



OFFICE OF INSURANCE REGULATION

2004 Legislative Summary

A Review of Appropriations and Legislation Affecting Insurance



July 22, 2004

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June 1, 2004

Dear Friends:

During the 2004 Legislative Session, the Florida Legislature passed several bills related to insurance. The Office of Insurance Regulation's "2004 Legislative Summary" provides you with a comprehensive summary of substantive bills and legislative appropriations affecting the Office.

One of the most notable pieces of legislation passed this year was SB 2488, the Hurricane Catastrophe Fund, signed by Governor Bush on May 11, 2004. This legislation was a collaborative effort by the Department of Financial Services, the Office of Insurance Regulation, the State Board of Administration and the insurance industry to bring stability and added capacity to the homeowner's insurance market of Florida.

In addition, SB 2994, the CFO Glitch/Adjusters Bill passed this Session. The legislation corrects references to the Department and Office, places the regulation of public adjusters under the purview of the Department of Financial Services and certain board appointment responsibilities are now given to the Director of the Office of Insurance Regulation. Although a deleterious viatical regulation amendment was placed on this good bill, important pieces of legislation were also amended onto the Glitch Bill, such as added protections for seniors investing in annuities and other enhanced consumer insurance protections.

I hope this summary proves to be a useful and informative tool.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin M. McCarty".

Kevin M. McCarty
Director, Office of Insurance Regulation

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2004-2005 General Appropriations Act

HB 1835 – Appropriations by Kyle / Pruitt

Issue	2003-2004 Funding	2004-2005 Funding	Difference Over/(Under)
Positions	298	305	7
	* OIR received 1 FTE position (Senior Research Economist) to analyze competition in the workers compensation market - \$92,096; 3 FTE positions in the Legal Services Office to assist in the prosecution of unauthorized insurance entities - \$257,388; and 3 FTE positions to regulate the Medical Discount Plan Organizations - \$169,069		
OPS	\$1,432,750	\$3,257,750	(\$275,000)
	* \$2.4 million is provided for the Company and Other Regulated Entities project to design and develop a Financial Analysis “Electronic Document Management System” Workflow		
	* \$300,000 is provided for the Public Hurricane Model to evaluate homeowners’ insurance rates – maintenance and support		
Expense	\$2,492,915	\$3,127,318	\$134,403
	* \$500,000 is provided for the development of a system to analyze competition in the workers compensation marketplace (SB 1926)		
OCO	\$2,000	\$153,500	\$151,500

DISCLAIMER: The Appropriations above represent funds allocated to the Office of Insurance Regulation as approved for the annual period beginning July 1, 2004 and ending June 30, 2005. Line item funding is contingent upon being approved or vetoed by the Governor.

In addition, HB 1629 – Health Care contains \$250,000 to implement the Small Employers Access Program and \$250,000 to enable the board of the Florida Health Insurance Plan to conduct an actuarial study.

Agency/Personnel Issues

Salaries/ Benefits	Effective December 1, 2004, eligible employees shall receive a non-recurring lump sum one-time bonus in the amount of \$1,000. Career Service, Senior Management Service, and Select Exempt Service employees are eligible.
State Group Health Insurance	EMPLOYEE (July 1, 2004 – June 30, 2005) - no increase <ul style="list-style-type: none">• \$48.68 individual coverage• \$175.14 family coverage STATE (July 1, 2004 – December 31, 2004) - no increase <ul style="list-style-type: none">• \$288.68 individual coverage• \$590.30 family coverage STATE (January 1, 2005 – June 30, 2005) – 10% increase <ul style="list-style-type: none">• \$322.44 individual share• \$666.85 family share
Prescription Drug Co-Payments	\$10 generic drugs <ul style="list-style-type: none">• \$20 generic mail order \$25 preferred brand name <ul style="list-style-type: none">• \$50 preferred brand name mail order \$40 non-preferred brand name <ul style="list-style-type: none">• \$80 non-preferred brand name mail order
HMO Office Visits	\$15 Primary Care Physician Office Visits - no increase \$25 Specialty Care Physician Office Visits - no increase
Legal Bar Dues	Funds in the General Appropriations Act may be expended for bar dues and for legal education courses for attorneys employed by the State as legal staff.
Tuition Waivers	The state shall provide up to six (6) credit hours of tuition-free courses per term at a state university or community college to full-time employees on a space available basis.

2004-2005 Agency Performance Measures

<u>MEASURE</u>	<u>STANDARD</u>
- Compliance and Enforcement -	
Average number of days from date of application for a new certificate of authority initially submitted to the DOI to the date the DOI approves or denies the application	180 days
Number of applications processed	328
Number of rate and forms review completed	13,000
Number of financial review and examinations completed	12,470
Number of market conduct examinations completed	760
Current number of licensed/regulated insurance entities	3,500
Percent of companies meeting required financial standards	95.00%
Residual market premium as a percent of total premium for homeowners' (total), mobile home, dwelling fire insurance	22.50%
Residual market premium as a percent of total premium for workers compensation insurance	0.75%
Residual market premium as a percent of total premium for automobile insurance	0.50%
Average risk based capital percentage	5.00%
- Executive Direction and Support Services -	
Administrative costs as a percent of total agency costs	< 12.6%
Administrative costs as a percent of total agency positions	< 12.6%

* NOTE: The 2004-2005 Agency Performance Measures and Standards were determined by the Legislature in HB 1837 – General Appropriations Act Implementing Bill. The Office of Insurance Regulation is required to revise their long-range program plan under 216.013, Florida Statutes, to be consistent with these performance measures and standards.

OIR Legislative Priority Bills

*This summary presents legislative changes enacted during the 2004 Legislative Session.
For more information, please visit <http://www.leg.state.fl.us/>*

SB 2488 – Florida Hurricane Catastrophe Fund by Alexander / Berfield

Increases the overall capacity in the CAT Fund from \$11 billion to \$15 billion. Allows capacity growth to increase with exposure growth (the growth of insured values). Provides language that restricts the dollar growth in capacity to no greater than the dollar growth of the cash balance of the Fund. Allows full recharging of the CAT Fund following a major hurricane (creates \$15 billion of subsequent season capacity which also grows over time). Provides a transitional provision for insurers, which allows an option to select coverage for the 2004-2005 year based on a capacity of \$11 billion and aggregate insurance industry retention of \$4.866 billion (similar to coverage before the law change).

Resets the insurance industry aggregate retention (deductible) to \$4.5 billion, which grows with exposure growth. Increases the emergency assessment authority to finance the increased capacity from 4% per year and 6% aggregate to 6% per year and 10% aggregate. Provides a three-year exclusion from emergency assessments for medical malpractice insurers. Changes the method insurers recoup emergency assessments from their policyholders. Adds surplus lines to the emergency assessment base of the CAT Fund.

Clarifies that emergency assessments may be used for debt service coverage and may also be used to refinance debt. Clarifies that mitigation appropriations are based on the most recent fiscal year-end audited financial statements. Increases the exposure limit for insurers who opt to be exempted from participation (from \$500,000 to \$10 million). Broadens the selection of reinsurers by allowing for the purchase of reinsurance through reinsurers approved by the Office of Insurance Regulation (OIR). Provides OIR with rulemaking authority to allow the charging of interest on late remittances. Allows the State Board of Administration to exclude by rule the deductible buy-back and commercial residential excess policies (excludes type or category policies that require individual ratemaking). Clarifies how excess recoveries will be allocated between Citizens' accounts.

Provides greater flexibility for covering additional living expenses, without limiting coverage for some insurers. Adds a definition of "corporation" to eliminate confusion when referring to the CAT Fund Finance Corporation and the Citizens Property Insurance Corporation. Clarifies the publication of borrowing capacity estimates and notification requirements to provide insurers with more meaningful and timely information. Deletes language that requires recoveries from reinsurers and the CAT fund shall not exceed 100% of the insurer's losses. Modifies auditing language requirements to reflect current reinsurance contracts with the CAT Fund.

Requires insurers to include an appropriate adjustment, if any, to reflect the expanded CAT Fund capacity growth and reinsurance provisions no later than their next annual rate filing or certification. States no adjustment is necessary if the rates are in compliance with section 627.062, Florida Statutes. EFFECTIVE DATE: *Except as otherwise provided in the bill, these provisions take effect May 11, 2004.* **{Chapter Law 2004-27}**

SB 2994 – CFO Glitch/Adjusters by Posey / Negron

Amends various sections of the insurance and banking code to comply with the governmental reorganization of the Department of Insurance and the Department of Banking and Finance. Corrects technical references, conforms language, and renumbers and transfers various sections. Authorizes the Chief Financial Officer (CFO) to contract for accounting and payroll services with state universities, community colleges, local governments, constitutional officers and other entities that have received funds from the state. Requires collected funds to be deposited into the General Revenue Fund. Provides the CFO with the ability to have an official seal (different from the former Comptroller's seal). Clarifies how the CFO shall administer a collateral management service for state agencies. Provides criteria for deposited or pledged eligible collateral. Provides authority for the CFO to adopt proper management and maintenance rules of the collateral management service. Clarifies that the CFO may use reverse repurchase agreements (a purchase of a security under an agreement to sell it back to the seller at future date).

