# PROPERTY INSURANCE

## CS/CS/SB 1980 — Property and Casualty Insurance

by Ways and Means Committee; Banking and Insurance Committee; and Senator Garcia

***Funding the 2005 Deficit of Citizens Property Insurance Corporation***

- The bill appropriates $715 million from General Revenue to Citizens Property Insurance Corporation ("Citizens") to offset the 2005 deficit, estimated to be about $1.73 billion. This appropriation is expected to reduce an estimated $920 million regular assessment against property insurers to about $205 million, and thereby reduce an estimated average 11 percent premium surcharge to about 2.5 percent for property insurance policyholders in the state (including Citizens policyholders). The bill also requires that the remaining estimated $800 million of the deficit, which would require about an 8 percent emergency assessment on policyholders if billed in one year, must be amortized and collected from policyholders over a 10-year period.

- Citizens and OIR are expected to levy the regular assessment (about $205 million due to the appropriation) for the 2005 deficit sometime this summer (2006), after which insurers may make rate filings to recoup this assessment, most of which are likely to become effective around January, 2007, and later. The bill requires that the premium notice sent to policyholders identify the dollar amount of the surcharge for the assessment by Citizens, and the dollar reduction in the surcharge due to the appropriation by the Florida Legislature.

- There will be about $800 million remaining of the $1.73 billion deficit for 2005, which will be paid by pre-event notes (debt) secured by Citizens, and funded by multi-year emergency assessments on all property insurance policyholders in Florida. The bill provides that this amount (which would be about an 8 percent assessment if collected in one year) must be amortized and collected over a ten-year period.

***Florida Hurricane Catastrophe Fund (FHCF)***

- The bill requires a 25 percent rapid cash build-up factor in the premiums paid by insurers for coverage from the FHCF, which is the state fund that reimburses most insurers for 90 percent of their residential hurricane losses above each insurer's retention, up to each insurer's share of a $15 billion cap on total annual payments. The State Board of Administration (SBA), the agency responsible for the operation of the FHCF, recently approved a 25 percent rapid cash build-up factor for the 2006-07 contract year premiums (that the bill requires each year), which is expected to increase total FHCF premiums from about $800 million to $1.0 billion. On average, this is estimated to increase residential property insurance premiums about 2.7 percent. But, this extra $200 million

may be used by the SBA to offset the current FHCF deficit, estimated to be about $1.3 billion, which will reduce assessments levied against most types of property and casualty insurance policyholders (including auto) to fund a bond issue to cover this deficit.

- The bill allows limited apportionment companies (i.e., companies with $25 million in surplus or less), for this year only, to buy coverage from the FHCF that would reimburse the insurer for up to $10 million of its losses from each of two hurricanes above the insurer's retention, or the amount of hurricane losses the insurer must pay before triggering coverage from the FHCF, which is set at 30 percent of the company's surplus. The insurer must pay a rate of 50 percent of the coverage selected, i.e., $5 million for the maximum $10 million in coverage, which is reinstated at no additional charge for a second hurricane. This one-year option is intended to address the current problem of private reinsurance either being unavailable or at an extremely high price, especially for small (low surplus) insurers that depend heavily on reinsurance. In total, limited apportionment companies write about 30 percent of the homeowners policies in Florida. This layer of coverage is in addition to the coverage that insurers currently purchase from the FHCF and is well below the current retention. But, the insurer must pay a premium (50 percent of the coverage amount) that is much greater than the premium for the current layer of FHCF coverage (about 7 percent of the coverage amount). Given the low retention, this does expose the FHCF to a significant chance of loss if there is a hurricane that impacts limited apportionment companies that buy this coverage, but this may prevent limited apportionment companies from non-renewing policyholders who would otherwise end up in Citizens and increase Citizens' exposure and potential deficit assessment liability. It is important to note that the bill also substantially eliminates the primary benefit that limited apportionment companies receive under current law, which is being exempt from paying their market share of the amount of a regular assessment by Citizens for the high-risk account in excess of $50 million, explained in the Citizens section, below.
- The bill's other changes to the FHCF:
    - Deletes the requirement that bonds of the FHCF be validated pursuant to ch. 75, F.S., and that the validation be appealed to the Supreme Court. The SBA met this requirement in 1996 and deleting the language removes any ambiguity that it must be done again.
    - Clarifies the premiums that are subject to assessment for funding bond obligations and the procedures for insurers to collect and transmit these assessments.
    - Allows Citizens and the SBA to determine the method of providing coverage for policies assumed by Citizens of insolvent insurers (for one year only).
    - Clarifies that the "cash balance" of the FHCF for determining the annual growth factor for the annual $15 billion limit of coverage refers to the FHCF balance as of December 31, as defined by rule.

