WORKERS' COMPENSATION

SB 50-A — Workers' Compensation

by Senators Clary, Alexander, and Atwater

The bill provides changes to the workers' compensation system that are designed to expedite the dispute resolution process, provide greater compliance and enforcement authority for the Division of Workers' Compensation to combat fraud, revise certain indemnity benefits for injured workers, increase medical reimbursement fees for physicians and surgical procedures, and increase availability and affordability of coverage.

Benefits

Permanent Total Disability – In each of the following cases, an injured employee would be presumed to be permanently and totally disabled unless the employer or carrier establishes that the employee is physically capable of engaging in at least sedentary employment within a 50-mile radius of the employee's residence:

- Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk.
- Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage.
- Severe brain or closed head injury.
- Second-degree or third-degree burns of 25 percent or more of the total body or third-degree burns of 5 percent or more to the face and hands.
- Total or industrial blindness.

In all other cases, the employee must establish that he or she is not able to engage in at least sedentary employment, within a 50-mile radius of the employee's residence, due to physical limitations. Generally, such benefits are payable until the employee reaches age 75. If the accident occurs on or after the employee reaches age 70, benefits are payable during the continuance of permanent total disability, not to exceed 5 years following the determination of permanent total disability. The bill provides that an employee is eligible to receive permanent total disability benefits after age 75, and to receive the annual 3 percent permanent total disability supplementary benefit after age 62, if the employee is not eligible for social security benefits due to the compensable injury preventing the employee from working sufficient quarters to be eligible for such benefits.

Permanent Partial Disability – The bill revises the impairment benefits for a permanent partial disability, by increasing the amount of the benefit from 50 percent to 75 percent of temporary

total disability benefit, (i.e., increased to 75 percent of 66.6 percent of average weekly wage (AWW), or to about 50 percent of AWW, rather than the current 50 percent of 66.6 percent of AWW, or about 33.3 percent of AWW). However, the amount of the impairment benefit would be reduced by 50 percent (i.e., to about 25 percent of AWW) if the employee is able to earn the same wage or greater after the injury.

The duration of this impairment benefit is changed from the current 3 weeks for each percent of impairment to the following schedule:

- 2 weeks for each percent of impairment from 1 to 10 percent.
- 3 weeks for each percent of impairment from 11 to 15 percent.
- 4 weeks for each percent of impairment from 16 to 20 percent.
- 6 weeks for each percent of impairment from 21 percent and higher.

The bill eliminates the permanent partial disability supplemental benefits for employees who have at least 20 percent impairment and who are unable to earn at least 80 percent of their pre-injury wage.

Permanent impairment benefits are limited for the permanent psychiatric impairment to a 1 percent permanent impairment.

The bill also provides that only the disability or medical treatment associated with a compensable injury is payable, excluding preexisting disability or medical condition.

Other Benefits -- Funeral and Death, Chiropractic, and Training and Education

The bill increases benefits for funeral expenses from $5,000 to $7,500 and increases death benefits for dependents from $100,000 to $150,000.

The bill increases caps on chiropractic treatments from 18 to 24 visits and the number of weeks of treatments from 8 to 12 weeks.

The bill provides that benefits for training and education authorized by the Department of Financial Services and funded by the Workers' Compensation Administration Trust Fund may include payment to attend a community college or vocational-technical school and this benefit would include securing a general education diploma (GED). The bill provides that temporary total compensation benefits paid during the training and education would be included within, and not added to, the maximum 104 weeks provided for temporary total benefits.

Compensability for Injuries

The bill requires that an accidental compensable injury must be the major contributing cause of any resulting injury, meaning that the cause must be more than 50 percent responsible for the injury as compared to all other causes combined, as demonstrated by medical evidence only.

An injury or disease caused by toxic substance would require clear and convincing evidence establishing that exposure to the specific substance caused the injury or diseases sustained by the employee. Both causation and sufficient exposure to support causation must be proven by clear and convincing evidence in cases involving occupational disease or repetitive exposure.

The bill provides that pain or other subjective complaints alone, in the absence of objective relevant medical findings, are not compensable.

For mental and nervous injuries, there must be a physical injury requiring medical treatment which is the major contributing cause. The mental or nervous injury must be demonstrated by clear and convincing evidence. Payment of temporary benefits for mental or nervous injuries is limited to no more than 6 months, after the date of maximum medical improvement for the employee's physical injury, which shall be included in the 104-week period.