Transfers the authority to license and regulate insurance adjusters from the Office of Insurance Regulation (OIR) to the Department of Financial Services (DFS). Clarifies that the Chief Financial Officer may also be known as "Treasurer", the Director of Insurance Regulation may also be known as "Commissioner of Insurance Regulation", and the Director of Financial Regulation may also be known as "Commissioner of Financial Regulation". Provides that the Director of the Office of Insurance Regulation, rather than the Chief Financial Officer, will make the appointment to the board of directors for the Florida Employee Long-Term Care Plan Act.

Provides that State University System employees are eligible to continue participation in the State Deferred Compensation Program. Clarifies that the State Deferred Compensation Program is funded in part from fees charged by investment providers to plan participants. Adds the Commissioner of Agriculture to the Financial Management Information Board and to the board's coordinating council. Extends the sunset date for the Enterprise Resource Planning Integration Task Force (coordinates the state's financial and accounting information systems) from July 1, 2004 to July 1, 2008.

Consolidates financing of deferred-payment purchases. Allows for a centralized financing process under the CFO for the financing of Guaranteed Energy Performance Savings Contracts. Provides a cap on the time period (10 years) for the repayment of funds drawn to the agreement. Provides that the Director of OIR, rather than the CFO, will make the appointment to the State Comprehensive Health Information System Advisory Council. Exempts any person or activity regulated under the laws administered

by the former Department of Insurance, now administered by the Department of Financial Services for purposes of the Deceptive and Unfair Trade Practices Act.

Addresses miscellaneous provisions (sections 17, 147-166) pertaining to property and casualty insurance; automobile insurance; credit life and disability insurance; premium finance companies; adoption of mortality tables; reinsurance; local government workers' compensation self-insurance, and other insurance issues (please refer to SB 2038 - these provisions are identical to the language in SB 2038).

Provides that the offer, sale, and purchase of viatical settlement contracts and the regulation of viatical settlement providers shall be within the exclusive jurisdiction of the Office of Insurance Regulation. Provides that the Director of OIR, rather than the CFO, will make the appointment to the Florida Commission on Hurricane Loss Projection Methodology and the board of the Small Employer Health Reinsurance Program.

Makes revisions to the banking code to clarify current law. Permits banks to comply with subpoenas in lieu of seeking a court order. Permits banks to set a reasonable cost for complying with a subpoena. Establishes criteria to prohibit deceptive use of a bank name. Permits banks to form as Limited Liability Companies. Removes daily liquidity calculations for financial institutions. Requires financial institutions to pay a nonrefundable \$35 fee for a background check by the Office of Financial Regulation (OFR) for prospective directors. Permits notification of OFR for branch and office relocations for banks. Amends the statute of limitations on fraudulent signatures to 180 days and fraudulent endorsements to one year. Conforms the Florida Banking Code to the Florida Probate Code as to safe deposit boxes.

Provides that the cancellation of a workers' compensation policy, if requested by the policyholder, is effective on the date the insurer sends the notification to the insured, and is not subject to the 30 days notice requirement (this provision is also contained in SB 2588). Makes numerous changes to the Florida Disposition of Unclaimed Property Act, providing for the reversion and disposition of abandoned property to the state. Increases the protection interest of missing property owners through the Department of Financial Services, Bureau of Unclaimed Property.

Creates standards and procedures for recommendations to senior consumers when purchasing or exchanging annuity products. Adds provisions based on model regulations adopted by the National Association of Insurance Commissioners. Defines a senior consumer as a person 65 years or older. Requires specified duties for the insurers and insurance agents involved in recommending the purchase or exchange of an annuity. Requires the insurer or insurance agent to have reasonable grounds for believing their recommendation is suitable based on the facts disclosed by the senior consumer. Requires reasonable efforts to be made to obtain the senior consumer's financial status, tax status, and investment objectives. Provides an obligation exemption if the senior consumer: (a) refuses to provide relevant information, (b) decides to enter into a transaction that is not based on the insurer or insurance agent recommendation, or (c) fails to provide accurate or complete information.

Requires insurers, insurance agents, and managing general agents to establish a system to supervise recommendations to senior consumers, such as: written procedures and periodic reviews of records. Allows contracting with a third party to establish a system to supervise recommendations to senior consumers. OIR may order an insurer to take reasonable appropriate corrective action for any senior consumer that is harmed by a violation of the senior annuities provisions. DFS may order an insurance agent or managing general agent to take reasonable appropriate corrective action for any senior consumer that is harmed by a violation of the senior annuities provisions. Requires information collected from the senior consumer, used in making the recommendations, to be kept for 5 years after the insurance transaction. Records may be maintained in hard copy, electronic format, or any other process that allows for reproduction of documentation. *EFFECTIVE DATE: Except as otherwise provided in the bill, the act shall take effect July 1, 2004. {Chapter Law 2004-390}*

Life and Health Bills

SB 708 – Local Government Accountability by Atwater / Stargel

Creates a pilot program in Monroe County to explore alternatives for making affordable health insurance coverage available in rural counties. Allows Monroe County, through a non-profit corporation, to create a self-insurance health plan. The self-insurance plan shall insure residents of a rural county or similar area, for those individuals unable to obtain adequate or affordable health insurance coverage. Requires the plan to be approved by the Office of Insurance Regulation and premiums to be actuarially sound. Requires the Office of Insurance Regulation to consult with the Department of Health, confirming the program is consistent with the purpose and scope of Chapter 381, Florida Statutes, relating to public health. *EFFECTIVE DATE: Upon becoming law.* **{Chapter Law 2004-305}**

SB 1088 – HMO Provider Contracts by Cowin / Homan

Requires health maintenance organizations (HMO) that have contracts with health care providers to disclose the complete schedule of all reimbursements for which the HMO and the provider of health care services have contracted. Disclosure includes any deviations from the contracted schedule of reimbursements requested by the HMO and agreed upon by the provider. Allows HMO's to provide the schedule of reimbursement to providers by either electronic means or in writing. Clarifies that reimbursement schedules are subject to the nondisclosure provisions of the contract, and the provider must maintain the confidentiality of the schedule. *EFFECTIVE DATE: January 1, 2005.* **{Chapter Law 2004-321}**

SB 1226 – Long-Term Care Service Delivery System by Health, Aging and Long-Term Care / Murman

Implements the recommendations contained in Senate Interim Project Report 2004-144, "Model Long-Term Care System/Analyzing Long-Term Care Initiatives in Florida." Requires the Department of Elderly Affairs to select long-term care community diversion pilot project providers that are determined by the Department of Financial Services (Chapter 641 is regulated by the Office of Insurance Regulation) to demonstrate the following: a) surplus requirements comparable to HMO's contained in s. 641.225, F.S.; b) HMO financial solvency standards in s. 641.285, F.S.; c) HMO prompt payment of claims in s. 641.3155, F.S.; d) strong data collection technology capabilities that meet federal HIPAA security requirements; and e) the capacity to contract with multiple providers of the same service type. *EFFECTIVE DATE: Upon becoming law.* **{Chapter Law 2004-386}**

HB 1629 – Health Care by Farkas / Peadar

Creates an act relating to affordable health care based upon the work and recommendations from the Select Committee on Affordable Health Care for Floridians. The Select Committee held public hearings around the state of Florida to understand the health insurance market and to identify, explore, and debate new ideas for change. The act is termed "The 2004 Affordable Health Care for Floridians Act". Provides that

the act was created to address the underlying cause of double-digit increases in health insurance premiums by mitigating the overall growth in health care costs.

Provides transparency and availability of health care facility information to patients. Requires health care facilities, providers, and health insurers to submit information to the Agency for Health Care Administration (AHCA). Requires AHCA to make performance outcome and financial data available to patients and consumers, including retail prices for the 50 most frequently prescribed medicines of licensed pharmacies, and patient charges and data for health care facility procedures. Requires pharmacies to make the financial data published by AHCA available on their websites and requires posting of where prescriptions are filled. Charges AHCA to require health care facilities, health care providers and health insurers to submit the number of patients treated in the emergency department of licensed hospitals. In addition, requires data on hospital-acquired infections, data on complications, and data on readmissions as specified by rule. Clarifies that AHCA shall conduct research, analyses, and studies relating to health care costs, health care access, and health care quality services in conjunction with the Office of Insurance Regulation as to the availability and affordability of health insurance for small businesses.

Provides that the State Center for Health Statistics will develop and implement, in conjunction with the State Comprehensive Health Information System Advisory Council, a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. Requires AHCA to submit an initial long-range plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by March 1, 2005, and requires the plan and report to be updated annually. Requires AHCA to make the plan and status reports available on its Internet website.

Renames the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program. Clarifies records that must be provided to AHCA by health care providers or managed care entities. Clarifies panel membership and defines a quorum as a majority of the panel.

Expands the definition of health flex plans to include a public-private partnership that develops and implements an approved health flex plan and is responsible for administering and paying claims for the health flex plan by enrollees. Provides statewide eligibility for the health flex plans by deleting language establishing the health flex plans as a pilot project in the three areas of the state with the highest number of uninsured persons and Indian River County. States that a health flex plan may include the option of a catastrophic plan supplement. Requires AHCA to ensure health flex plans have standard grievance procedures similar to those required of health maintenance organizations. Provides OIR with regulatory oversight of health flex plan advertisement and marketing procedures.