- Specifies that the FHCF does not reimburse insurers for claims for "loss of rent or rental income," rather than "loss of use," to clarify that the FHCF reimburses insurers for additional living expenses paid under their policies.
- Clarifies that any annual assessments that are necessary to fund bonding obligations continue "for as long as" (rather than "until") the revenue bonds are outstanding.

***Insurance Capital Build-Up Incentive Program***

- The bill establishes the Insurance Capital Build-Up Incentive Program, which provides for the lending of state funds in the form of "surplus notes" to new or existing authorized residential property insurers, under specified conditions.
- The amount of the surplus note may not exceed $25 million or 20 percent of total funds available for the program. A total of $250 million is appropriated in non-recurring funds from General Revenue to the State Board of Administration (SBA) for this program.
- The insurer must contribute new capital to its surplus at least equal to the surplus note and must apply to the SBA (headed by the Governor, Attorney General, and Chief Financial Officer) by July 1, 2006.
- If the insurer applies after July 1, 2006, but before June 1, 2007, the surplus note is limited to one-half of the new capital contributed by the insurer. No applications are permitted beyond June 1, 2007.
- The combination of surplus, new capital, and the surplus note must be at least $50 million. That is, after obtaining the surplus note, the insurer must have a surplus of at least $50 million.
- The surplus note must be repayable to the state, with a 20-year term, at the 10-year Treasury Bond interest rate (with interest-only payments for the first 3 years). The Insurance Commissioner must approve payments on the surplus note, unless he determines the payment would substantially impair the financial condition of the insurer.
- The insurer must commit to meeting a minimum writing ratio of net written premium to surplus of at least 2:1 for the term of the surplus note. The written premium must be for residential property insurance in Florida, covering the peril of wind.
- The SBA may approve issuance of a surplus note to an applicant, unless the SBA determines that the financial condition of the insurer and its business plan place an unreasonably high level of financial risk to the state of nonpayment in full of the interest and principal. The SBA must consult with the Office of Insurance Regulation and may contract with independent financial and insurance consultants in making this determination.
- If the total amount of surplus notes requested exceeds the funds available, the SBA may prioritize insurers based on financial strength, the viability of the proposed business plan

for writing additional residential property insurance in the state, and the effect on competition in the market.

- The state of Florida would be a preferred, "class 3" creditor if the insurer becomes insolvent, being placed first in line after costs of the receiver and claims to policyholders.

***Hurricane Loss Mitigation***

- The bill establishes the Florida Comprehensive Hurricane Damage Mitigation Program within the Department of Financial Services (DFS).
- Provides for free inspections of site-built, residential property, to determine what mitigation measures are needed to reduce vulnerability to hurricane damage, performed by qualified inspectors under contract with DFS, pursuant to a request for proposals.
- Home inspections must include a rating scale specifying the current and projected wind resistance rating, and insurer-specific information on insurance credits and discounts.
- Provides for 50 percent matching grants to encourage single-family (and up to four-family), site-built homes to retrofit to reduce vulnerability to hurricane damage. Eligible property must have a homestead exemption, an insured value of $500,000 or less, and have undergone an acceptable hurricane mitigation inspection. Grants are limited to $5,000 (for up to a $10,000 project), with up to 100 percent grants ($5,000) for low-income homeowners, as defined. The bill specifies the types of improvements (opening protection, roof covering, etc.) for which grants may be used.
- Matching fund grants are also made available to local governments and nonprofit entities for projects that will reduce hurricane damage to single-family, site-built residential property.
- An Advisory Council to DFS must be appointed for the program, including representatives of lending institutions, residential property insurers, and home builders, a faculty member of a state university, two members of the House of Representatives, two members of the Senate, the chief executive officer of the Federal Alliance for Safe Homes, the senior officer of the Florida Hurricane Catastrophe Fund, the executive director of Citizens, and the director of the Division of Emergency Management of the Department of Community Affairs.
- DFS must adopt rules for the program and establish priorities for grants based on objective criteria that gives priority to reducing the state's probable maximum loss from hurricanes, while also establishing priorities based on the insured value of the dwelling, whether or not the dwelling is insured by Citizens, and whether the area under consideration has sufficient resources and the ability to perform the retrofitting required.
- Appropriates $250 million of non-recurring funds from General Revenue to DFS for this program. The unexpended balance reverts after three years (June 30, 2009).