Workers' Compensation Joint Underwriting Association (Availability and Affordability of Coverage)

The bill revises the current subplans within the Florida Workers' Compensation Joint Underwriting Association (JUA) to address affordability and availability for small employers and charitable and nonprofit organizations. A new subplan "D" is created, in which the premiums for small employers with 15 or fewer employees and an experience modification factor of 1.10 or less would be capped at 125 percent of the rate for the voluntary market manual rate, and premiums for charitable organizations meeting certain criteria with an experience modification factor of 1.10 percent or less would be capped at 110 percent of the voluntary market rate. However, any deficits in subplan "D" would be assessed against the employers in that subplan.

The board of the JUA is reduced from 13 to 9 members. Currently 11 of the 13 members are chosen by insurance industry representatives. Under the bill, three members are appointed by the Financial Services Commission; two members by domestic insurers (Florida domiciled); two members by foreign insurers (non-Florida domiciled); one member by the largest property and casualty insurance agents' association; and the Insurance Consumer Advocate of the Department of Financial Services. The Financial Services Commission would designate a member of the board to serve as chairperson.

Dispute Resolution

The bill limits an employer and employee to one independent medical examination (IME) per accident rather than one per medical specialty. The party requesting and selecting the IME is responsible for all expenses associated with the examination. An employee may recoup the costs of an IME from the employer or carrier if the employee prevails in a medical dispute, as determined by a judge of compensation claims, or if benefits are paid or treatment provided after the employee has obtained an IME.

As an alternative to resolving a medical dispute, the bill authorizes the use of a consensus medical examination, if both parties agree. The findings and conclusions of such examination would be binding on both parties, would constitute resolution of the medical dispute, and would not affect the rights of the employee and carrier to have one IME per accident.

The bill also allows an employee, employer, and carrier to agree to seek consent from a judge of compensation claims to enter into binding claim arbitration in lieu of any other remedy provided in ch. 440, F.S.

Attorney's Fees

The bill continues the use of the current contingency fee schedule in awarding attorney's fees. The fee for benefits secured are limited to 20 percent of the first $5,000 of benefits secured, and 15 percent of the next $5,000 of benefits secured, 10 percent of the remaining amount of benefits secured to be provided during the first 10 years after the claim is filed, and 5 percent of the benefits secured after 10 years.

As an alternative to the contingency fee, the judge of compensation claims may approve an attorney's fee not to exceed $1,500 once per accident, based on a maximum hourly rate of $150 per hour, if the judge of compensation claims determines that the contingency fee schedule, based on benefits secured, fails to compensate fairly the attorney for a disputed medical-only claim.

If there is a written offer to settle issues, including attorney's fees, at least 30 days prior to the hearing date, for purposes of calculating the amount of attorney's fees to be taxed against the carrier or employer, the term "benefits secured" would include only that amount awarded to the claimant above the amount specified in the offer.

Medical Fee Reimbursement

The bill increases the maximum reimbursement for all physicians to 110 percent of the reimbursement allowed by Medicare; and increases the maximum reimbursement for surgical procedures to 140 percent of Medicare. The bill continues to allow deviations from fee schedules in certain circumstances, and reduces outpatient reimbursement for scheduled (nonemergency) surgeries from 75 percent to 60 percent of charges. The bill also specifies that outpatient observation status cannot exceed 23 hours.

The bill includes legislative intent to fund increases in payments to physicians by reductions in payments to hospitals.

Reimbursements for prescription drugs are reduced from 1.2 times the average wholesale price (plus a $4.18 dispensing fee) to the average wholesale price (plus the same $4.18 dispensing fee).

Coverage Requirements and Construction Industry Exemptions

Effective January 1, 2004, the bill limits exemptions from coverage in the construction industry to three corporate officers each having at least a 10 percent stock ownership. The bill eliminates exemptions for sole proprietors and partners in the construction industry and deletes the provisions enacted in 2002 that disallowed all exemptions for commercial construction sites valued over $250,000, while allowing exemptions for other construction sites. The type of construction site would no longer be relevant. All persons in the construction industry remunerated for their services would be required to have coverage, except for up to three corporate officers meeting the 10 percent ownership requirement. The bill provides that an exemption certificate is applicable to the corporate officer named on the notice of exemption and applies only within the scope of the business or trade listed.

Any employer with employees engaged in the construction industry in Florida is required to obtain a Florida policy or endorsement that uses Florida class codes and rates. Failure to comply is a second-degree felony.