Creates the Florida Patient Safety Corporation as a not-for-profit corporation to serve as a learning organization assisting health care providers in improved quality and safety of health care. Requires the Corporation to work with a consortium of patient safety

centers and other patient safety programs in Florida universities. Creates a board of directors to include: (a) the chair of the Florida Council of Medical School Deans, (b) two representatives with expertise in patient safety issues for the authorized health insurer and authorized health maintenance organization with the largest market shares, (c) one representative of an authorized medical malpractice insurer appointed by the Florida Insurance Council, (d) the president of the Central Florida Health Care Coalition, (e) two Florida hospital representatives that implement innovative patient safety initiatives, appointed by the Florida Hospital Association, (f) a physician with expertise in patient safety, appointed by the Florida Medical Association, (g) a physician with expertise in patient safety, appointed by the Florida Osteopathic Medical Association, (h) a physician with expertise in patient safety, appointed by the Florida Podiatric Medical Association, (i) a physician with expertise in patient safety, appointed by the Florida Chiropractic Association, (j) a dentist with expertise in patient safety, appointed by the Florida Dental Association, (k) a nurse with expertise in patient safety, appointed by the Florida Nurses Association, (l) an institutional pharmacist, appointed by the Florida Society of Health-System Pharmacists, and (m) a representative of the Florida AARP, appointed by the state director of the Florida AARP.

Requires AHCA to assist the Corporation in its organizational activities. Requires the Corporation to seek private funding and apply for grants to accomplish its goals and duties. Requires the Corporation to submit a report of its activities to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2004 and report annually thereafter.

Provides legislative intent to secure a more stable and orderly health insurance market, through the establishment of a plan to assume risks deemed uninsurable by the private marketplace. Creates the Florida Health Insurance Plan (a high risk pool) to make coverage available to individuals with no other options, at a premium commensurate with the risk and benefits provided. Creates a board of directors to implement the plan and provides that the plan shall operate subject to the supervision and control of the board. The board consists of (a) the Director of the Office of Insurance Regulation or his or her designated representative, who shall serve as chair, (b) five members appointed by the Governor, at least two of whom shall be individuals not representative of insurers or health care providers, (c) one member appointed by the President of the Senate, (d) one member appointed by the Speaker of the House of Representatives, (e) and one member appointed by the Chief Financial Officer. Requires the plan to be submitted to the Financial Services Commission (within one year after appointment of the board of directors) for approval.

Establishes a plan of operation to include procedures for the following: operation of the plan; selection of an administrator; creation of a fund for administrative expenses; handling, accounting, and auditing of assets, moneys, and claims of the plan; publication and marketing of the plan's existence; plan eligibility requirements; enrollment procedures; grievances; and other matters as necessary for the board to meet its obligations and duties.

Provides the plan with general powers and authority similar to health insurers. Allows the plan to enter into contracts, with the approval of the Chief Financial Officer; take legal actions to recover or collect assessments; take legal action to avoid payment of improper claims or recover erroneous amounts; establish and modify rates, rate schedules, rate adjustments, expense allowances, agents' commissions, claims reserve formulas, and other actuarial functions; issue insurance policies; appoint appropriate legal, actuarial, investment, and other technical assistance personnel; employ and set the compensation of employees; prepare and distribute certificate of eligibility forms and enrollment instruction forms; provide for reinsurance risks incurred by the plan; provide for and employ cost-containment measures; and design, use, contract, or arrange for the delivery of cost-effective health care services.

Requires the board to submit an actuarial study to the Governor, the President of the Senate, and the Speaker of the House of Representatives that determines the impact the plan's creation will have on the small group market, the number of individuals the pool could reasonably cover at various funding levels, a recommendation as to the best source of funding for anticipated deficits, and the effect on the individual and small group market by including persons eligible for HIPAA coverage. Requires the report to be submitted by December 1, 2004 and annually thereafter to the Governor and the Legislature.

Provides plan funding through premiums capped at 300 percent of standard risk rate. Allows the board to approve a sliding scale surcharge based on the insured's income. Provides that any additional deficits may be funded through amounts appropriated by the Legislature from general revenue sources, including a portion of the annual growth in premium taxes. Requires the board to take the necessary steps to ensure plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure. States the plan is exempt from any Florida tax. Requires the plan to apply for federal tax exemption status.

Provides eligibility of the plan to individuals who are residents of Florida for at least 6 months if evidence is provided that: 1) the person received notices of rejection or refusal to issue substantially similar insurance for health reasons from two or more health insurers; or 2) the person is enrolled in the Florida Comprehensive Health Association (FCHA) the date the plan is implemented. Denies plan eligibility for individuals that are eligible for health insurance coverage substantially similar or more comprehensive, eligible for Medicaid, Medicare, the state's children's health insurance program, or any other federal, state, or local government program that provides health benefits. Requires the plan to offer standard and basic benefit plans to small employers with an option of alternative coverage, such as: catastrophic coverage with a minimum level of primary care coverage and a high deductible plan that meets the federal requirements of a health savings account.

States the plan's implementation may not occur (other than administration of coverage for persons insured by the FCHA and entering into a contract for an actuarial study) until funds are appropriated for start-up costs and any projected deficits. Provides that the FCHA is abolished and subsumed under the board, upon implementation of the plan.

Defines implementation as the effective date after the first meeting of the board when legal authority and administrative ability exist for the board to subsume the transfer of all statutory powers and duties. Provides that FCHA insureds convert to the new benefits of the plan by January 1, 2005.

Amends the group health insurance, blanket health insurance, and franchise health insurance provisions to be subject to the Florida Statutes relating to the use of specific methodology for payment of claims and the inappropriate utilization of emergency care. Requires small group carriers to offer a high deductible plan that meets the federal requirements of a health savings account plan or health reimbursement arrangement by September 1, 2004.

Provides legislative intent that increased access to health care coverage for small employers with up to 25 employees could improve employees' health and reduce the incidence and costs of illness and disabilities. States that many employers do not offer health care benefits to their employees because of the increased costs of health care. Requires insurers to offer a high deductible medical plan that meets the federal requirement of a health savings account (HSA) plan or a health reimbursement arrangement (HRA) to small businesses seeking medical insurance coverage.

Creates the "Small Employers Access Program" that authorizes OIR to select an insurer, through competitive bidding, as an alternative method to provide coverage to small employers with 2-25 employees within established geographical areas. Allows a small employer, without prior coverage for the last 6 months, to be eligible to participate. Additional eligible groups include: any municipality, county, school district, or hospital employer located in a rural community; nursing home employers; and each dependent of a person eligible for coverage. Provides that the contract term shall not exceed 3 years and at least 6 months prior to the expiration of each contract period, OIR shall invite eligible entities, including the current insurer, to submit bids to serve as the insurer for a designated geographic area. Requires OIR to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than March 15 following the close of the prior calendar year. Requires the report to summarize the activities of the program in the preceding calendar year, including the net written and earned premiums, program enrollment, the expense of administration, and the paid and incurred losses.

Provides legislative intent that finds and declares emergency services and emergency care premiums are significantly increasing. States health care providers and insurers should encourage patients and the insureds to assume responsibility for their treatments, including emergency care. Places the obligation for educating consumers and creating mechanisms to decrease the over-utilization of emergency services on health insurers and providers. Requires health insurers and health maintenance organizations (HMO's) to post website information regarding appropriate utilization of emergency care services. Requires health insurers and HMO's to develop community emergency department diversion programs. Allows health insurers and HMO's to require higher co-payments for urgent care or primary care provided in an emergency

department and higher co-payments for use of out-of-network emergency departments (as a disincentive for insureds to inappropriately use emergency care). Prohibits higher co-payments from being charged for the utilization of the emergency department for emergency care.

Requires each prepaid limited health services organization and health maintenance organization to submit information on health, accident, and medical plan insurance being marketed and in force in Florida. Requires information to be reported to OIR no later than April 1 of each year.

Establishes a comprehensive regulatory scheme for "Discount Medical Plan Organizations". Defines discount medical plan as a "business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. In addition, provides key definitions for plan organizations, marketers, providers, provider networks, medical services and members. Requires medical discount plan organizations to be incorporated in Florida and licensed through OIR prior to doing business in the state. Requires discount plans to fill out an application packet, as determined by the Financial Services Commission, which requires corporation articles and bylaws, background and biographical statements, fingerprint cards, audited financials, etc. (the licensing process is similar to Specialty Insurers). Provides that issued licenses are in effect for one year. Requires a \$50 annual license fee.

Provides OIR with the authority to exam and investigate discount medical plan organizations. Defines that exams and investigations shall be conducted in accordance with Chapter 624, Florida Statutes. Requires exam costs to be paid by the licensee. Allows discount medical plan organizations to charge a monthly fee; however, if it charges more than a monthly fee it must, in case of cancellation by either party, make a pro rata refund to the member. Prohibits discount medical plan organizations from using certain insurance terminology in its marketing and advertising. Prohibits restrictions of free access to the providers with whom the discount medical plan organization has contracted. Prohibits the discount medical plan organization from making payments to its providers. Prohibits a discount medical plan organization from collecting fees for services from the members, in effect acting as an administrator for the providers, unless the discount medical plan organization has a third party administrator license.

