2008 Legislative Summary

Prepared by
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Florida
Office of Insurance Regulation
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COMMISSIONER

July 23, 2008

Dear Fellow Floridians:

The Florida Legislature passed several significant bills during the 2008 Regular Legislative Session that will greatly impact the Office of Insurance Regulation (OIR), the insurance industry and consumers. The following *2008 Legislative Summary* is intended to provide you with a comprehensive review of major bills and budgetary appropriations relating to insurance.

With virtually every aspect of the insurance industry making headlines across the state in 2007 and 2008, it was clear that statutory changes to Florida's insurance laws were inevitable during the 2008 Regular Legislative Session.

Senate Bill 2082, a priority bill for OIR, was designed to provide Florida's senior citizens greater protections when they purchase annuity products. This legislation, which implements aggressive suitability requirements for agents who sell annuities, puts Florida at the forefront in the battle against the fraudulent sale of these complex insurance products.

Health care was also deliberated during session. The passage of Senate Bill 2534 creates greater opportunities for uninsured Floridians to gain access to affordable health care. Specifically, the Cover Florida Health Care Access Program, championed by Governor Charlie Crist, will provide a low-cost, guaranteed-issue health plan for Floridians that are currently unable to purchase health insurance.

Addressing property insurance was a sizeable undertaking by the Legislature, which led to several committee meetings in both the House and Senate. During this period, OIR staff and insurance industry representatives testified about all aspects of the rate-making process. Senate Bill 2860 mandates several important changes to the regulatory structure of the insurance industry, which will significantly impact the way OIR operates and regulates insurance products.

Over the coming months, OIR will be working to implement these new legislative requirements. As always, OIR is committed to offering fair, fast and professional service to the insurance industry, as well as continuing to champion greater protections for the insurance-buying public.

Sincerely,

Kevin M. McCarty
Florida Insurance Commissioner

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2008 General Appropriations Act

HB 5001 - Approved by the Governor June 11, 2008

Issue	2007-2008 Funding	2008-2009 Funding	Difference Over/(Under)
Positions	315	314	-1
OPS	$1,132,750	$175,000	-$957,750
For 2008-2009, all OPS funds were transferred to Contracted Services category except for OPS employee salaries			
Expense	$3,668,681	$3,389,957	-$278,724
OCO	$37,578	$2,000	-$35,578
For 2007-2008, funds were provided for technology hardware.			
Contracted Services	$5,063,848	$845,726	-$4,218,122
For 2007-2008, funds were provided for the implementation of three technology applications.			
Special Categories -	$1,201,384	$623,512	-$577,872
Public Hurricane Model - For 2007-2008, additional funds were provided to design, develop and implement the expansion of the model to include commercial properties.			
Wind Loss Mitigation Study	$700,000	$0	-$700,000

Disclaimer: The Appropriations above represent funds allocated to the Office of Insurance Regulation as approved for the annual period beginning July 1, 2008 and ending June 30, 2009. The Office is funded entirely by the Insurance Regulatory Trust Fund.

OFFICE OF INSURANCE REGULATION PRIORITIES

SB 2082 – Insurance by Senator Bennett

Named the "John and Patricia Seibel Act," this bill increases penalties for specified unfair or deceptive insurance practices related to the sale of life insurance and annuity contracts. It also strengthens the standards for making recommendations to seniors about the appropriateness of purchasing annuities.

Unfair or Deceptive Insurance Practices

Imposes increased fines and penalties for the unfair and deceptive insurance practices known as "twisting" and "churning," and adds a prohibited practice of submitting a document with a false signature to an insurer on behalf of a consumer. "Twisting" and "churning" involves misleading representations in an attempt to induce a consumer to cash in funds from a current investment or insurance product to purchase another product. Classifies this practice of "twisting" and "churning" as a first degree misdemeanor, and willfully submitting a false signature would now be a third degree felony. Increases fines (administrative penalties) for these practices:

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

- $30,000 for each willful violation (currently $20,000), up to a maximum aggregate amount of $250,000 (currently $100,000).

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

Sales of Annuities to Senior Consumers

Strengthens the standards that apply to recommendations to a senior consumer to purchase an annuity contract. Specifically:

- Requires that the insurer or insurance agent have an objectively reasonable basis for believing that an annuity recommendation to a senior consumer is suitable.

- Requires insurance agents, prior to recommending a product to a senior consumer, to obtain specified personal and financial information from the consumer relevant to the suitability of the recommendation on a form adopted by the Department of Financial Services (DFS).

- Requires the insurer or agent to provide the consumer with an information form adopted by DFS concerning differences between the annuity recommended for purchase and the existing annuity that would be surrendered or replaced.

- Authorizes the Office of Insurance Regulation (OIR) to order an insurer to void an insurance policy or annuity and provide a full refund of the premiums paid or accumulation value, whichever is greater, when a senior consumer is harmed due to a violation of the suitability statute.

- Requires insurers, managing general agents, and insurance agencies to make available to DFS (or OIR) records of information collected from consumers and other information for five years after the insurance transaction has been completed.

- Deems that any person who is registered with a member of the federal Financial Regulatory Authority, and who is required to make a suitability determination, is deemed to have satisfied the section's requirements.

"Free Look" Period; Annuity Regulation

Increases the "free look" period from 10 days to 14 days. Following the purchase of a life insurance or fixed annuity, the consumer has a "free look" period in which they can request a refund at no charge. Expands this benefit to all annuities, not merely "fixed" annuities.

Clarifies the regulatory jurisdiction of the agencies under DFS regarding the sale of annuities.

Other Provisions

- Requires applicants for agent licensure to provide their home and business telephone numbers and email address in the application and to notify the department within 60 days of any changes.

- Requires all licensees to complete three hours of DFS-approved continuing education on the subject of suitability in annuity and life insurance transactions. The hours may be used to satisfy the current ethics continuing education requirement.