- The program does not create an entitlement or obligate the state to pay for inspection or retrofitting of residential property and implementation is subject to annual legislative appropriations.
- The bill also creates the Manufactured Housing and Mobile Home Mitigation and Enhancement Program, which will provide grants for manufactured home communities and mobile home parks, administered by Tallahassee Community College. The bill appropriates $7.5 million of the $250 million appropriated for the comprehensive mitigation program, described above.

***Insurance Rates: Requirements and Exceptions for Approval by the Office of Insurance Regulation (OIR)***

- Requires OIR to approve a rating factor that provides an insurer a reasonable rate of return that is commensurate with the risk of covering hurricane losses, for that portion of the rate for which the insurer has exposed its capital and surplus and has not purchased reinsurance.
- Places the burden on OIR to establish that a proposed rate by an insurer is excessive for personal lines residential coverage with insured value of $1 million or more. The insurer must provide OIR, upon request, with loss and expense information, as reasonably needed for OIR to meet this burden.
- Requires OIR to reevaluate the insurance discounts and credits for homes built to meet the Florida Building Code and to determine the full actuarial value of such discounts, by July 1, 2007, for use by insurers in rate filings.
- Effective July 1, 2007, for residential property insurance in those areas for which OIR determines that a reasonable degree of competition exists, an insurer may increase or decrease rates by up to 5 percent on a statewide average, or 10 percent for any territory, without being subject to a determination by OIR that the rate is excessive or unfairly discriminatory (except for unfairly discriminatory rating factors prohibited by law). This provision may be used by an insurer once in a 12-month period.
- Authorizes the Insurance Consumer Advocate appointed by the Chief Financial Officer to represent the public in insurance rate proceedings before an arbitration panel (in addition to the current authority to represent the public at a rate proceeding before the Division of Administrative Hearings). The bill also appropriates $250,000 from the Insurance Regulatory Trust Fund to the Office of the Insurance Consumer Advocate.

***Insurance Rates: Use of Hurricane Loss Projection Models***

- Requires the public hurricane loss model (developed by Florida International University under contract with DFS) to be submitted for review by the Florida Commission on Hurricane Loss Projection Methodology ("Commission"), by March 1, 2007. OIR is

allowed to continue to use the public model in reviewing rate filings until the Commission determines it is not accurate or reliable.

- In a rate hearing, the hearing officer, judge, or arbitration panel may determine whether OIR and the Insurance Consumer Advocate were provided with access to all of the assumptions and factors used in developing a hurricane loss projection model approved by the Commission and used by the insurer in its rate filing, and rule on the admissibility of such findings and factors. (Legislation in 2005 provided that OIR and the Insurance Consumer Advocate must be provided such access in order for the findings and factors (the model), to be admissible in a rate proceeding, and created a public records exemption for information that is a trade secret.

***Citizens Property Insurance Corporation ("Citizens"); Oversight, Internal Controls, and Standards of Conduct***

- Requires the Financial Services Commission (Governor and Cabinet), rather than the Office of Insurance Regulation (OIR), to approve Citizens' plan of operation.
- Requires the Executive Director of Citizens to be confirmed by the Senate.
- Requires Citizens to have an internal auditor.
- Requires OIR to do a market conduct examination of Citizens every two years.
- Requires the Auditor General to conduct an operational audit of Citizens every three years.
- Requires competitive bidding on contracts of $25,000 or more, with exceptions, and board approval of contracts of $100,000 or more.
- Requires OIR background checks of applicants for senior management positions.
- Subjects board members and senior managers to the code of ethics and financial disclosure requirements applicable to public officials, and requires all employees to annually submit a statement attesting that no conflict of interest exists.
- Prohibits board members and employees from accepting any gift from any person or entity under contract with Citizens or under consideration for a contract.
- Prohibits Citizens from retaining lobbyists, but allows employees to register as lobbyists.
- Prohibits senior managers, for two years following termination of employment, from representing any person or entity before Citizens, or from being employed or under contract with an insurer that received a take-out bonus from Citizens.
- Requires Citizens to conduct a cost-benefit analysis of using legal services provided by in-house (employee) attorneys, or to contract with outside attorneys.