Compliance and Enforcement -- Fraud

The bill establishes several measures designed to fight fraud and increase prosecution of fraud in the workers' compensation system, including:

- Provides that an employer that fails to pay stop-work order penalties is ineligible for an exemption from coverage.
- Requires a carrier to submit an annual report to the department detailing losses and recoveries attributable to workers' compensation fraud and authorizes the department to fine carriers for noncompliance.
- Requires an annual report by the Bureau of Workers' Compensation Fraud and the Division of Workers' Compensation of the Department of Financial Services to provide greater accountability regarding compliance and enforcement activities.
- Authorizes the Division of Unemployment Compensation to release information in certain circumstances concerning an employee's wages to determine if an injured worker is employed and receiving workers' compensation benefits.
- Incorporates certain violations of ch. 440, F.S., in the Offense Severity Ranking Chart which would assist in the prosecution and sentencing of workers' compensation fraud by establishing ranking for these violations.

Carrier Compliance

The bill authorizes the department to examine and investigate carriers, self-insured employers, and servicing agents to determine compliance with ch. 440, F.S., and increases the department's authority to examine and fine such entities that engage in patterns or practices of unreasonable

delay in claims handling or patterns or practices of harassment, coercion, or intimidation of claimants.

The department may impose an administrative penalty in an amount not to exceed $2,500 for each pattern or practice constituting a nonwillful pattern or practice, not to exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. Any administrative penalty imposed under this section (s. 440.525, F.S.) for a nonwillful violation cannot duplicate an administrative penalty imposed under another provision in ch. 440, F.S., or the Insurance Code. The department is also authorized to impose an administrative penalty for patterns or practices constituting a willful violation in an amount not to exceed $20,000 for each willful practice or pattern. Such fines cannot exceed $100,000 for all willful violations arising out of the same action.

Safety in the Workplace

The bill requires the Division of Workers' Compensation to publicize on its Internet site, and encourage carriers to publicize, the availability of free safety consultation services and safety program resources. All policyholders in the Florida Workers' Compensation Joint Underwriting Association are required to participate in a safety program.

Horizontal Immunity

The bill provides immunity to a subcontractor from lawsuits by employees of another subcontractor or the contractor, if the subcontractor is providing services in conjunction with a contractor on the same project or contract work, under certain conditions. The conditions are: 1) that the subcontractor or contractor has secured workers' compensation coverage for the subcontractor's employees and 2) that the subcontractor's own gross negligence was not the major contributing cause of the injury.

Intentional Torts

Provides that the liability of an employer for compensation under s. 440.10, F.S., is exclusive and in place of all other liability except in cases where the employer commits an intentional tort that causes the death or injury of an employee. An employer's actions are deemed to constitute an intentional tort only when the employee proves by clear and convincing evidence that the employer deliberately intended to injure the employee or the employer engaged in conduct that the employer knew was virtually certain to result in injury or death to the employee. The bill also expands immunity from third-party civil liability for safety consultants to all employees of the employer or employees of its subcontractors on a jobsite.

Joint Select Committee on Workers' Compensation Rating Reform

The bill establishes a Joint Select Committee on Workers' Compensation Rating Reform to study the merits of requiring each insurer to individually file its expense and profit portion of a rate filing, while permitting each insurer to use a loss cost filing made by a licensed rating organization. The committee must also study options for the current prior approval system, including procedures that would promote greater competition and would encourage insurers to write coverage in the state while protecting employers from rates that are excessive, inadequate, or unfairly discriminatory. The committee, consisting of three Senators and three Representatives, must issue its final report by December 1, 2003.

If approved by the Governor, these provisions take effect October 1, 2003, unless otherwise provided.
Vote: Senate 25-14; House 81-34

AUTOMOBILE INSURANCE

CS/SB 32-A — Motor Vehicle Insurance

by Banking and Insurance Committee and Senator Alexander

This bill creates the "Florida Motor Vehicle Insurance Affordability Reform Act" which implements various changes to the personal injury protection (PIP) automobile insurance laws and other related statutory provisions. The bill provides for the following:

Criminal Penalties for PIP Fraud

The bill creates new crimes for soliciting accident victims; intentionally causing motor vehicle accidents; disclosing confidential vehicle accident reports; presenting false or fraudulent motor vehicle insurance cards; and specified fraudulent actions by insurers and providers. It increases penalties for soliciting accident victims and presenting false or fraudulent insurance applications; provides minimum mandatory penalties for intentionally causing motor vehicle accidents and soliciting accident victims during the 60-day period accident reports are confidential; and increases the ranking of solicitation crimes and certain motor vehicle insurance fraud offenses under the Offense Ranking Chart law.