EFFECTIVE DATE: January 1, 2009. {Chapter Law 2008-237}

SB 2534 – Health Insurance by Senator Peaden

Initiates two new programs designed to provide more affordable health care access to uninsured individuals and for small employers.

Cover Florida Health Access Program

Creates the "Cover Florida Health Access Program Act" designed to provide affordable health care options for uninsured residents. Allows insurers, health maintenance organizations (HMO's), health-care-sponsored-organizations, and/or health care districts to offer consumers a choice of benefit plans at affordable prices. A Cover Florida plan entity must provide non-catastrophic coverage and may provide catastrophic coverage, supplemental insurance, and discount medical plan product options to enrollees.

Enrollment Eligibility Requirements:

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

Administration of the Cover Florida Health Access Program:

Designates the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR) are jointly responsible for establishing and administering the program. Requires OIR and AHCA to issue an invitation to negotiate no later than July 1, 2008, to health insurers, health maintenance organizations, health care provider-sponsored organizations, and health care districts ("Cover Florida plan entities"). Requires AHCA and OIR to approve at least one Cover Florida plan entity that must have an existing statewide provider network, and may approve at least one regional network plan for each Medicaid area.

Changes in plan benefits, premiums, and forms are subject to regulatory oversight by AHCA and OIR. Requires AHCA to ensure that the plans follow standardized grievance procedures, and submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the status of the program.

Health Flex Plan Program

Expands the population eligible to purchase health flex plans by raising the family income limit from 200 to 300 percent of the federal poverty level (FPL).

Allows a person who is covered under subsidized Medicaid or KidCare coverage and who lost eligibility due to the income limits to apply for coverage without a lapse in coverage if all other requirements are met. Under current law, these persons would be required to be uninsured for the prior six months prior to enrolling in a health flex plan.

Expands the population eligible for health flex plans by allowing individuals who are covered under an individual contract issued by an HMO that has an approved health flex plan (as of October 1, 2008) to enroll in the HMO's health flex plan. These individuals would not be subject to the current requirement of being uninsured for the prior six months.

Allows a person who is part of an employer group with at least 75 percent of the employees having income equal to or less than 300 percent of the FPL and not covered by private insurance during the last six months to be eligible for coverage. If the health flex plan is offered by an insurer, only 50 percent of the employees must meet the income test.

Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

Florida Health Choices Program

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

Authorized Vendors

Authorizes the following entities to be eligible vendors of these products and plans:

(1) insurers authorized under ch. 624, F.S.,
(2) HMOs authorized under ch. 641, F.S.,
(3) prepaid health clinics licensed under ch. 641, part II, F.S.,
(4) health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers,
(5) provider organizations, including services networks, group practices, and professional associations, and
(6) corporate entities providing specific health services.

Specifies that vendors may not sell products that provide "risk-bearing coverage" unless those vendors are authorized by a certification of authority issued by OIR under the Florida Insurance Code. Requires all vendors to make all risk-bearing products offered through the program guaranteed-issue policies, subject to preexisting condition exclusions established by the corporation.

Administration of the Program

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

Specifies the corporation is governed by a fifteen member board including:

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

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

Entitles Board Members to per diem and travel expenses but no other compensation is allowed. Allows the board to secure staff and consultant services necessary to the operation of the program. Appropriates a total of $1.5 billion (the sum of three separate appropriation categories) in non-recurring funds from the General Revenue Fund for this program.

Eligibility and Enrollment

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

Pricing; Risk Pooling

Specifies that prices for products sold through the program must be based on age, gender, and the location of the participants. Requires the corporation to develop a methodology for evaluating the actuarial soundness of the product; this methodology must be reviewed by OIR. Requires the corporation to use this methodology to compare the expected costs and benefits of the products, which must be reported to individuals participating in the program. Prices must remain in force for at least one year. The corporation must add a

surcharge not to exceed 2.5 percent to generate funding for administrative services provided by the corporation and payments to buyer's representatives (including insurance agents).

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

OIR Recommendation on Risk-Bearing Products

Prior to making a risk-bearing product available through the program, the corporation must provide OIR information about the product. OIR has 30 days to review the product and make a recommendation that it should, or should not, be made available through the program. If OIR recommends that a risk-bearing product should not be made available, the product may be offered only if a majority of the Board votes to include the product.

Florida KidCare Program

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

Dependent Coverage

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

Requires dependents to be covered until age 25 if the child is dependent on the parent for support, or if the child either lives in the household of the parent or is a full-time or part-time student. This requirement currently applies only to group health insurance policies, which the bill interprets as including individual health insurance policies and all HMO contracts.

Insurance Code Exemption for Certain Religious Organizations

Creates an exemption from the Florida Insurance Code for nonprofit religious organizations that qualify under Title 26, sec. 501 of the IRS Code. To meet this exemption, the nonprofit religious organization must:

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

EFFECTIVE DATE: Upon becoming law. {Chapter Law 2008-32}

SB 2860 — Insurance by Senators Atwater and Geller

Entitled the Homeowners Bill of Rights Act.

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

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

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

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

Provides for an expedited hearing process for rate filings by:

- Requiring Division of Administrative Hearings (DOAH) to conduct a hearing within 30 days after the request for the hearing.

- Requiring the hearing officer to issue the recommended order within 30 days after the hearing (or after receipt of the transcripts).

- Requiring parties to submit written exceptions within 10 days.

- Requiring the OIR to enter a final order within 30 days after the entry of the recommended order.

- Allowing timeframes to be waived upon agreement of all parties.

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

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

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

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

Administrative Proceedings in Rate Determinations

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

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

Specifies requirements for a person to claim that a document received by the OIR or the Department of Financial Services (DFS) is a "trade secret." Requests that each page or portion that is a trade secret must be labeled as such and be separated from non-trade

secret material. The submitting party must include an affidavit certifying certain information about the trade secret status of the documents.