- Requires Citizens to establish a fraud unit or division to investigate possible fraudulent claims or repairs and to meet the same anti-fraud requirements imposed on authorized insurers. Requires employees to notify the Division of Insurance Fraud within 48 hours of having information that would lead a reasonable person to suspect that fraud may have been committed by an employee of Citizens.

***Eligibility for Coverage in Citizens (Nonhomestead Property and $1 Million Homes)***

- Effective March 1, 2007, nonhomestead property is not eligible for coverage in Citizens and is not eligible for renewal unless the property owner provides a sworn affidavit from one or more insurance agents that they have made their best efforts to obtain coverage and that the property has been rejected by at least one authorized insurer and three surplus lines insurers (for all agents combined).

- Defines "homestead property" as: a) property granted a homestead tax exemption under ch. 196, F.S.; b) property for which the owner has a written lease with a renter for a term of at least 7 months and which is insured by Citizens for $200,000 or less; c) an owner occupied mobile home permanently affixed to real property, owned by a Florida resident, and either granted a homestead tax exemption or, if the owner does not own the land, for which the owner certifies that the mobile home is his principal place of residence; d) tenants coverage; e) commercial lines residential property; or f) any county, district, or municipal hospital; not-for-profit hospital; or continuing care retirement community that is certified under ch. 651, F.S., and receives an ad valorem tax exemption under ch. 196, F.S. All other property is "nonhomestead property."

- Effective July 1, 2008, a personal lines residential structure that has a dwelling replacement cost of $1 million or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $1 million or more, is not eligible for coverage by Citizens. Such dwellings insured by Citizens on June 30, 2008, may continue to be covered until the end of the policy term and may reapply for coverage for up to an additional three years if the property owner provides a sworn affidavit from one or more insurance agents that they have made their best efforts to obtain coverage and that the property has been rejected by at least one authorized insurer and three surplus lines insurers (for all agents combined).

***Rates Charged by Citizens***

- Requires that for policies in the personal lines account and the commercial lines account issued or renewed on or after March 1, 2007, a rate is deemed inadequate if the rate, including investment income, is not sufficient to provide for the purchase of reinsurance coverage from the Florida Hurricane Catastrophe Fund and private reinsurance (whether or not purchased) and to pay all claims and expenses reasonably expected to result from a 100-year probable maximum loss event (i.e., a 1-in-100 year hurricane), without resort to assessments or other outside funding sources.

- Requires that for policies in the high-risk account of Citizens (wind-only coverage in coastal areas) issued or renewed on or after March 1, 2007, a rate is deemed inadequate if the rate, including investment income, is not sufficient to provide for the purchase of reinsurance coverage from the Florida Hurricane Catastrophe Fund and private reinsurance (whether or not purchased) and to pay all claims and expenses reasonably expected to result from a 70-year probable maximum loss event (i.e., a 1-in-70 year hurricane), without resort to assessments or other outside funding sources. For policies in the high-risk account issued or renewed in 2008 and 2009, the rate must be based upon an 85-year and 100-year probable maximum loss event, respectively.
- Provides that Citizens' rate filings for personal lines, wind-only policies (i.e., in the high-risk account) must be approved or disapproved by OIR within 90 days after receipt of the filing, or shall be considered deemed approved.
- Requires use of the public hurricane loss model as the minimum benchmark for determining windstorm rates for Citizens, after the public model has been found to be accurate and reliable by the Florida Commission on Hurricane Loss Projection Methodology.
- Makes the current "top 20" requirement that Citizens' rates not be competitive with authorized insurers, inapplicable in a county or area for which OIR determines that no authorized insurer is offering coverage.