Requires discount medical plan organizations to make five disclosures to prospective and actual members: (1) the plan is not a health insurance policy, (2) the plan does not make payments to providers, (3) the plan provides discounts to medical services, (4) the member is responsible for the full amount of the discounted fee, and (5) provide the corporate name and location of the discount medical plan organization. Requires discount medical plan organizations to have a written provider agreement with every individual provider who offers discounts under its discount medical plans. Requires the agreements to state the services and discounts being offered, and must include an agreement that the provider will not charge members in excess of the discount.

Requires discount medical plan organizations to file their forms and rates with OIR. Provides that any charges to members exceeding \$30 per month or \$360 annually must be pre-approved by OIR. Requires forms to be pre-approved by OIR. Establishes that each discount medical plan organization must file an annual report to include: audited financials, a listing of principals, the number of plan members, and other information as required by the Office of Insurance Regulation and Financial Services Commission.

Penalizes organizations that fail to timely file the annual report. Establishes up to a \$500 fine each day, for the first 10 days of failure to file, and up to \$1,000 for each day after the first 10 days of failure to file. Provides that a discount medical plan organization's authority to enroll new members may be suspended by OIR for late-filed annual reports (during which the neglect continues). Provides up to \$50,000 per organization that may be collected for fines related to the annual report. Establishes minimum capital requirements of at least \$150,000 in order for an organization to be licensed. Provides OIR the authority to suspend or revoke the license of a discount medical plan organization when it violates the law, or when its continuing business would be harmful to the public. Requires discount medical plan organizations to provide OIR at least 30 days notice before changing its name or address. Requires organizations to keep an up-to-date web page with a listing of all its providers. Requires the web page address to be located on all marketing materials and discount cards.

Requires discount medical plans to be responsible and financially liable for any acts of its marketers that do not comply with the medical discount plan provisions. Requires a licensed organization to deposit and maintain at least \$35,000 in trust with OIR, in order to protect the plan members. States that violations of the medical discount plan provisions constitute a second-degree misdemeanor. Provides the Financial Services Commission with rulemaking authority regarding discount medical plan organizations.

Creates insurance rebates for healthy lifestyles. Provides that any rate, rating schedule, or rating manual (filed with OIR) by a health insurer or health maintenance organization shall provide an appropriate rebate of premiums paid in the last calendar year when the majority of members have enrolled and maintained participation in any health wellness, maintenance, or improvement program offered by an employer. Authorizes health maintenance organizations that offer point-of-service riders to offer such riders to employers for employees living and working outside the approved geographic service area, without having to obtain a health care provider certificate, as long as the master group contract is within the service area. Requires insurance agents to have a written contract before they may receive any fee or commission for providing or offering advice, counsel, recommendations, or information.

Appropriates \$250,000 from the Insurance Regulatory Trust to OIR for the purpose of implementing the Small Employers Access Program. Appropriates \$250,000 from the Insurance Regulatory Trust Fund to conduct the required actuarial study under the Florida Health Insurance Plan. Provides \$169,069 from the Insurance Regulatory Trust Fund to OIR, and three full-time positions, to regulate the Discount Medical Plan Organizations. Appropriates \$650,000 from the General Revenue Fund to AHCA for the

purposes of implementing the Florida Patient Safety Corporation. Appropriates \$350,000 for start-up funds for the Florida Patient Safety Corporation. Provides \$1,136,171 to AHCA, and 11 full-time positions, for the provisions related to reporting performance and cost data for hospitals, physicians, and pharmacies. *EFFECTIVE DATE: Except as otherwise provided in the bill, these provisions take effect July 1, 2004. {Chapter Law 2004-297}*

SB 2000 – Florida KidCare Program by Appropriations / Kyle

Makes numerous changes to the Florida KidCare program and the Florida Healthy Kids Corporation. Provides for open enrollment periods based upon a unanimous recommendation from the KidCare administrators after consultation with the Social Services Estimating Conference. States that open enrollment is on a first-come, first-served basis and ends when the enrollment ceiling is reached. Defines potential open enrollment periods as January 1-30 and September 1-30.

Requires individuals not already enrolled in the program, including those on the waiting list after January 30, 2004, to re-apply by submitting a new application during an open enrollment period. Provides for an exception to the open enrollment period for the Children's Medical Services Network to enroll up to 120 additional chronically ill children based on emergency disability criteria. Clarifies that insurers under contract with Florida Healthy Kids Corporation are the payers of last resort and must coordinate benefits with any other third party payers who may be liable for the enrollee's medical care.

Requires the Auditor General to recommend mechanisms preventing the enrollment of ineligible children in the program -- due to the Governor and Legislature by March 1, 2005. In addition, the Auditor General is required to periodically audit the Florida Healthy Kids Program through fiscal year 2005-2006 to ensure that only eligible children are enrolled. Grants the Auditor General access to any records, books, accounts, or other documentation relating to the corporation. Requires the Florida Healthy Kids Corporation to contract for an actuarial study on the impact of full paying members on the Florida KidCare program. Instructs the Office of Program Policy Analysis and Government Accountability to perform a study on KidCare premiums and provide a report to the Legislature by January 1, 2005.

Provides an appropriation of \$25 million for fiscal year 2003-2004 to serve the 90,280 children who submitted an application to the KidCare program as of January 30, 2004 and are determined eligible for Title XXI funding. *EFFECTIVE DATE: Except as otherwise provided in the bill, these provisions take effect March 11, 2004. {Chapter Law 2004-1}*

SB 2306 – Radiologists Performing Mammograms by Lynn / Green

States quality mammography services are of the utmost public importance. Stipulates that other diagnostic tools remain available to detect and treat breast cancer. Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) and the Department of Health to study issues relating to the availability, utilization, quality, and cost of mammography services in all facilities performing mammography. Aspects

of the study include, but are not limited to: reimbursement fees, co-payment fees, lawsuits filed, equipment and liability insurance costs, equipment maintenance and calibration, staffing requirements and training, type and number of facilities performing mammography, and other factors that relate to the demand and availability of mammography services. OPPAGA shall complete its study and submit its report to the Legislature by December 15, 2004.

Creates the Workgroup on Mammography Accessibility within the Department of Health. Provides that the workgroup consists of 13 members staffed by the Department of Health, and chaired by the Secretary of Health or his or her designee. The remaining 12 members shall be appointed as follows: the Governor shall appoint four members, the President of the Senate shall appoint four members (one of whom shall be a member of the Senate), and the Speaker of the House of Representatives shall appoint four members (one of whom shall be a member of the House of Representatives). Requires the non-legislative members to have a background in mammography. Directs the workgroup to study: (a) availability, quality of care, and accessibility; (b) need for research and educational facilities; (c) availability of resources, including health personnel and management personnel and (d) patient wait times for screening and diagnostics. Requires the Department of Health to report the workgroup's findings and recommendations for legislative action to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 15, 2004. *EFFECTIVE DATE: Upon becoming law. {Chapter Law 2004-57}*

SB 2448 – Public Health by Saunders / Farkas

Establishes within the Department of Health an Officer of Women's Health Strategy that reports directly to the Secretary of Health. Creates duties for the Officer of Women's Health Strategy that considers gender-specific health care needs of women and takes into account the distinct characteristics of women's health issues. Requires the Officer to review the state's insurance code as it relates to women's health issues. Creates an interagency Committee for Women's Health for the purpose of integrating women's health programs in current operating and service delivery structures. Comprises the committee of the heads or directors of state agencies, including, but not limited to: the Department of Health, the Agency for Health Care Administration, the Department of Education, the Department of Elderly Affairs, the Department of Corrections, the Office of Insurance Regulation of the Department of Financial Services, and the Department of Juvenile Justice.

Establishes a Governor's statewide conference on women's health, co-sponsored by the agencies participating in the Committee for Women's Health and other private organizations and entities impacting women's health in Florida. Requires the Officer of Women's Health Strategy to provide the Governor, the President of the Senate, and the Speaker of the House of Representatives a report with policy recommendations on women's health care needs by January 15 of each year. Requires the chief financial officer of MRI clinics that bill less than 15 percent of its scans to personal injury protection insurance, to ensure billings are not fraudulent. *EFFECTIVE DATE: July 1, 2004. {Chapter Law 2004-350}*

Property and Casualty Bills

SB 160 – Child Support by Lynn / House Insurance

Creates the “Insurance Claim Data Exchange” within the Department of Revenue. Requires the Department to develop and operate an automated data exchange system, wherein an insurer would voluntarily provide monthly information identifying non-custodial parents who owe past due child support and have a claim with the insurer. Provides insurers with several options to conduct the match and submit information. Allows the Department to establish by rule a standard fee, not to exceed actual costs, to pay insurer’s for conducting a data match. Provides civil liability immunity for insurers and other participants in the data match process. Provides the Department with general rulemaking authority to implement this provision. *EFFECTIVE DATE: Upon becoming law. {Chapter Law 2004-334}*

HB 251 – Firefighter and Police Pensions by Sansom / Fasano

Requires the Department of Revenue to create and maintain an electronic database for insurers that report or remit excise taxes on property and casualty insurance premiums. Requires participating local taxing jurisdictions to provide information to enable the Department to properly allocate insurance premium tax remittances due to the firefighter and police pension plans under Chapters 175 and 185, Florida Statutes. Defines “due diligence” for insurance company participation and compliance as two attempted contacts with the agent responsible for a commercial property insurance application. Insurance companies exercising due diligence will be held harmless from any liability related to the payment of the tax. Subjects insurance companies to a 0.5% penalty of tax paid for not exercising due diligence in reporting requirements.