Authorizes OIR to release a document marked as trade secret to a requestor if OIR provides the insurer with 30-days notice and an opportunity to obtain a court order prohibiting disclosure. Allows OIR or DFS to disclose a trade secret to employees or officers of another governmental agency whose use of the trade secret is within the scope of their employment.

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

Authorizes OIR to order an insurer to file its claims handling practices and procedures as a public record based on the findings of a market conduct examination. The OIR findings must conclude that the insurer had a pattern or practice of willful violations of an unfair insurance trade practice related to claims-handling causing harm to policyholders. The requirement applies to the claims-handling procedures for the line of insurance that was the subject of the market conduct exam. Requests that the filings must be held by OIR for a 36-month period.

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

Doubles all current fines that may be imposed by OIR for violation of the Insurance Code or for violating any rule or order. A maximum fine of $40,000 (rather than $20,000) may be levied for a willful violation, not to exceed an amount equal to $200,000 (rather than $100,000), for all willful violations arising out of the same action. Also allows OIR or DFS to issue a maximum fine of $5,000 (rather than $2,500) for a non-willful violation, not to exceed an amount of $20,000 (rather than $10,000) for all non-willful violations arising out of the same action.

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

Doubles all current fines that may be imposed by OIR or DFS upon a person who violates any unfair or deceptive act or practice related to insurance. A maximum fine of $40,000 (rather than $20,000) may be levied for a willful violation, not to exceed an amount equal to $200,000 (rather than $100,000), for all willful violations arising out of the same action. OIR or DFS may also issue a maximum fine of $5,000 (rather than $2,500) for a non-willful violation, not to exceed an amount of $20,000 (rather than $10,000) for all non-willful violations arising out of the same action.

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

Prohibits an insurer from failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance polices within 90 days after determining the amount and agreeing to coverage. There is no exception if the payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or

due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed. Violations are grounds for a private civil remedy action, due to the cross-reference in current s. 624.155, F.S.

Notice of Non-Renewal

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

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

Requires that for purposes of a rate filing insurers must use, and may not modify or adjust, a model or method found to be accurate or reliable by the Commission on Hurricane Loss Projection Methodology. Deletes the current law that requires an approved model to be admissible and relevant if OIR has access to all of the assumptions and factors used in developing the model. The Commission is required to adopt findings related to a model's probable maximum loss calculations. An insurer must use and may not modify or adjust models found by the Commission to be accurate or reliable in determining probable maximum loss levels for rate filings made more than 60 days after the commission has made such findings. Specifies that the processes, standards, and guidelines of the Commission do not constitute a final agency action or statements of general applicability that implement, interpret, or prescribe law and are exempt from chapter 120, F.S.

Use of Public Hurricane Loss Model

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

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

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

inspection or otherwise qualify for the revised credit, during which time the insurer must continue to apply the old mitigation credits.

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

Provides that, effective January 1, 2010, the potential purchaser of a residential property with an insured value of $500,000 or more, insured by Citizens, and located in the wind-borne debris region be informed of the structure's windstorm mitigation rating. Effective January 1, 2011, a purchaser of residential property located in the wind-borne debris region must be informed of the windstorm mitigation rating of the structure, either in the contract for sale or as a separate document attached to the contract. Authorizes he FSC to adopt rules, including the form of the disclosure and the requirements for the inspection or report.

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

Extends the freeze on rate increases in Citizens from January 1, 2009 to January 1, 2010. Requires Citizens to make an annual, actuarially sound rate filing beginning July 15, 2009, to be effective no earlier than January 1, 2010. Revises the required assessments to fund a deficit in *each* of Citizens' three accounts (high risk, personal lines, or commercial lines) to:

- Require up to a 15 percent of premium surcharge for 12 months on all Citizens' policies, collected upon issuance or renewal;

- If this is insufficient, require a regular assessment against insurers which may be recouped from their policyholders, of up to 6 percent (rather than 10 percent) of premium for most lines of property and casualty insurance or 6 percent of the deficit, whichever is greater;

- Require any remaining deficit to be funded by a bond issue, funded by multi-year emergency assessments on policyholders on most types of property and casualty insurance, of up to 10 percent of premium for most lines of property and casualty insurance, or 10 percent of the deficit, whichever is greater.

- Grants the board of Citizens the discretion to apply the amount of any assessment or surcharge which exceeds the amount of the deficit to various business purposes.

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

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

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

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

Multi-Policy Discount

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

Citizens Property Insurance Corporation Mission Review Task Force

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

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

Revises the requirements for the Insurance Capital Build-Up Incentive Program (Program), which provides for surplus note loans to insurers of up to $25 million, repayable over 20 years at the 10-year Treasury bond rate, as approved by the State Board of Administration (SBA). Insurers that apply by September 1, 2008 are eligible for a surplus note loan equal to the amount of new capital that an insurer contributes. Insurers that apply after September 1, but before June 1, 2009, may apply for a surplus note equal to one-half of the amount of new capital that the insurer contributes.

Revises the minimum premiums that the insurer must commit to write, by adding a minimum *gross* premium to surplus ratio requirement, as an alternative to the current *net* premium to surplus writing ratio requirement. The distinction is that net premiums deduct the reinsurance premiums that the insurer pays (cedes) to a reinsurer. Requires an insurer to write at least 15 percent of its premiums for new policies for policies taken out of Citizens, for each of the first three years of the surplus note.

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

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

Florida Hurricane Catastrophe Fund (FHCF); $10 Million Coverage Option

Requires the FHCF to offer $10 million of additional coverage to limited apportionment companies (having $25 million in surplus or less and writing at least 25 percent of premiums in Florida), insurers approved to participate in the Insurance Capital Build-Up Incentive Program, and insurers that purchased the supplemental coverage in 2007. (Similar coverage was offered in 2006 and 2007.)

