state of residence and further limited to the specific lines authorized under nonresident licensure issued by this state.
- Declaring that the requirements of the Insurance Code would apply equally to all insurance transactions, insurance agents, and insurance agencies, unless otherwise specified in the Insurance Code.

- Clarifying that advertising and other communications materials developed by insurers regarding products must indicate that the communication relates to insurance products.

- Authorizing the Department of Insurance to promulgate rules to govern the use of a consumer's personal financial and health information. The rules must be consistent with the model regulation developed by the National Association of Insurance Commissioners (NAIC) and with the standards contained in Title V of the Gramm-Leach-Bliley Act (GLB) of 1999, Pub. L. No. 106-102. The GLB allows banks, securities firms and insurance companies to merge, affiliate with each other, and engage in new business activities outside their traditional areas. The GLB also authorizes state insurance departments to issue regulations protecting the privacy of insurance consumers' personal information. In response to the GLB, the NAIC adopted a model regulation to provide specific protection for financial and health information about consumers held by insurers, agents and other entities engaged in insurance activities. The model regulation requires insurers to:

    - notify consumers about their privacy policies;

    - give consumers the opportunity to prohibit the sharing of their protected financial information with non-affiliated third parties (a company that is not affiliated with an insurer); and

    - obtain affirmative consent from consumers before sharing protected health information with any other parties, affiliated and non-affiliates alike.

  The NAIC model is now under consideration by the states. The Florida Department of Insurance needed to secure specific authorization from the Legislature before the department could promulgate consumer protection rules consistent with the NAIC regulations.

If approved by the Governor, these provisions take effect July 1, 2001.
Vote: Senate 39-0; House 120-0

SB 2240 — Warranty Associations

by Senator Garcia

This bill revises ch. 634, F.S., relating to warranty associations. The bill amends and creates sections within all three parts of the chapter relating to the regulation of motor vehicle service agreement companies, home warranty associations, and service warranty associations. This bill would provide for the following:

- Specifies that a company licensed under ch. 634, F.S., does not require a sales representative license to market and sell its own contracts.

- Revises provisions relating to the determination of the financial condition of entities offering warranties under this chapter.

- Provides that the Department of Insurance may by rule require motor vehicle service companies, home and service warranty associations to submit information contained in financial reports electronically. Further, it authorizes the department to promulgate rules to identify specific methods of unfair competition or deceptive acts under ch. 634, F.S.

- Creates and amends sections defining certain practices as unfair methods of competition and unfair or deceptive acts as those practices relate to the advertising, sale, or delivery of motor vehicle service agreements. Provides the Department of Insurance with investigative and enforcement authority relative to motor vehicle service agreement companies.

- Prohibits the use of advertisements that would be defined as an unfair or deceptive practice when that advertisement would mislead or mistakenly lead a reasonable person to believe that the federal or state government is responsible for the motor vehicle service agreement sales activity or would guarantee any returns on the agreement or the payment of obligations arising under the agreement.

- Defines the term "additive product" and includes within the definition of "motor vehicle service agreement" any agreement to repair or replace a motor vehicle offered in conjunction with an additive product.

- Provides that when the premium or charge for a motor vehicle service agreement is included in the overall purchase price of the purchase of merchandise or property, the vendor must separately state and identify the amount charged for the motor vehicle service agreement and the classification upon which it is based.

- Authorizes the Department of Insurance to conduct proceedings pursuant to ch. 120, F.S., when it has reason to believe a person is engaging in an unfair or deceptive act relating to motor vehicle service agreements. Also, it allows the department to issue cease and desist orders, to suspend or revoke licenses, and impose specified fines.

- Provides that all home warranty contracts must disclose exclusions, restrictions, or limitations on the benefits offered or the coverage provided under the contract and include on the front page in bold type a disclaimer similar to this one: "Certain items and events are not covered by this contract. Please refer to the exclusions listed on page ____ of this document."

- Prohibits the advertising, offering, or providing of a free service warranty as an inducement to the purchase or sale of real or personal property or services connected therewith.

- Provides an effective date of January 1, 2002, for the sections of the bill which delineate the assets and liabilities that may be used to determine the financial condition of a home warranty association.

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