Provides a one-time appropriation of \$300,000 to the Department to create and implement the initial database. Authorizes recurring appropriations to the Department of Revenue from the Police and Firefighter’s Premium Tax Trust Fund for administrative and maintenance costs; not to exceed \$50,000 annually, increased by an inflationary adjustment for future years. Provides the Department with rulemaking authority to implement these sections. *EFFECTIVE DATE: Upon becoming law. {Chapter Law 2004-21}*

SB 626 – Anesthesiologist Assistants by Fasano / Kyle

Provides for the licensure of anesthesiologist assistants under the regulatory jurisdiction of the Board of Medicine or the Board of Osteopathic Medicine. Allows anesthesiologist assistants to practice under the direct supervision of a supervising anesthesiologist or group of anesthesiologists. Provides rulemaking authority to the Board of Medicine and the Board of Osteopathic Medicine to require all anesthesiologist assistants licensed in Florida, to maintain medical malpractice insurance or provide proof of financial responsibility. Allopathic and osteopathic physicians are now subject to disciplinary measures for failure to adequately supervise anesthesiologist assistants. *EFFECTIVE DATE: July 1, 2004. {Chapter Law 2004-303}*

HB 639 – Insurance Guaranty Associations by Fields / Diaz de la Portilla

Revises the definition of “covered claim” for both the Florida Insurance Guaranty Association (FIGA) and the Florida Worker’s Compensation Insurance Guaranty Association (FWCIGA) to exclude claims that have been rejected in another state because the insured’s net worth is greater than allowed under another state’s guaranty fund or liquidation law. Claimants would now have to seek recovery from the company/corporation. Provides for an exception in the FWCIGA for employers who, prior to April 30, 2004, entered into an agreement with the FWCIGA preserving the employer’s right to seek coverage of claims rejected by another state’s guaranty fund. *EFFECTIVE DATE: Upon becoming law. {Chapter Law 2004-89}*

SB 1184 – Condominium and Community Associations by Campbell / Sullivan

Makes several changes to laws governing community associations, including condominium associations, cooperative associations, and homeowner’s associations. Prohibits an insurer to require community associations that purchase or acquire external defibrillator devices to purchase medical malpractice liability coverage as a condition of issuing any other coverage carried by an association. Prohibits an insurer from excluding damages resulting from the use of an automated external defibrillator device from coverage under a general liability policy issued to an association (similar to language in SB 2984). *EFFECTIVE DATE: October 1, 2004. {Chapter Law 2004-345}*

HB 1251 – Workers’ Compensation Underwriting Plan by Berfield / Banking and Insurance

Restructures the existing Workers’ Compensation Joint Underwriting Association (JUA) by eliminating the current subplans and establishing three tiers based on an employer’s loss experience. Tier One provides coverage for employers that have an experience-rating modification factor below 1.0 or, if non-rated, requires employers to have a continuous three-year history of workers’ compensation coverage and a good loss history. Tier Two provides coverage for new employers, employers with moderate experience (an experience-rating modification factor between 1.0 and 1.10), and employers with good experience who do not have a continuous 3-year history of workers’ compensation coverage. Tier Three provides coverage for all other employers that do not meet the criteria for Tiers One and Two.

Caps Tier One premiums at 25 percent above the voluntary market premium and Tier Two premiums at 50 percent above the voluntary market premium, until there is sufficient experience for the JUA to establish actuarially sound rates for the tiers, but not prior to January 1, 2007. Allows the board to establish and charge actuarially sound rates to Tier Three insureds. Requires the JUA to establish actuarially sound premiums (not to exceed \$2,500) for minimum premium policies in Tier One and Tier Two for employers that do not employ non-exempt employees or report payroll. Provides that the premium cap will exist until there is sufficient experience for the JUA to establish actuarially sound rates for Tier One and Tier Two (or no earlier than January 1, 2007). Provides that policyholders in all tiers are subject to a \$475 annual fee to cover administrative and fraud prevention costs. Prohibits the annual fee from being subject to commission.

Permits the 9-member board of governors to request the Office of Insurance Regulation to levy, by order, a “below-the-line” assessment if any deficit exists in Tier One, Tier Two, or any of the former subplans. Provides for a deficit assessment against the premiums charged to insureds on all workers’ compensation policies in the voluntary market for a period of one year. Requires the Office to issue the order after verifying the amount of the deficit. Defines the assessment as a specified percentage of future premium collections, as recommended by the board and approved by the Office. Requires insurers to collect the assessment at the same time they collect the premium payment for each policy. Collected assessments shall be remitted to the plan as provided in the order. Deficit assessments are not considered part of an insurer's rate, are not premiums, are not premium taxes, are not surplus lines taxes, are not fees, are not commissions, and are not considered income. Prohibits deficit assessments to be levied after July 1, 2007. Provides that all policies issued to Tier Three insureds are assessable. Requires Tier Three policies to clearly be identified as assessable by containing at least 10-point type and requires further disclosures.

Provides a one-time appropriation of \$10 million from the Workers’ Compensation Administration Trust Fund (WCATF) in the Department of Financial Services (DFS) for transfer to the JUA to fund any deficit in the JUA (**this \$10 million appropriation was line-item vetoed by the Governor on 5/28/04**). The Chief Financial Officer shall transfer such funds to the plan no later than July 31, 2004. Authorizes the JUA to request from DFS a transfer of an amount not to exceed \$15 million from the WCATF to fund any remaining subplan D deficits, subject to approval by the Legislative Budget Commission.

Requires the Auditor General to perform an operational audit of the Workers’ Compensation Joint Underwriting Association to include: (1) an analysis of the adequacy and appropriateness of the Association’s rates and reserves by an independent consulting actuary, and 2) an analysis of the costs associated with the administration and servicing of policies issued by the JUA to determine cost reduction alternatives. The Auditor General shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2004. *EFFECTIVE DATE: Except as otherwise provided in the bill, the act shall take effect July 1, 2004. {Chapter Law 2004-266}*

SB 1414 – Mobile and Manufactures Homes by Diaz de la Portilla / Russell

Contains a number of statutory changes relating to the regulation of mobile and manufactured homes. Requires each new mobile or manufactured home manufactured or sold in Florida to meet the manufactured home construction and safety regulations promulgated by the U.S. Department of Housing and Urban Development (HUD), pursuant to the Manufactured Housing Improvement Act. Deletes some provisions relating to standards in local building codes, ordinances, and regulations to include: blocking and leveling, tie-downs, utility connections, conversions of appliances, and external improvements on the mobile home. Requires that mobile homes, manufactured homes, and park trailers must be installed on a permanent foundation that resists wind, flood, flotation, over-turning, sliding and lateral movement. Provides that the owner of

the mobile or manufactured home is responsible for the installation in accordance with the Department of Highway, Safety, and Motor Vehicle rules. Removes specific standards such as "hurricane and windstorm resistive". Defines "manufactured homes" to conform to terminology used in the industry. Extends the repeal date of the Hurricane Loss Mitigation Program from June 30, 2006 to June 30, 2011. *EFFECTIVE DATE: Upon becoming law. {Chapter Law 2004-283}*

SB 1926 – Workers’ Compensation by Atwater / Berfield

Requires insurers to notify the Office of Insurance Regulation of any significant underwriting changes that limit or restrict the number of workers' compensation policies or premiums written (the General Appropriations Act requires the Office to establish a database and electronic system to meet these requirements). Provides the Financial Services Commission with rulemaking authority to administer this requirement. Allows workers' compensation insurers to use excess rates with the written consent of the policyholder for a period of 3 years, for employers the insurer takes or keeps out of the Workers' Compensation Joint Underwriting Association, without the policies being subject to the maximum limitation of 10 percent of an insurer's commercial policies. Provides that a workers' compensation insurer may apply a rate deviation to a particular insured (may apply a deviation to some employers and not to other employers) according to underwriting guidelines filed with and approved by the Office. Revises the criteria used in considering an insurer's rate deviation application from the approved workers' compensation rate filed by a licensed rating organization. Allows the Office to continue to consider standards related to a rate's actuarial soundness and financial condition of the insurer, but would no longer allow consideration of the impact of the deviation on the composition of the market, the stability of rates, and the level of competition of market.

Requires the Office to submit an annual report evaluating competition in Florida's workers' compensation market. Defines the reporting criteria, to include: an analysis of the availability and affordability of workers' compensation coverage, whether the current market structure, conduct, and performance are conducive to competition, based upon economic analysis and tests. Requires the annual report to document the Office's investigation and study of all workers' compensation insurers in the state, including any data, statistics, schedules, or other information that assists in the review of workers' compensation rate filings. Provides that the annual report is due to the President of the Senate and the Speaker of the House of Representatives by January 1 each year. *EFFECTIVE DATE: July 1, 2004. {Chapter Law 2004-82}*

SB 2696 – Insurance/Public Construction by Atwater / Brown

Creates owner-controlled insurance programs for public construction projects. Defines "owner-controlled insurance program" as a consolidated insurance program or series of insurance policies issued to a public agency that may provide insurance coverage for public construction project contractors or subcontractors. Includes general liability, property damage excluding coverage for damage to real property, workers' compensation, employer's liability, and pollution liability coverage. Allows a state agency, political subdivision, state university, community college, airport authority, or

other public agency, to purchase an owner-controlled insurance program if it is determined necessary, in the best interest of the entity, and all of the following conditions are met: (a) total project costs are in excess of \$75 million, (b) the program maintains completed operations insurance coverage for a term no less than 5 years, (c) the proposal specifications clearly state the required coverage and minimum safety requirements, (d) the program does not prohibit a contractor or subcontractor from purchasing additional insurance coverage necessary to protect against any liability, (e) provides a deductible or self-insured retention if the deductible or self-insured retention does not exceed \$1 million per occurrence, (f) the program does not include surety insurance, and (g) the public agency is responsible for the deductible payment of all claims.