This coverage would reimburse the insurer for up to $10 million in losses, for each of two hurricanes. The coverage will again be priced at a 50 percent rate on line (e.g., $5 million premium for $10 million in coverage) with a free reinstatement for a second storm. The insurer's retention for such coverage remains at 30 percent of the company's surplus. Coverage expires on May 31, 2009.

Annual Report by CFO

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

EFFECTIVE DATE: July 1, 2008 with Appropriations veto. {Chapter Law 2008-66}

PROPERTY & CASUALTY

HB 343 – Financial Services By Representative Carroll

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

Defines "debt cancellation product," and specifies that these products may be sold by financial institutions (banks, credit unions, etc.) and their subsidiaries and other business entities authorized by law. It also asserts this product is not insurance for purposes of the Florida Insurance Code. Requires a creditor selling a debt cancellation product to cancel or suspend all or part of a customer's obligation to make payments due to specified events, including guaranteed asset protection contracts and other debt cancellation or suspension agreements.

Requires financial institutions to manage risks associated with debt cancellation products prudently, and instructs these institutions to establish and maintain effective risk management and control programs. A financial institution may not require the purchase of a debt cancellation product as a condition for making the loan, line of credit, or loan extension. Defines insurance purchased by a creditor for its financial debt cancellation products as a form of casualty insurance.

Eliminates the $50,000 limit on insurance that may be procured on the life of a debtor under a debtor group contract, or pursuant to a credit life insurance policy. Instead, the bill specifies this limit is the amount of the person's indebtedness to the creditor. Allows the term of credit disability insurance to extend for the term of the indebtedness, rather than the current 10-year time limitation.

Specifies that a deposit or account made in the name of two persons who are husband and wife should be considered a tenancy by the entirety unless otherwise specified in writing.

Raises the minimum proposed capitalization for any proposed bank to $8 million and deletes the different capitalization requirements for banks in metropolitan areas versus those in rural counties. Raises the minimum total capital accounts for a trust company from $2 million to $3 million and sets different capitalization standards for banks owned by single-bank holding companies and banks owned by multi-bank holding companies.

Eliminates the need for a bank or trust company to obtain approval from the Office of Financial Regulation (OFR) to increase its capital. Also requires a state bank or trust

company must notify the OFR in writing 15 days before increasing its capital stock. Deletes the prohibition against a bank or trust company issuing capital stock greater than a $100 par value. Prohibits financial institutions from issuing or selling stock of the same class which creates different rights, options, warrants, or benefits among the purchasers or stockholders of that class of stock. The financial institution may create uniform restrictions on the transfer of stock.

Deletes the current prohibition against a bank or trust company issuing capital stock that has a par value greater than $100, thus giving these institutions more flexibility.

Clarifies who can assert dissenter's rights pursuant to the approval of the sale of stock by a state bank or trust company. The procedures in s. 607.1326, F.S. and s. 607.1331, F.S. will be used to determine the fair value of the shares of stock – the same as is applied to corporations.

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

EFFECTIVE DATE: October 1, 2008. {Chapter Law 2008-75}

HB 601 – Department of Business and Professional Regulation By Representative Hudson

Revises and clarifies numerous insurance requirements for condominiums. Maintains the current requirement for adequate insurance but uses the term "adequate hazard insurance" to specify the type of insurance that is required. Maintains the current provision that allows three or more communities to obtain insurance for an amount equal to the probable maximum loss for a 250 year windstorm event.

EFFECTIVE DATE: July 1, 2008. {Chapter Law 2008-240}

HB 679 – Residential Properties By Representative Gardiner

Provides that three or more condominium associations may form a self-insurance fund to cover insurance deductibles.

EFFECTIVE DATE: July 1, 2008. Vetoed by Governor on June 30, 2008.

HB 937 – Title Insurance By Representative Ambler

Creates the Florida 2008 Title Insurance Study Advisory Council (Council) which will undertake a comprehensive examination of the title insurance system in Florida and make findings and recommendations in its final report to the Governor, Speaker of the House of Representatives and President of the Senate on or before December 31, 2009.

The final report must be approved by at least two-thirds of the Council's membership with the chair voting to approve. The Council will terminate after submitting its final report, but no later than December 31, 2009.

The Council is composed of 21 members, including:

- the Governor or designee serving, chair
- the Chief Financial Officer or designee, vice chair
- one member of the Senate appointed by the President
- one member of the House of Representatives appointed by the Speaker of the House
- the Insurance Consumer Advocate
- the Commissioner of Insurance Regulation or designee
- the Commissioner of Financial Regulation or designee
- three representatives of title insurers appointed by the Senate President
- two independent title agents appointed by the Senate President
- four representatives of title insurers appointed by the Speaker of the House
- one independent title agent appointed by the Speaker of the House
- two members designated by the Real Property, Probate and Trust Law Section of the Florida Bar
- one member of the banking industry appointed by the Commissioner of Financial Regulation
- one member of the real estate industry appointed by the CFO

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

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

EFFECTIVE DATE: Upon becoming law. {Chapter Law 2008-198}

SB 2012 – Insurance Policies By Senator Deutch

Amends various provisions of the Insurance Code to provide for the following:

Long-Term Care Insurance (This section affects Life and Health Policies)

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

Holocaust Victims

Extends the statute of limitations for filing insurance claims under the Holocaust Victims Insurance Act, from July 1, 2008 to July 1, 2018.

Multiple Employer Welfare Arrangement (MEWA)

Allows the Office of Insurance Regulation (OIR) to waive the requirement that each MEWA maintain its principal place of business in this state if the MEWA has been operating in another state for at least 25 years, has been licensed in such state for at least 10 years, and has a minimum fund balance of $25 million at the time of licensure.