Regulation of Health Care Clinics

The bill transfers health care clinic regulation from the Department of Health to the Agency for Health Care Administration (AHCA) to be funded by license application fees up to $2,000, effective October 1, 2003. License applications must be submitted by March 1, 2004. The bill strengthens clinic regulation by requiring licensed clinics to meet specified financial and other conditions; authorizes AHCA to conduct clinic inspections; and requires Level 2 criminal

background screenings, under ch. 435, F.S., of clinic applicants who have a 5 percent or more ownership interest in the clinic, and other licensed medical employees.

It further prohibits an applicant who has committed a Level 2 crime (including violations relating to insurance fraud) within the past 5 years from obtaining a clinic license or working as a licensed medical provider, medical director, or clinical director; provides that civil rights must be restored prior to obtaining a license; mandates clinics to allow AHCA complete access to premises and records; authorizes the agency to impose administrative fines or seek corrective action from clinic owners or directors under specified circumstances; and requires magnetic resonance imaging (MRI) clinics to become accredited by specified national organizations within one year of licensure, with a single 6-month extension if there is evidence of good cause shown.

The bill authorizes AHCA to promulgate rules and to institute injunctive proceedings and other agency actions under specified circumstances. It provides for new crimes and penalties associated with operating an unlicensed clinic and requires that providers who are aware of the operation of an unlicensed clinic, but fail to report such clinic, be reported to an appropriate licensing board. The bill appropriates $2.5 million from the Health Care Trust Fund for 51 full-time equivalent positions for AHCA to implement the clinic licensure program.

PIP Payment and Billing Provisions, Disclosure and Acknowledgment Form; Unnecessary Diagnostic Tests, Independent Medical Examinations

The bill revises provisions governing the submission and payment of PIP benefits so that statements are in compliance with specified coding and billing requirements. It provides that consideration may be given to evidence of the usual and customary charges and payments accepted in the community when determining whether a particular charge for medical services covered by PIP is reasonable, including consideration of other reimbursement levels in the community, state and federal fee schedules, and other information applicable to automobile and other insurance coverages. It provides that PIP coverage will be voided by an act of insurance fraud that is admitted to in a sworn statement or determined by a court of competent jurisdiction. It allows insurers to sue to recover monies paid to a person who committed insurance fraud and provides for recovery of costs and attorneys fees to the prevailing party in any such action.

The bill specifies that PIP insureds and insurers are not required to pay for charges that are not lawful, contain false or misleading statements, or are improperly upcoded or unbundled for the purpose of obtaining a higher reimbursement than otherwise due. However, an MRI facility may globally combine both the technical and professional components, if the total billed amount is not more than the components billed separately.

The bill clarifies that the current fee schedule that applies to specified services based on a percentage of the Medicare fee schedule is the participating physician fee schedule under Medicare Part B, and revises the method for making an annual adjustment to the fee schedule on August 1 of each year.

The bill requires the Financial Services Commission to adopt by rule (by October 1, 2003) a "disclosure and acknowledgment form" which providers and the insured person or his or her guardian must execute, at the *initial treatment* of the insured. The form must reflect that:

- The insured or guardian attests to the fact that the services set forth therein were actually rendered.
- The insured or guardian was not solicited to seek medical services from the provider.
- The provider rendering the service explained the services to the insured or guardian.
- If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

This legislation further requires the original disclosure and acknowledgment form to be furnished to the insurer when billed by the provider. The bill mandates that for subsequent services, a provider (except for a hospital) maintain a patient log signed by the patient by date of service that is consistent with services being rendered. Hospitals must, however, maintain specified medical records and make such records available to insurers upon request.

The bill provides for an anti-fraud financial incentive to consumers that if, based on a written report by a person, the insurer finds improper billing by a medical provider, the insurer would pay the person 20 percent of the amount of the reduction up to $500, or pay 40 percent if the provider is arrested due to improper billing. The bill also prohibits insurers from systematically downcoding with the intent to deny reimbursement otherwise due.

The bill authorizes the Department of Health, in consultation with the appropriate professional licensing boards, to establish by rule a list of diagnostic tests that are *not medically necessary*, and therefore not compensable, by January 1, 2004. Such lists shall be revised from time to time as determined by the department.