Requires liability insurers to offer coverage at an appropriate additional premium for liability arising out of current or completed operations under an owner-controlled insurance program for any period beyond which the program provides liability coverage.
EFFECTIVE DATE: October 1, 2004. {Chapter Law 2004-377}

SB 2984 – Homeowners’ Associations by Atwater / Judiciary

Makes several changes to laws governing homeowners’ associations. Prohibits an insurer to require community associations that acquires external defibrillator devices to purchase medical malpractice liability coverage as a condition of issuing any other coverage carried by an association. Prohibits an insurer from excluding damages resulting from the use of an automated external defibrillator device from coverage under a general liability policy issued to an association (similar to language in SB 1184).
EFFECTIVE DATE: Except as otherwise provided in the bill, these provisions take effect upon becoming law. {Chapter Law 2004-353}

Specialty and Miscellaneous Bills

SB 222 – Delivery of Written Legal Notice by Crist / Simmons

Permits the Chief Financial Officer, in lieu of sending service of process by registered or certified mail, to send process by any other verifiable means. Provides that failure of a witness to appear in response to a subpoena not served by certified mail may not be grounds for finding witnesses in contempt. Allows posting of criminal witness subpoenas at the witness's residence if service has been attempted three times and failed. *EFFECTIVE DATE: July 1, 2004. {Chapter Law 2004-273}*

SB 528 – Funeral and Cemetery Industry by Pruitt / Brown

Provides that this act may be called the "Senator Howard E. Futch Act." Merges funeral and cemetery regulation into one board under the Department of Financial Services, and consolidates all cemetery and funeral provisions into one chapter. Consolidates and eliminates duplicative provisions from the two chapters. Creates the Board of Funeral, Cemetery, and Consumer Services and the Division of Funeral, Cemetery, and Consumer Services within the Department of Financial Services. *EFFECTIVE DATE: Except as otherwise provided in the bill, the act shall take effect October 1, 2005. {Chapter Law 2004-301}*

HB 723 – Foster Care by Murman / Lynn

Directs the Florida Coalition for Children, in consultation with the Department of Children and Families, to develop a statewide community-based care risk pool for the protection of eligible lead community-based care providers, their subcontractors, and providers of other social services. Requires the statewide community-based care risk pool plan to be based on an independent actuarial study. Requires the Coalition and Department to develop the plan in consultation with the Office of Insurance Regulation. Requires the plan to be submitted to the Department, the Executive Office of the Governor, and the Legislative Budget Commission for adoption prior to January 1, 2005. *EFFECTIVE DATE: July 1, 2004. {Chapter Law 2004-356}*

SB 1062 – Health Care Facilities by Bennett / Murman

Amends the definition of "facility" to distinguish a Continuing Care Retirement Community's (CCRC) entire facility and the application of the term to its nursing home facility in regard to standards for the use of sheltered nursing home beds (for annual reporting and financial information purposes, the Office of Insurance Regulation only receives information in a comprehensive format from CCRC facilities and does not receive separate data on the nursing home facility portion). Provides that a CCRC's certificate of authority is proof to the Agency for Health Care Administration that the facility has the financial ability to perform. *EFFECTIVE DATE: Upon becoming law. {Chapter Law 2004-298}*

SB 2038 – Insurance by Fasano / Rivera

Requires the Department of Financial Services, Division of Consumer Services, to designate an employee as a primary contact for consumers on insurance issues relating

to sinkholes. Authorizes the Division of Workers' Compensation to enter into a penalty payment agreement schedule with an employer who is unable to pay the full penalty at the time a stop-work order is issued at a jobsite for noncompliance with workers' compensation coverage requirements. Allows an employer to resume business operations if the employer meets coverage requirements and the terms of the penalty payment agreement.

Requires an insurer to reinstate an insurance policy, retroactive to the date of cancellation, if a mortgage lender fails to timely pay an insurance premium, and the payment is less than 90 days overdue. Requires the mortgage lender to reimburse the property owner for any penalty or fees imposed by the insurer and paid by the property owner to reinstate the policy. Provides that the lender must pay the difference between the cost of the previous insurance policy and a new, comparable policy for 2 years, if the premium payment is more than 90 days overdue or if the insurer refuses to reinstate the policy.

Creates a new subsection of law allowing commercial self-insurance funds by two or more local governmental entities to pay workers' compensation benefits. Specifies that the local government self-insurance funds created after October 1, 2004, must initially be subject to the requirements of a commercial fund under subsection 624.4621, F.S. States the funds will be subject to the requirements applied to commercial self-insurance funds or to group self-insurance funds for the first five years. Funds created after January 1, 2005, must, for its first 5 fiscal years, file full and true statements of its financial condition, transactions, and affairs with the Office of Insurance Regulation (OIR). Requires annual and quarterly financial statements. Requires the financial statement forms to be the approved National Association of Insurance Commissioners forms for use by property and casualty insurers. Provides OIR with the ability to grant filing extensions. Requires annual statements to contain an opinion on loss and loss adjustment expense reserves through a member of the American Academy of Actuaries. Grants the Office the ability to review the actuarial opinion through access to work papers upon request.

Modifies reinsurance requirements for a single assuming insurer (reinsurer) to require that at least 50 percent of trust fund monies covers the assuming insurer's liabilities related to reinsurance ceded by United States ceding insurers. Requires trusted surplus to consist of quality assets similar to the requirements for domestic and commercially domiciled insurers under Chapter 625, part II, F.S. Allows the balance of the trust and trusted surplus to be funded through clean, irrevocable, unconditional, and evergreen letters of credit issued by a qualified U.S. financial institution.

Exempts credit disability insurance from the requirement that a health insurer's active life reserve shall not be less than the aggregate pro rata gross unearned premiums for such policies. Requires minimum reserves for single-premium credit disability insurance, monthly premium credit life insurance, monthly premium credit disability insurance, and single-premium credit life insurance policies issued prior to or after January 1, 2004. Allows reserves to be set using new mortality and disability tables.

Permits the Financial Services Commission to adopt the National Association of Insurance Commissioner's (NAIC) mortality and disability tables by rule for policies issued on or after July 1, 2004. Allows for the inclusion of ordinary life policies, disability benefits in or supplemental to ordinary policies, accidental death benefits in or supplemental to policies, annuities, and pure endowment contracts. Permits insurance companies to substitute the ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, for determining the minimum non-forfeiture standard. Requires the mortality table adoption through Financial Services Commission rules. Repeals the minimum reserve for credit life and disability policies to be the unearned gross premium. Repeals the minimum reserve basis for single-premium credit disability insurance.

Provides that a limited license for personal accident insurance may be issued to a business entity that offers rented or leased motor vehicles. Provides that a limited license for baggage and motor vehicle excess liability insurance may be issued to a business entity that offers rented or leased motor vehicles, if the insurance activities are in connection with and incidental to the rental of motor vehicles. Provides that an entity applying for a limited insurance agent license for baggage and motor vehicle excess liability insurance is required to submit only one application for all licenses to be issued for each office. Allows business entities that offer baggage and motor vehicle excess liability insurance or personal accident insurance to use part-time employees to offer such insurance.

Creates claim adjustment and settlement practices relating to personal and commercial motor vehicle insurance. Prohibits insurers from recommending that a third-party claimant make a claim under his or her own policy solely to avoid having to pay the claim under the policy issued by that insurer, when liability and damages are reasonably clear. Allows the insurer to identify repair options to a third-party claimant. Requires insurers that require a specific repair shop for vehicle repairs, to restore the damaged vehicle to its prior physical condition, performance, and appearance immediately prior to the loss. Prohibits insurers from charging additional costs to the insured or third-party claimant other than as stated in the policy. Prohibits insurers from requiring the use of replacement parts in the repair of a motor vehicle, which are not the equivalent in kind and quality to the damaged parts prior to the loss in terms of fit, appearance, and performance.

Requires insurers to use the following methods when an insurance policy provides for the adjustment and settlement of first-party motor vehicle total losses on the basis of actual cash value or replacement provisions: (a) the insurer may elect a cash settlement based on the actual cost to purchase a comparable motor vehicle, including sales tax, (b) the insurer may elect to offer a replacement motor vehicle that is comparable, including sales tax, and (c) any other method agreed to by the claimant. Requires the determination of value to be supported by documentation (when a motor vehicle total loss is adjusted or settled on a basis that varies from (a) and (b) above), and any deductions from value must be itemized and specified in appropriate dollar amounts. Requires insurers to maintain information in the insurer's claim file when the amount

offered in settlement reflects a reduction by the insurer because of betterment or depreciation. Requires the settlement basis to be explained to the claimant in writing, if requested. Requires a copy of the explanation to be retained in the insurer's claim file. Requires insurers to notify insureds prior to termination of payment for previously authorized automobile storage charges. Requires a 72-hour notice for the insured to remove the vehicle from storage before terminating payment of the storage charges. Defers payment of the sales tax for insurers, if the tax will be incurred by a claimant upon replacement of a total loss or repair of a partial loss.