Motor Vehicle Personal Injury Protection Insurance

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

Hospital Self-Insurance Alliances

Allows self-insurance alliances to be considered insurers only for the purpose of purchasing reinsurance coverage which would not be subject to the premium tax. Clarifies that contracts of reinsurance issued to a hospital alliance shall receive the same tax treatment as reinsurance contracts issued to insurers.

Citizens Property Insurance Corporation (Citizens)

Provides that a policyholder (and his or her attorney) who has filed suit against Citizens may have access to his or her own claim file to the same extent that discovery would be available from a private insurer in litigation as provided by the Florida Rules of Civil Procedure. This same right of access to claim files is provided to a third party in litigation

pursuant to subpoena. Access to such files is subject to any confidentiality protections requested by Citizens.

Authorizes Citizens to release confidential underwriting and claims file contents as it deems necessary to underwrite or service insurance policies and claims, subject to confidentiality protections. Allows Citizens to release confidential underwriting file records to other governmental agencies upon written request and demonstration of need; although these records must remain confidential.

Requires Citizens to electronically report claims data and histories to a consumer reporting agency upon the request of such agency. A consumer reporting agency, as defined by the federal Fair Credit Reporting Act (Act), must be in compliance with the confidentiality requirements of the Act, and must maintain claims data and histories in connection with the underwriting of insurance involving a consumer. Insurers are entitled to review the claims history of insureds using the service provided by a consumer reporting agency.

Public Housing Authority Self-Insurance Funds

Provides criteria that public housing authorities who form self-insurance funds and spread liabilities of their members for property and casualty insurance, must follow specific requirements to form a self-insurance fund:

- Having annual premiums in excess of $5 million;
- Using a qualified actuary to determine rates and reserves;
- Maintaining excess insurance coverage and reserve evaluation to protect the financial stability of the fund;
- Submitting annual audited financial statements to the OIR;
- Having a governing body comprised of commissioners of public housing authorities;
- Using knowledgeable persons or business entities to service the fund; and
- Certifying to the OIR that the fund meets the above provisions.

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

Public Adjusters

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

Amends various provisions of the Insurance Code to provide for the following changes:

- Requires the Department of Financial Services to create a specific examination for public adjusters and mandates continuing education requirements for such adjusters;

- Prohibits public adjusters from contacting an insured or claimant until 48 hours after the occurrence of an event that may be the subject of a claim under a policy;

- Prohibits public adjusters from soliciting an insured or claimant except on Monday through Saturday and only between the hours of 8 a.m. and 8 p.m.;

- Prohibits public adjusters from charging a fee unless a written contract was executed prior to the payment of a claim;

- Prohibits public adjusters from charging more than:

  - 20 percent of the insurance claims payment on non-hurricane claims;

  - 10 percent of the insurance claims payment on hurricane claims for claims made during the first year after the declaration of emergency;

- Provides for no cap on re-opened or supplemental hurricane claims; however, the fee cannot be based on any payments made by the insurer to the insured prior to the time of the public adjuster contract;

- Allows insureds or claimants to have five business days after the date on which the contract is executed to cancel a public adjuster's contract during a state of emergency declared by the Governor; insureds or claimants have three business days to cancel a contract as to claims involving non-emergencies;

- Creates a public adjuster apprentice license and examination;

- Requires public adjuster contracts to be in writing and to display an anti-fraud statement; and

- Provides for nonresident public adjuster qualifications.

Title Insurance (UCC Personal Property Insurance)

Allows a title insurer to petition OIR for a rate deviation under s. 627.783, F.S., for personal property title insurance, a Uniform Commercial Code (UCC) insurance product. Requires that OIR must be guided by "Standards for national rates for the product being offered in other states" when determining whether to approve a rate deviation for a personal property title insurance product.

Florida Hurricane Catastrophe Fund

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

Insurance Agents and Other Insurance Representatives

Allows applicants to be exempt from the customer representative licensing examination if they have earned a specified degree and have completed at least nine academic hours in property and casualty insurance.

Prohibits insurers, including Citizens Property Insurance Corporation (Citizens), from requiring appointees (insurance agents) to complete specified continuing education (CE) courses offered by such insurers or by Citizens for the appointment to be issued or renewed.

Requires appointees of insurers, including Citizens to attend non-CE training and education programs offered by such insurers or by Citizens for the appointment to be issued or renewed;

Allows Citizens to require its employees to take training relevant to their employment and to require appointees to take CE courses which pertain solely to Citizens' internal procedures or products; and

Authorizes independent study programs offering CE courses through correspondence to allow students to take a final closed book examination without being monitored provided that the student submits a sworn affidavit attesting he or she did not receive assistance while taking the exam.

EFFECTIVE DATE: Except as otherwise provided, July 1, 2008. {*Chapter Law 2008-220}*

SB 2462 – Group Self Insurance Funds By Senator Gaetz

Allows two or more employers to pool their liabilities under the workers' compensation act and form a group self-insurance fund.

Amends current law relating to the process by which group self-insurance funds pay dividends to members. Allows trustees of a fund, established prior to June 1, 2008, to distribute dividends to fund members without prior approval of the Office of Insurance Regulation (OIR). Requires the fund to notify OIR within 10 days after the dividend distribution and provide certain information to support the dividend payment.

Limits the amount of the dividend. Prohibits the distribution of dividends if it jeopardizes the financial condition of the fund. Group self-insurance funds established after June 1, 2008 are required to obtain prior approval from OIR for the distribution of dividends for the first seven years of operation.

EFFECTIVE DATE: Upon becoming law. {*Chapter Law 2008-181}*

HB 5057 – Insurance Capital Build-Up Incentive Program By Representative Reagan

Provides that insurers must apply for a surplus note loan equal to the amount of new capital that an insurer contributes by September 1, 2008. Insurers that apply after September 1, but before June 1, 2009, may apply for a surplus note equal to one-half of the amount of new capital that the insurer contributes. Revises the minimum writing ratio of premium to surplus that an insurer must maintain.