***Assessments and Surcharges for Funding Deficits in Citizens***

- Provides that if a deficit is incurred in any account, the board must levy an immediate assessment on each nonhomestead property (see definition above) of up to 10 percent of the premium. If this is insufficient to eliminate the deficit, the board must levy an additional assessment against all Citizens' policyholders (including nonhomestead policyholders), collected upon renewal, of up to 10 percent of premium. Any remaining deficit is funded by regular and emergency assessments as under current law, either recouped from, or directly paid by, non-Citizens' policyholders of property insurance. The regular assessment against insurers could still be imposed as soon as a deficit is determined, but must be reduced by the amounts estimated to be collected from the two new 10 percent surcharges.
- Requires that deficit assessments against insurers (and recouped from their policyholders) also be reduced by amounts estimated to be collected from "Citizens policyholder" surcharges, previously called the "market equalization" surcharge. The current surcharge is imposed on Citizens' policyholders at the same statewide average percentage that is recouped by insurers from non-Citizens policyholders, but collected by Citizens in addition to the assessment on the insurers that fully funds the deficit. Under the bill, Citizens would be required to estimate the amount to be collected from this surcharge and reduce the regular assessment by that amount. To enable Citizens to cover the entire deficit, the Citizens policyholder surcharge is calculated based on the full amount of the

regular assessment, before deducting the estimated Citizens policyholder surcharge. This has the effect of shifting a disproportionate share of the deficit assessment to Citizens' policyholders, resulting in the percentage assessment being about 1 percentage point greater than the voluntary market assessment, based on Citizens' current market share. This also appears to result in the voluntary market assessment capping out (for each of three accounts) at about 9 percent of premium, rather than 10 percent of premium, based on Citizens' current market share.

- Requires limited apportionment companies (i.e., insurers with $25 million in surplus or less) to pay the full amount of a regular assessment by Citizens. Currently, limited apportionment companies are not required to pay a regular assessment for any amount of a deficit in the high-risk account over $50 million. But, the bill allows limited apportionment companies up to 12 months to pay the assessment, as compared to 30 days as required for other insurers pursuant to Citizens' plan of operation. The limited apportionment companies would also be allowed to make a rate filing to begin recouping the assessment after it has been levied and before it is paid.

***Other Changes to Citizens***

- Requires Citizens to maintain separate accounting records that consolidate data for non-homestead properties, including number of policies, insured values, premiums written, and losses, and to annually report a summary of such data to OIR and the Legislature.
- Requires a 10-day waiting period for new applications, but allows for Citizens to bind coverage during this period under certain circumstances. If an authorized insurer offers coverage during this 10-day period, the applicant is not eligible for coverage in Citizens regardless of whether the insurer appoints the agent who submitted the application. (That is, the "Consumer Choice" law, does not apply during the first 10 days after a new application for coverage has been submitted to Citizens.)
- Requires Citizens to offer policyholders quarterly and semiannual premium payment plans.
- Allows Citizens to adopt policy forms that contain more restrictive coverage than provided in the voluntary market.
- Requires that coverage on mobile homes built prior to 1994 be limited to actual cash value, rather than replacement cost.
- Allows Citizens to assume policies of an insolvent insurer pursuant to court order, and to use policy forms and rates deemed appropriate and approved by OIR. This is intended to allow Citizens to charge the same rates and use the same policy forms of the insolvent insurer, until the end of that insurer's policy term.

- Requires insurers writing the non-wind coverage to contract with Citizens to provide claims adjusting services for the wind coverage provided by Citizens in the high risk account.
- Extends for three years (until February 1, 2010), the requirement that the board reduce the boundaries of the high risk (wind-only) territory, in order to reduce the 100-year probable maximum loss (PML) of the high risk account by at least 25 percent below the 100-year PML as of February 1, 2002.
- Requires that any take-out bonus paid to an insurer be conditioned on the insurer keeping the policy for five years. The bill also limits take-out bonuses to $100 per policy and requires other conditions as specified in s. 627.3511(2), F.S. Citizens must evaluate the cost-benefit of approved take-out plans for which a take-out bonus is paid, by tracking whether properties removed from Citizens are later insured by Citizens.
- Requires Citizens to report to the Legislature its recommendations regarding consolidating its three accounts and actions taken to minimize the cost of carrying debt.
- Requires Citizens to report to the Legislature on the feasibility of requiring insurers providing the non-wind coverage to issue and service Citizens' wind policies.
- Provides immunity from liability for insurance agents for the insolvency of any take-out insurer.
- Requires Citizens to make available to registered general lines agents, through a secured website, underwriting and claims files of policyholders with insured values of $1 million or more, subject to a required notice from Citizens to such policyholders and the option to elect not to make such information available.