Creates claim adjustment and settlement practices relating to property insurance. States that any physical damage that occurs as a result of the repair or replacement of an item or part, and is covered by the policy, shall be included in the loss to the extent of any applicable limits. Prohibits insurers from requiring the insured to pay for betterment required by an ordinance or code, except the applicable deductible, unless specifically excluded or limited by the policy. Requires the insurer to make reasonable repairs or replacement of items in adjoining areas of the home, when a loss requires the repair or replacement of portions of a home, and the replaced items do not match in quality, color, or size. Allows an insurer to consider cost, degree of uniformity, remaining useful life of the damaged portion, and other relevant factors when determining the extent of repairs or replacement (this requirement does not make the insurer a warrantor of repairs).

Requires 90 days' written notice (increases from 60 to 90 days) to the Florida Automobile Joint Underwriting Association (FAJUA) and the Department of Financial Services prior to a civil cause of action being filed against the FAJUA. Requires the notice to include the violation, which is the basis for the cause of action. The authority for this notice expires on October 1, 2007. Provides that the FAJUA may require from its insured proof that he or she has obtained the mandatory types and amounts of insurance from another admitted carrier prior to the cancellation of a policy the insured obtained from the FAJUA.

Requires insurers to provide applicants that are denied coverage due to adverse underwriting information, specific information regarding the reasons for refusal. Includes the following lines: private passenger auto, homeowner's, mobile home owner's, condominium unit owner's, or other insurance covering a personal residential structure. Requires insurers to identify the loss underwriting history and notify the applicant of his or her right to obtain a copy of the report from the consumer-reporting agency.

States insurers may not use a single claim on a property insurance policy, from resulting water damage, as the sole cause for cancellation or non-renewal of a policy. Requires the insured to take reasonable action as requested by the insurer to prevent a future similar occurrence of damage to the insured property.

Requires the Florida State University Department of Risk Management and Insurance to conduct a feasibility and cost-benefit study of a potential Florida Sinkhole Insurance Facility and other matters related to the affordability and availability of sinkhole

insurance. Requires the university to submit a preliminary report of its analysis, findings, and recommendations to the Financial Services Commission and the Legislature by February 1, 2005, with a final report due on April 1, 2005. Provides the study is to be funded through an assessment on Florida insurers (property insurance). Requires the Office of Insurance Regulation to collect the assessments. Provides up to \$300,000 for the study.

Eliminates the \$10 filing fee for premium finance agreement forms. Modifies requirements for canceling an insurance contract when a premium finance agreement contains a power of attorney or other authority enabling the premium finance company to cancel any insurance contract listed in the agreement. Adds time requirements upon a finance insurance contract being canceled, stating the insurer must return the unpaid balance due under the finance contract to the premium finance company and any remaining unearned premium to the agent or insured, within 30 days of the cancellation date (previous law was “promptly”). Requires the premium finance company to provide the insured any refund due on the account within 15 days of the account being overpaid. Requires the premium finance company to provide the agent with a return or credit of the overpayment and notify the insured of the refunded amount.

Requires the Legislative Auditing Committee to contract with the Department of Risk Management and Insurance at Florida State University to conduct a detailed analysis of factors affecting costs and potential assessments on consumers, availability of personal lines property and casualty insurance in Florida, and areas in which coverage is underwritten by the Citizens Property and Casualty Insurance Company. Requires completion of the analysis by February 1, 2005. Provides that the study will be funded by assessments on insurers issuing personal lines property and casualty insurance. Requires the Office of Insurance Regulation to collect the assessments. Provides up to \$250,000 for the study (similar provisions are contained in SB 2994). *EFFECTIVE DATE: July 1, 2004. {Chapter Law 2004-370}*

SB 2588 – Insurance by Diaz de la Portilla / Berfield

Deletes certain statutory restrictions on nonresident insurance agents licensed in Florida. Deletes the requirement that a Florida resident agent countersign insurance policies written by a nonresident general lines agent’s license. Deletes the requirement that a nonresident agent must pay part of his or her commission to the countersigning resident agent. Deletes the prohibition against a nonresident agent having an office or place of business in this state and from having any pecuniary interest in any licensed insurance agent or agency as a resident of this state. Deletes the prohibition against a nonresident agent soliciting, negotiating, or effecting insurance contracts in this state unless accompanied by the countersigning resident agent. Deletes the prohibition against a nonresident agent being licensed as a surplus lines agent and establishes requirements for licensure of nonresident surplus lines agents. Eliminates the requirement (a minimum of two hours every two years) that insurance agent continuing education classes include instruction on the subject of unauthorized insurance entities.

Authorizes the Department of Financial Services to issue a new personal lines insurance agent's license. Currently a general lines agent license is issued for all types of property and casualty insurance. Requires the applicant to complete at least 52 hours of classroom courses in insurance to qualify for licensure as a personal lines agent. Limits the new license to property and casualty insurance sold to individuals and families for noncommercial purposes, such as auto and homeowners insurance. Requires that each branch office of a general lines agent or agency have at least one licensed general lines agent who is appointed to represent one or more insurers. Clarifies that a salaried employee of Citizens Property Insurance Corporation, who performs policy administration services, is not required to be a licensed insurance agent. Provides that an entity applying for a limited insurance agent license for baggage and motor vehicle excess liability insurance is required to submit only one application for all licenses to be issued for each office. Allows business entities that offer baggage and motor vehicle excess liability insurance or personal accident insurance to use part-time employees to offer such insurance.

Requires workers' compensation insurers to notify employers of the availability of a discount for a drug free workplace plan at the time of the initial quote for the policy and at the time of each renewal of the policy. Provides the Financial Services Commission with rulemaking authority to implement the drug free workplace provisions. Provides an additional option to a mutual insurer that converts to a stock insurance company, through the formation of a mutual insurance holding company with a subsidiary stock insurance company. Allows policyholders of an affiliated stock insurer to be members of the mutual insurance holding company and have stock in the newly formed mutual insurance holding company if they were policyholders of a mutual insurer whose policies were assumed by the affiliated stock insurer.

Strengthens the powers of the Department of Financial Services, as receiver of an insolvent insurer, to acquire the assets belonging to the insurer and reducing the amount assessed against other insurers to fund payment of the insolvent insurer's claims and debts. Provides exclusive jurisdiction to domiciliary courts that acquire jurisdiction over persons in an insurance delinquency proceeding, and provides the Circuit Court of Leon County exclusive jurisdiction with respect to assets or property of any insurer subject to such proceedings. Provides that the estate of an insurer in rehabilitation or liquidation is entitled to actual damages, including costs and attorney fees, if injured by a willful violation of an applicable stay or injunction. Provides that the receivership court may impose additional sanctions.

States that a managing general agent or holding company with a controlling interest in a Florida domestic insurer is subject to jurisdiction of the court. Allows the Department to recover expenses for employing a special agent, counsel, clerks, or assistants in a delinquency proceeding in which recovery of administrative expenses is authorized. Specifies that an order of conservation, rehabilitation, or liquidation against an insurer cannot be deemed an anticipatory breach of a reinsurance contract, and cannot be used to retroactively revoke or cancel a reinsurance contract. Creates a standard arbitration provision to replace any other arbitration provision the insurer in receivership has entered into for resolution of disputes. Provides that a transfer or lien upon the

property of an insurer or its affiliate made between 4 months and 1 year prior to the commencement of a delinquency proceeding, is void if the transfer or lien benefited a director, officer, employee, or other specified parties. Provides that a transfer made within 1 year of a successful petition for a delinquency proceeding, or made after such petition, is not made until the insurer or affiliate has acquired rights in the transferred property.

Prohibits the Florida Insurance Guaranty Association (FIGA) or the Florida Workers' Compensation Insurance Guaranty Association (FWCIGA) from providing coverage on claims that have been rejected in another state because the insured's net worth is greater than allowed under another state's guaranty fund or liquidation law. Claimants would now have to seek recovery from the company/corporation. Provides for an exception in the FWCIGA for employers who, prior to April 30, 2004, entered into an agreement with the FWCIGA preserving the employer's right to seek coverage of claims rejected by another state's guaranty fund (similar to language in HB 639).

Authorizes a sales representative who sells motor vehicle service agreements, home warranties, or service warranties for consumer products to offer sales commission rebates to consumers. Requires the rebate amount to conform to a schedule that is prominently displayed in the sales representative's office and must be offered to all consumers in the same actuarial class. Provides that a service warranty association is not required to maintain an unearned premium reserve or contractual liability insurance and may allow its premiums to net assets ratio to exceed 7-to-1 if the association has a net worth of at least \$100 million; or the association maintains at least \$750,000 in net assets and is a wholly owned subsidiary of a parent corporation with a net worth of at least \$100 million which guarantees the performance of the warranty obligations of the association.