Provides that an insurer must also commit to writing at least fifteen percent of its net or gross written premium for new policies, not including renewal premiums, for policies taken out of Citizens Property Insurance Corporation during each of the first three years after receiving the surplus note. Provides that an insurer must commit to maintaining a level of surplus and reinsurance sufficient to cover in excess of its 1-in-100 years probable maximum loss.

Allows the SBA to charge a late fee for repayments. Provides that amendments made by the Act do not affect the terms of the surplus notes approved prior to January 1, 2008, but authorizes the SBA and an insurer to renegotiate such terms consistent with such amendments.

Citizens Property Insurance Corporation is directed to transfer $250 million to the General Revenue Fund by December 15, 2008 if the combined surplus of each of its accounts exceeds $1 billion. Although this bill makes available $250 million to the

General Revenue Fund for the ICBIP, it does not provide an appropriation of those funds to the program. The appropriation is made in House Bill 5001, the proposed General Appropriations Act for Fiscal Year 2008-2009, which was vetoed by Governor Crist on June 10, 2008.

Beginning July 1, 2009, the SBA is directed to quarterly transfer any interest and principle repaid on any surplus notes issued after December 1, 2008 to Citizens provided that the surplus notes were funded exclusively by an appropriation to the ICBIP by the Legislature for the 2008-2009 fiscal year.

Provides that Citizens may not use any amendments made to s. 215.5595, Florida Statutes, or any transfer of funds authorized by this Act as justification for seeking any rate or assessment increases.

This bill also relates to the End of Session Summary for CS/CS/SB 2860, Third Engrossed. This bill provides that provisions of SB 2860 shall supersede and control any conflicting provisions adopted by HB 5057 to the extent of such conflict, if both bills becomes a law.

EFFECTIVE DATE: July 1, 2008. Vetoed by the Governor on June 10, 2008.

LIFE & HEALTH

HB 461 – Health Flex Plans By Representative Patronis

Expands the population eligible to purchase health flex plans by raising the income limit from 200 to 300 percent of the federal poverty level. Extends the expiration date of the program from July 1, 2008 to July 1, 2013.

EFFECTIVE DATE: July 1, 2008. {Chapter Law 2008-118}

HB 535 – Health Insurance By Representative Cretul

Requires health insurance companies and health maintenance organizations to provide policyholders and subscribers with identification cards. These cards must contain specified information that can be used to estimate the financial responsibility of the covered person, in compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as contact information for the insurer or health maintenance organization. This information is gathered to assist hospitals and other providers to determine coverage and the financial responsibility of the covered person.

Expands the definition of bone marrow transplant for purposes of required health insurance coverage to include nonablative therapy and authorizes coverage for bone marrow transplants for life-prolonging intent, not just for curative purposes. Updates coverage requirements to reflect current practice and advancements in the area of bone marrow transplants.

EFFECTIVE DATE: January 1, 2009. {Chapter Law 2008-119}

SB 648 – Insurable Interest Contracts By Senator Posey

Clarifies current Florida law defining insurable interests and the purchase of life insurance. Prohibits the issuance of a life insurance policy to someone who does not have an insurable interest in the insured.

States that a person may purchase insurance on his or her own life or body for payment to any beneficiary. However, no person may purchase an insurance contract on the life or body of another individual unless the benefits under the insurance are payable to the individual insured, the insured's personal representatives, or a person who had an "insurable interest" in the life of the insured when the contract was consummated.

Defines the various circumstances that constitute an insurable interest for purposes of life, health, or disability insurance. Allows such insurance to be purchased on:

- *Yourself*: an individual has an insurable interest in his or her own life, health and body.

- *Family members and loved ones*: an individual has an insurable interest in another person who is a close relation by blood or law and in whom the individual has a substantial interest engendered by love and affection.

- *Persons whose health and life is of substantial benefit to you financially*: an individual has an insurable interest in another person if there is a substantial pecuniary advantage in the continued life, health, and safety of that other person and the individual will have a substantial pecuniary loss upon the death, illness, or disability of that other person.

- *Other parties to a contract for the sale of a business*: an individual party to a contract for the purchase or sale in a business entity has an insurable interest in the life of the other parties for purposes of that contract.

- *Grantors of trusts, their relations, and others*: A trust or trustee acting in its fiduciary capacity has an insurable interest in the life of the trust grantor, persons closely related by blood or law to the grantor, or individuals in whom the grantor has an insurable interest. The insurable interest only exists if the life insurance proceeds are primarily for the benefit of trust beneficiaries who have an insurable interest in the life of the insured. *Beneficiaries*: a guardian, trustee, or fiduciary who acts in a fiduciary capacity has an insurable interest in a beneficiary and in any person for which the beneficiary has an insurable interest.

- *Persons who consent in writing to a charity*: a charitable organization has an insurable interest in the life of any person who consents in writing to the charity's ownership or purchase of insurance on that person. This provision is the substance of current s. 627.404(2), F.S.

- *Participants in a retirement or deferred compensation plan who consent in writing*: a trustee or custodian of a retirement or deferred compensation plan has an insurable interest in the life of participants in the plan who consent in writing to the plan's ownership of a life insurance policy on that person. The bill prohibits an employer, trustee, or custodian from taking adverse action against a plan participant who refuses to give consent.

- *Owners, directors, officers, partners, managers, and key employees of a business*: a business entity has an insurable interest in its owners, directors, officers, partners, and managers, and in key employees if their loss will result in a substantial pecuniary loss.

Requires the written consent, (i.e. a signature), of the insured as a prerequisite to the issuance of a contract of insurance on the insured, with exceptions for group life insurance or group or blanket accident, health or disability insurance.

Provides a right of recovery against persons who receive insurance policy benefits if they did not have an insurable interest in the insured when the insurance contract was consummated.