The bill requires that only Florida physicians may conduct independent medical examinations (IME); prohibits insurers or their employees from improperly requiring physicians to materially change IME reports (provided that this does not preclude the insurer from notifying the physician of errors of fact in the report based on information in the claim file); and, provides that the denial of payment as the result of such a changed opinion constitutes a material misrepresentation by the insurer under the Insurance Code. The bill mandates physicians who prepare IME reports, and physicians rendering expert opinions on behalf of persons claiming PIP benefits, to maintain such reports and applicable payment records for at least 3 years.

Demand Letter

This legislation expands the current presuit demand letter provision to be applicable to all PIP disputes and increases the time for insurers to respond to the demand letter from 7 business days to 15 calendar days. A demand letter must be sent to a PIP insurer prior to filing any action for

PIP benefits, and if the claim is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount, up to $250, no action may be brought against the insurer (and, therefore, no attorney's fees would be awarded against the insurer).

Increased PIP Benefits by the Financial Services Commission

The bill provides that if the Financial Services Commission determines that cost savings under PIP have been realized due to the provisions in this act, prior reforms, or other factors, then the Commission *may increase* the minimum $10,000 benefit coverage requirement. However, in establishing the amount of the increase, the Commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized by the $10,000 PIP coverage.

Deductibles

The bill changes the calculation of the PIP deductible to require that it must be applied to 100 percent of medical expenses, rather than to the current 80 percent of expenses that PIP pays. It also changes the calculation of the PIP deductible so that the full $10,000 in PIP benefits can be obtained. This latter provision has the effect of requiring PIP to pay more than it does currently if a deductible is elected. The bill also eliminates the $2,000 PIP deductible, so that the allowable deductibles would be: $250, $500, and $1,000. The bill further provides that liability suits may be brought by an injured person to recover the amount of his or her PIP deductible from the at-fault driver.

PIP Reports to the Legislature

The bill requires the Department of Financial Services, the Department of Health, and AHCA to each submit a report by December 31, 2004, to the President of the Senate and the Speaker of the House of Representatives on the implementation of this bill and recommendations, if any, to further improve the automobile insurance market, and reduce costs, fraud, and abuse. The report by the Department of Financial Services must include a study of the medical and legal costs associated with PIP claims.

Sunset Provision

The bill provides that effective October 1, 2007, the Florida Motor Vehicle No-Fault Law is repealed, unless reenacted by the Legislature during the 2006 Regular Session.

Repeals $10 Fee Increase Pertaining to Licensed General Lines Agents

The bill repeals the $10 per policy fee increase (from $10 to $20) that general lines agents would have been authorized to charge to cover administrative expenses on motor vehicle insurance policies which passed during the 2003 Regular Session in CS/SB 2364. The bill provides that,

notwithstanding the amendments made by CS/SB 2364, s. 627.7295(5)(a), F.S., is *not amended* and is reenacted. In effect, the bill returns to current law the agent fee provision.

Effective Dates

The bill takes effect October 1, 2003, with certain exceptions. In addition to the specific effective dates noted above, the bill provides the following effective dates:

- Section 456.0375, F.S., relating to clinic regulation by the Department of Health, is repealed effective March 1, 2004 (because that is the date applications for clinic licenses are to be submitted to AHCA).
- Any increase in benefits approved by the Financial Services Commission under this bill shall apply to new and renewal policies that are effective 120 days after the order issued by the commission becomes final.
- The provisions pertaining to PIP deductibles shall apply to new and renewal policies issued on or after October 1, 2003.
- The provisions applying to the presuit demand letter shall apply to actions filed on and after August 1, 2003.
- The provisions applying to IMEs shall apply to examinations conducted on and after October 1, 2003.
- The provisions applying to subsection (5) of s. 627.736, F.S., (charges for treatment of injured persons) shall apply to treatment and services occurring on or after October 1, 2003.

If approved by the Governor, these provisions take effect October 1, 2003.
Vote: Senate 36-0; House 97-19

USE OF CREDIT REPORTS BY INSURERS

SB 40-A — Insurance Consumer Protection (Use of Credit Reports; Managing General Agent Fees)

by Senator Miller

This bill regulates and limits the use of credit reports and credit scores by insurers for underwriting and rating personal lines motor vehicle insurance and personal lines residential insurance. The bill takes effect January 1, 2004, except that it shall not take effect unless SB 42-A or similar legislation is adopted and becomes law. SB 42-A was also adopted, which provides a public records exemption for credit scoring methodologies filed with the Office of Insurance Regulation. See the summary of SB 42-A for additional information.