Provides that the cancellation of a workers' compensation policy, if requested by the policyholder, is effective on the date the insurer sends the notification to the insured, and is not subject to the 30 days notice requirement. Requires the completion of continuing education courses for the reinstatement of an insurance agent's license, appointment, or eligibility, after a second suspension. *EFFECTIVE DATE: July 1, 2004.*
{Chapter Law 2004-374}

Agency/Administrative Bills

SB 124 – Domestic Security Initiatives Chief by Dockery / Public Safety & Crime Prevention

Amends the state's domestic security initiatives to require a security assessment of all buildings, facilities, and structures owned or occupied by state agencies. Requires the assessment to be completed by state employees, within existing resources of state agencies. Reporting requirements shall be in a format prescribed by the Chief of Domestic Security Initiatives. The initial assessment of each building, facility, or structure owned or leased by a state agency, shall be completed and provided to the Chief no later than November 1, 2004. Requires the Chief to report any suggestions for security enhancements of specific buildings and facilities and overall best practices for security and safety to the Governor, Senate President and Speaker of the House by November 1 of each year. *EFFECTIVE DATE: Upon becoming law. {Chapter Law 2004-258}*

SB 192 – Magistrates and Masters by Campbell / Mahon

Renames "magistrates" as "trial court judges" in order to conform to the 1972 revision to Article V, State Constitution. Renames "masters" as "magistrates". Replaces references to the term "hearing officer" with the term "administrative law judge" in order to conform to prior legislation re-designating hearing officers as administrative law judges. *EFFECTIVE DATE: October 1, 2004. {Chapter Law 2004-11}*

HB 317 – Public Records Requirement/Exemption by Reagan / Bennett

Exempts certain documents from public records including building plans, blueprints, schematic drawings and diagrams depicting the internal layout or structural elements of privately owned buildings and structures. Provides for records to be released to a governmental entity if disclosure is necessary to perform its duties and responsibilities. Allows records to be released to the owner of the structure in question or the owner's legal representative or upon a showing of good cause before a court of competent jurisdiction. Provides for repeal of the exemption on October 2, 2009 unless reviewed and reenacted by the Legislature. States that these exemptions are necessary to ensure public safety from terrorist acts. *EFFECTIVE DATE: Upon becoming law. {Chapter Law 2004-9}*

SB 348 – Personal Identification Information by Peaden / Evers

Creates exemptions from public-records requirements. Diminishes the opportunity for fraud and identity theft by limiting the use of social security numbers. Exempts complete social security numbers of agency employees held by an agency from public disclosure if the employee or employing agency submits a written request for confidentiality. Allows commercial entities to continue to verify the accuracy of personal information received using only the last four digits of social security numbers of agency employees. Allows commercial entities to also use an employee's date of birth or maiden name to verify the accuracy of personal information. Provides that commercial entities shall have access to

complete social security numbers provided in a lien filed with the Department of State. *EFFECTIVE DATE: July 1, 2004. {Chapter Law 2004-95}*

SB 1250 – Employee Benefits by Pruitt

Modifies the state employees' prescription drug program co-payment to the following: generic drug with card \$10 (a \$3 increase), preferred brand name drug with card \$25 (\$5 increase), non-preferred brand name drug with card \$40 (\$5 increase), generic mail order drug \$20 (\$9.50 increase), preferred brand name mail order drug \$50 (\$20 increase) and non-preferred brand name mail order drug \$80 (\$27.50 increase).

Clarifies that the state employee health insurance plan is not subject to the regulatory provisions applicable to multiple employer welfare arrangements. Provides that county employees moving to state employment, who have 12 months of continuous coverage in the county-sponsored health insurance plan, will meet the pre-existing condition limitations applicable in the state health insurance plan. Resolves the mandatory collective bargaining issues at impasse for the State of Florida. *EFFECTIVE DATE: Upon becoming law. {Chapter Law 2004-347}*

SB 1650 – State Financial Matters/Florida Retirement System by Wise / Brown

Provides for purposes of the retiree health insurance subsidy that the spouse at the time of death shall be the participant's beneficiary (unless another beneficiary has been designated). Defines "retiree" as a former participant of the Florida Retirement System (FRS) Public Employee Optional Retirement Program who has terminated employment and has taken a distribution, except for a mandatory distribution of a de minimus account of less than \$5000. Modifies the election participation dates in the defined contribution plan for those on leave of absence. Revises the investment guidelines for funds in the defined benefit plan. Requires all FRS employers to communicate to employees the two FRS enrollment plan choices through materials supplied by the State Board of Administration (SBA) and the Department of Management Services (DMS).

Maintains that Florida adhere to the federal Employee Retirement Income Security Act of 1974 (ERISA) provisions even though ERISA legislation exempts government plans. Allows the SBA to disclose to Investment Plan participants the actual institutional fees charged by its investment providers. Permits both the SBA and DMS to cash out or transfer, to an eligible custodian, an account with a minimum balance of \$5000 or less for plan participants who have terminated employment for at least six months. Provides that the survivor of a disabled Investment Plan member only receives the remaining balance in the plan in which membership was established. Requires employers to reimburse optional plan participant accounts, as a result of employer errors or corrections for market losses resulting from late contributions. Provides that participants have an obligation to return excess contributions. Permits the SBA to invest in fixed-income obligations issued by foreign governments if they are rated investment grade by at least one nationally recognized rating agency. Provides that the cost of acquisition of private equity interests will be calculated into the overall investment cost. Re-designates

investment plans as "Investment Policy Statements." *EFFECTIVE DATE: July 1, 2004.*
{Chapter Law 2004-71}

SB 1678 – Public Records by Governmental Oversight and Productivity / State Administration

Rearranges the Public Records Act into topical sections. Transfers and alphabetizes all terms with definitions into one section. Defines the term "redact" to mean "...to conceal from a copy of an original public record, or to conceal from an electronic image that is available for public viewing, that portion of the record containing exempt or confidential information." Repeals various sections but requirements remain in effect because they are simultaneously transferred to other sections of the act. Requires that when an agency's duty or responsibility is transferred to another agency or entity, the receiving agency or entity becomes the official records custodian. Designates the Executive Office of the Governor as the official records custodian when an agency or entity is dissolved. Specifies that any public officer who knowingly violates the provisions of this act is subject to suspension and removal or impeachment and, in addition, commits a misdemeanor of the first degree. Organizes public record penalty provisions pursuant to modern statutory law. Removes references to "general or special law" due to conflicts with the State Constitution. Reduces the retention time for various types of records such as the Office of Financial Regulation (OFR) examination reports, investigation records, and applications (from 10 years to three years). Provides that application records and related information compiled by OFR be retained for at least two years. Removes language requiring the Office of Insurance Regulation (OIR) to reproduce each page of a public record in exact conformity with the original and allows OIR to keep electronic records. Removes antiquated language referring to programs no longer in existence and makes conforming changes. *EFFECTIVE DATE: October 1, 2004.* **{Chapter Law 2004-335}**

HB 1837 – Appropriations Implementing Bill by Appropriations

Authorizes the Executive Office of the Governor (EOG) to transfer funds in *Special Categories-Risk Management Insurance* between departments in order to align the budget authority granted with the premiums paid by each department for risk management insurance. Authorizes the EOG to transfer funds in *Special Categories-Transfer to the Department of Management Services (DMS) Human Resources services Purchase Per Statewide Contract* between departments in order to align the budget authority granted with the assessments that must be paid by each agency to DMS for human resource management services. Authorizes the EOG to transfer funds appropriated for the State Employees Group Health Insurance plan in the *Salaries and Benefits* category between departments in order to align the budget authority granted in accordance with the redesign of the State Employees Group Health Insurance Program and necessary realignment for state contribution revisions and the results of the open enrollment period. Extends the date to June 30, 2005 for DMS to determine premium levels necessary to fund the state employees' health insurance program. Continues the exclusion of Class C travel reimbursement for state travelers during the 2004-2005 fiscal year. *EFFECTIVE DATE: Except as otherwise provided in the bill, the act shall take effect July 1, 2004.* **{Chapter Law 2004-269}**

Trust Fund Bills

SB 1240 – Insurance Regulatory Trust Fund by Clary

Re-creates the Insurance Regulatory Trust Fund (IRTF) without modification. Provides funding for the regulation of the insurance and fire protection industries. The sources of IRTF revenue include licenses, fees, fines and taxes. The Office of Insurance Regulation administers the Insurance Regulatory Trust Fund. *EFFECTIVE DATE: November 4, 2004. {Chapter Law 2004-323}*

HB 1841 – Budget Stabilization Fund by Appropriations

Provides that moneys in the Budget Stabilization Fund may be transferred to the State Risk Management Trust Fund to provide funding for an emergency. Establishes an emergency exists when uninsured losses to state property exceed \$2 million per occurrence or \$5 million annual aggregate. Mandates the Division of Risk Management, within the Department of Financial Services, to request a budget amendment should they certify an emergency. Establishes that transfers into the Risk Management Trust Fund may not exceed \$38 million in any fiscal year. *EFFECTIVE DATE: July 1, 2004. {Chapter Law 2004-239}*

Acknowledgments

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Executive Office of the Governor

Department of Financial Services

Office of Insurance Regulation

Office of Financial Regulation

Florida Senate Members

Florida House of Representatives Members

Florida Senate Staff

Florida House Staff

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