EFFECTIVE DATE: July 1, 2008. {Chapter Law 2008-36}

SB 1012 – Health Insurance Claims Payments By Senator Gaetz

Makes changes to current law regarding the assignment of benefits by policyholders or subscribers, third party access to provider networks, and recouping of certain overpayments to providers.

Assignment of Benefits

Requires any insurer that contracts with a preferred provider to make payments directly to the preferred provider for such services to its insureds. Allows a health insurance policy insuring against loss or expense due to hospital confinement or medical and related services to provide direct payment to licensed ambulance providers, in addition to recognized hospitals and physicians to whom current law authorizes direct payment.

Pursuant to s. 395.1041, F.S., an insurance contract may not prohibit the direct payment of a licensed ambulance provider for emergency services. Pursuant to part III of ch. 401, F.S., an insurance contract may not prohibit medical transportation services. Payment to the medical provider may not be greater than the payment the insurer would have paid without an assignment of benefits by the policyholder.

Requires a Health Maintenance Organization (HMO) to directly pay contracted hospitals, ambulance providers, physicians, and dentists for covered services if their subscribers make an assignment of benefits. Pursuant to s. 395.1041, F.S., an HMO contract may not prohibit the direct payment of benefits to a licensed hospital, ambulance provider, physician or dentist for covered services, for emergency services. Also, pursuant to part III, ch. 401 a HMO contract may not prohibit the direct payment of benefits for ambulance transport and treatment.

Payment to the medical provider may not be more than the payment due in the absence of an assignment of benefits. These requirements do not affect the prohibition against balanced billing and other requirements in s. 641.3154, F.S., or the requirements for payment of emergency services in s. 641.31, F.S.

Third Party Access to Provider Networks

Establishes requirements for a contracting entity to lease, rent, or grant access to the health care services of a preferred provider or exclusive provider to a third party (sometimes referred to as a "silent Preferred Provider Organization") not involved in the original contract. These requirements apply if the participating provider is licensed under ch. 458, F.S., (physicians), ch. 459, F.S., (osteopaths), ch. 460, F.S., (chiropractors), ch.

461, F.S., (podiatrists), or ch. 466, F.S., (dentists). This also applies to group, blanket, and franchise health insurance. The requirements include:

- The health care contract between the contracting entity and participating provider must expressly authorize granting access to provider's services to third parties. When the contract is entered into, the contracting entity must identify any third party it has granted access to the health care services of the participating provider.

- The contracting entity may sell, lease, rent or otherwise grant access to the participating provider's services only to the following third parties:

  - A payer or third-party administrator or other entity responsible for administering claims on the payer's behalf.

  - A preferred provider organization or network that is required to comply with all of the terms to which the originally contracted primary participating provider network is bound.

  - An entity that is engaged in the business of providing electronic claims transport.

- Upon request by a participating provider, a contracting entity must provide the identity of any third party that has been granted access. A contracting entity must also maintain an Internet website or a toll-free telephone number through which the provider may obtain a listing of the third parties that have been granted access.

- A contracting entity must ensure that an explanation is furnished to the participating provider that identifies the contractual source of any applicable discount.

- A contracting entity must ensure that all third parties given access comply with the physician contract, unless otherwise agreed by a participating provider.

- The right of a third party to exercise the rights and responsibilities of a contracting entity terminates on the day following the termination of the contract with the contracting entity, subject to applicable continuity-of-care laws.

- A health care contract may provide for arbitration of disputes under the section.

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

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

- An employer or other entity providing coverage and the employer or entity has a contract with the contracting entity for the administration or processing of claims for payment or services provided under the health care contract;

- An entity providing administrative services to, or receiving administrative services from, the contracting entity; or

- An affiliate or a subsidiary of a contracting entity, or other entity if operating under the same brand licensee program as the contracting entity (Blue Cross Blue Shield operates under a brand licensee program).

Claims for Overpayment and Underpayment

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

Other Provisions:

- Revises the definition of small employer for group health insurance coverage to provide that companies that are affiliated groups as defined in s. 1504(a) of the Internal Revenue Code are considered one employer, for purposes of calculating the number of employees. Certain companies currently considered small employers will no longer be entitled to guaranteed issue and modified community ratings since they will no longer be deemed small employers. Exempts from the definition small employers formed primarily for the purpose of providing health insurance, which conforms Florida law to the current National Association of Insurance Commissioners Model Act.

- Allows the Office of Insurance Regulation (OIR) to waive the requirement that a multiple employer welfare arrangement must have its principal place of business in Florida and maintain complete records of its assets, transactions and affairs at that locale if an arrangement has been operating in another state for at least 25 years, has been licensed in that state for at least 10 years, and has a minimum fund balance of at least $25 million at the time of licensure.

EFFECTIVE DATE: Except as otherwise provided, November 1, 2008.
{Chapter Law 2008-212}

SB 2654 – Autism Spectrum Disorder By Senator Geller

Authorizes the Agency for Health Care Administration (AHCA) to seek federal approval through a Medicaid waiver or state plan amendment for the provision of occupational

therapy, speech therapy, physical therapy, behavior analysis, and behavior assistant services to individuals who are five years old and younger and have a diagnosed developmental disability, an autism spectrum disorder, or Down syndrome. Coverage must be limited to $36,000 annually and $108,000 in total lifetime benefits. AHCA must submit an annual report beginning on January 1, 2009 to the Legislature reporting progress on obtaining federal approval and recommendations for the implementation of services. AHCA may not implement the provision of these services without prior legislative approval.

Creates the "Window of Opportunity Act," which requires the Office of Insurance Regulation (OIR) to convene a workgroup by August 31, 2008, to negotiate a binding compact agreement among participants for insurance and access to services for persons with developmental disabilities. The working group must include representatives from all licensed health insurers, all licensed health maintenance organizations, and employers with self-insured health benefit plans. No party must agree to the compact, but a party that does agree to the compact is bound to its terms and conditions. The compact agreement must include:

- A requirement to increase coverage for behavior analysis and behavior assistant services, speech therapy, physical therapy, and occupational therapy due to the presence of a developmental disability.