This bill also repeals the increase in the maximum per-policy fee (from $25 to $40) that managing general agents (MGAs) would have been permitted to charge, as provided in HB 513 that was adopted during the 2003 Regular Session. Notwithstanding the amendments to s. 626.6451, F.S., by HB 513, this bill (SB 40-A) provides that s. 626.7451(11), F.S., is not amended and is reenacted. In effect, the current law and the current MGA fee remain unchanged.

This bill requires that a rate filing that uses credit reports or credit scores must comply with the requirements of s. 627.062, F.S., or s. 627.0651, F.S., to ensure that rates are not excessive, inadequate, or unfairly discriminatory.

Insurers would be required to notify an applicant or insured, in the same medium as the application is received, that a credit report is being requested for underwriting or rating purposes. An insurer would be prohibited from requesting a credit report based upon the race, color, religion, marital status, age, gender, income, national origin, or place of residence of the applicant or insured. If an insurer makes an adverse underwriting or rating decision based upon a credit report, the insurer, or a designated third party, would be required to provide a copy of the credit report to the applicant or insured. The insurer would be required to include the four primary reasons, or fewer if applicable, that were the primary influences of the adverse decision. The bill would establish rights and responsibilities for the insured or applicant and the insurer to address adverse underwriting or rating decisions made by the insurer and would establish an appeal process for an insured or applicant whose credit report or credit score is unduly influenced by the death of a spouse or temporary loss of employment.

The bill would prohibit an insurer from making an adverse decision relating to underwriting or rating solely because of the credit information contained in a credit report or credit score. An insurer would be prohibited from making an adverse decision if based, in whole or in part, on any of the following factors: 1) the absence of, or insufficient credit history, in which case the insurer must treat the consumer as otherwise approved by the Department of Financial Services if the insurer presents information that such an absence or inability is related to the risk for the insurer; 2) collection accounts with a medical industry code, if so identified on the consumer's credit report; 3) place of residence; or 4) any other special circumstance that the Financial Services Commission determines, by rule, lacks sufficient statistical correlation and actuarial justification as a predictor of insurance risk. An insurer would be authorized to use the number of credit inquiries requested or made regarding the applicant or insured except in certain circumstances.

An insurer would be required to re-evaluate the credit history of an insured that was adversely impacted by the use of the insured's credit history, at the initial rating of the policy or at a subsequent renewal, every 2 years or upon the request of the insured, whichever occurs first. As an alternative, an insurer could re-evaluate the insured within the first 3 years after the inception of the policy based on other allowable underwriting or rating factors, excluding credit information, provided that the insurer does not increase the rates or premium charged to the insured based on the exclusion of credit reports or credit scores.

The Financial Services Commission would be authorized to adopt rules to administer the provisions of this act and the rules may include: 1) certain information in the filings to demonstrate compliance relating to adverse decisions by the insurer; 2) statistical information an insurer must retain and report annually to the Office of Insurance Regulation; 3) standards that ensure that the use of a credit report or credit score does not unfairly discriminate, based upon race, color, religion, marital status, age, gender, income, national origin, or place of residence; and 4) standards for reviewing methods to grade or rank credit report data.

If approved by the Governor, these provisions take effect January 1, 2004, except that it shall not take effect unless SB 42-A or similar legislation is adopted and becomes law.
Vote: Senate 40-0; House 114-1

CS/SB 42-A — Credit Scoring Insurance Information/Public Records

by Banking and Insurance Committee and Senator Miller

This bill creates a public records exemption for credit scoring methodologies and related information that are trade secrets as defined in s. 688.002, F.S., and that are filed with the Office of Insurance Regulation (OIR) pursuant to a rate or other filing by an insurance company. Section 688.002, F.S., defines a "trade secret" to be information, including a formula, device, or method that derives independent economic value from not being generally known to other persons who can obtain economic value from its disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

The bill further provides that it is a public necessity for credit scoring methodologies and related data to be confidential and exempt because such information contains proprietary information that has economic value and could harm the business of the insurer. The bill provides for future review and repeal.

The related substantive credit scoring bill, which also passed during 2003 Special Session "A" (SB 40-A), regulates and limits the use of credit reports and credit scores by insurers for underwriting and rating purposes relating to personal lines motor vehicle and homeowner's insurance.

If approved by the Governor, these provisions take effect January 1, 2004, provided that SB 40-A or similar legislation is adopted in the same legislative session, or extension thereof, and becomes law.
Vote: Senate 37-1; House 112-2