- Procedures for clear and specific notice to policyholders identifying the amount, scope, and conditions under which coverage is provided for such services.

- Penalties for documented cases of denial of claims for medically necessary services due to the presence of a developmental disability.

- Proposals for new product lines to be offered in conjunction with health insurance.

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

Creates the "Steven A. Geller Autism Coverage Act," which requires insurer large group health insurance plans and HMO large group health maintenance contracts to provide coverage for diagnostic screening, intervention, and treatment of autism spectrum disorder in children through speech therapy, occupational therapy, physical therapy, and applied behavior analysis that is prescribed by the insured's treating physician in accordance with a treatment plan.

Requires all large group health insurance policies and HMO contracts issued or renewed on or after April 1, 2009, to provide the mandated autism spectrum coverage, except that the mandate is not enforceable against an insurer or HMO that is a signatory of the

developmental disabilities compact for developmental disabilities, described above, as of April 1, 2009. However, the autism spectrum mandate is enforceable against a signatory of the developmental disabilities compact if the insurer or HMO has not complied with the terms of the compact by April 1, 2010.

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

Prohibits health insurance plans and HMOs from refusing or denying to issue or reissue coverage, terminate, or restrict coverage because an individual is diagnosed with autism spectrum disorder.

EFFECTIVE DATE: July 1, 2008. {Chapter Law 2008-30}

SPECIALTY

SB 2264 – Motor Vehicle Warranty Associations By Senator Lawson

Makes changes to the regulation of warranty associations, including motor vehicle service agreement companies and service warranty associations.

- Creates a definition of "motor vehicle manufacturer" that includes the subsidiaries and affiliates of an automobile manufacturer. It further defines "subsidiary" in this context.

- Exempts motor vehicle manufacturers from complying with certain financial solvency requirements that are required of other companies selling automobile service warranties. However, motor vehicle manufacturers still are required to file forms and rates, comply with the unfair trade practices statutes, and are subject to other provisions in this chapter and regulation by the Office of Insurance Regulation (OIR).

- Exempts motor vehicle manufacturers from submitting fingerprinting or background information for anyone except those serving as officers or directors of the applicant entity.

- Gives OIR the authority to develop by rule an abbreviated form for statistical reporting of sales of service agreements sold by motor vehicle manufacturers. Therefore, motor vehicle manufacturers will be required to file the abbreviated form instead of submitting the detailed financial report required by current Florida law.

- Specifies that the warranty register required in s. 634.4165, F.S., of warranty associations selling service warranties for consumer products (which are not motor vehicle service agreements or home warranties) must include the name and address of warranty holders, to the extent that the warranty holders provide that information.

- Requires that service warranty companies provide an alternate means for consumers to submit their name and address such as online registration, postcard remittance, or other methods acceptable to the OIR.

- Expands the existing list of what constitutes an unfair or deceptive claim settlement practice by a service warranty association. The bill prohibits a service warranty association from denying a claim solely because it was unable to confirm that a customer in fact purchased a warranty due to the association not collecting the customer's name and address.

EFFECTIVE DATE: Upon becoming law. {Chapter Law 2008-178}

ADMINISTRATION

HB 165 – Agency Inspectors General By Representative Bean

Requires agency inspectors general to comply with standards published by the Association of Inspectors General. Requires that a final audit or investigation report contain the response of a contracting entity that is the subject of the audit or investigation. Requires Inspectors General to submit to their agency heads all complaints relating to their duties or alleged misconduct of their employees and agencies under the direction of the Governor; must also submit such complaints to the Chief Inspector General.

EFFECTIVE DATE: July 1, 2008. {Chapter Law 2008-183}

SB 704 – Administrative Procedures By Senator Bennett

Revises provisions in the Administrative Procedure Act (APA), codified in ch. 120, F.S., relating to unadopted agency rules. Creates incentives for agencies to adopt rules and for affected persons to challenge unadopted rules by:

- Creating requirements for agency adoption of policy statements as rules; and
- Modifying provisions relating to the award of costs and fees in rule challenges.
- Modifies provisions of the APA concerning the incorporation by reference of materials into agency rules. In addition to technical or administrative refinements to ch. 120, F.S., the bill makes the following significant changes:
- Provides additional requirements for the use of material that is being incorporated by reference in rules;
- Requires electronic publication of the Florida Administrative Code (FAC);
- Provides for material incorporated by reference to be filed in electronic form, unless doing so would constitute a violation of federal copyright law;
- Provides that if an agency head is a board or other collegial body created under Department of Business and Professional Regulation or Department of Health, then the agency head must conduct at least one of the requested public hearings itself;
- Provides an award of attorney's fees to the petitioner in an unadopted rule challenge if, prior to the final hearing, the agency initiates rulemaking and the agency knew or should have known that the agency statement was an unadopted rule, but provides no attorney's fees if the agency initiates rulemaking in response to notice prior to the filing of an unadopted rule challenge;

- Provides for the granting of a stay in an unadopted rule challenge when certain conditions are met;

- Appropriates non-recurring funds of $50,000 in FY 2008-2009 and $401,000 in FY 2009-2010 from the Records Management Trust Fund to implement electronic publication of the Florida Administrative Weekly;

- Requires a temporary space charge fee increase to cover the cost of implementing system changes required for electronic publication;

- Authorizes one full-time-equivalent position and appropriates $22,399 in recurring Salaries and Benefits from the Records Management Trust Fund; and

- Allows the Department of State to carry forward unencumbered cash balance in the Records Management Trust Fund at the end of FY 2008-2009.

EFFECTIVE DATE: Except as otherwise provided, July 1, 2008. {Chapter Law 2008-104}

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