***Annual Report by Financial Services Commission of Assessment Burden***

- Requires the Financial Services Commission to provide an annual report to the Legislature of the probable maximum losses, financing options, potential assessments of Citizens and the FHCF, and the assessment burden on Florida policyholders.

***Sinkhole Claims***

- Requires the Department of Financial Services to certify engineers and geologists to serve as "neutral evaluators" of sinkhole claims disputes. This process would be mandatory if requested by either party, but nonbinding, and the costs would be paid by the insurer. If the insurer timely complies with the recommendation of the neutral evaluator, but the policyholder declines to resolve the matter in accordance with the evaluator's recommendation, the insurer is not liable for extra-contractual (bad faith) damages related to issues determined at the neutral evaluation. Also, the insurer is not liable for attorney's fees, unless the policyholder obtains a more favorable judgment at trial. OIR is appropriated funds and 2 FTEs for this purpose.

- Allows residential policies to provide a deductible for sinkhole losses equal to 1, 2, 5, or 10 percent of the dwelling limits.
- Allows the insurer to make payment directly to the persons selected by the policyholder to make the repairs, if approved by the policyholder and lien holder.
- Deletes the current requirement that testing by a geologist to determine the presence or absence of a sinkhole loss be conducted in compliance with a specified publication of the Florida Geological Survey.
- Requires OIR to calculate a presumed factor to reflect the impact on rates of the changes made by the act related to sinkhole claims and the changes made by provisions of the 2005 property insurance act related to sinkhole claims. OIR is appropriated $250,000 for the purposes of this study. Each residential property insurer must, in it next rate filing after October 1, 2006, reflect a rate change that takes into account the presumed factor.
- Requires that insurers file information regarding paid sinkhole claims with the county clerk of court, rather than the county property appraiser, and specifies that the recording of the report does not constitute a lien or restriction on the title, and does not create any cause of action or liability.
- Makes it unlawful for a contractor or business providing sinkhole remediation services to communicate with any attorney for the purpose of assisting the attorney in the solicitation of legal business.

***Florida Insurance Guaranty Association (FIGA)***

- Authorizes FIGA to impose annual emergency assessments on insurers of up to 2 percent of written premium for specified lines of property and casualty insurance (in addition to the current authority to impose up to a 2 percent assessment), if necessary to fund revenue bonds issued by a municipality or county to pay claims of an insurer rendered insolvent due to a hurricane.
- Increases the maximum amount of FIGA's liability for a covered homeowners insurance claim against an insolvent insurer from $300,000 to $500,000.
- Provides that FIGA covers claims of a business (as a policyholder or claimant of an insolvent insurer) that has its principal place of business in Florida, rather than incorporated in Florida.
- Allows FIGA to pay claims of unearned premium refunds, under certain conditions, without requiring the policyholder to file a proof of claim form.

***Emergency Orders; Standardized Rules for Hurricanes***

- Authorizes the Commissioner of Insurance Regulation to issue general orders applicable to all insurance companies, after the Governor declares a state of emergency, which orders may be effective for up to 120 days.
- Requires the Financial Services Commission to adopt rules standardizing requirements that may be applied to insurers after a hurricane, addressing claims reporting requirements, grace periods for payment of premiums, and temporary postponement of cancellations and nonrenewal. Provides that any emergency rule that conflicts with the standardized rules must be by unanimous vote of the Financial Services Commission.

***Other Provisions***

- Requires that an insurer make a claims payment directly to the primary policyholder without requiring an endorsement from a lien holder or mortgage holder, for: a) personal property and contents; b) additional living expenses; and c) other covered items not subject to a security interest recorded in the dual interest provision of the insurance policy.
- Allows insurers to make electronic payment of insurance claims, under certain conditions, without written authorization.
- Permits alien surplus lines insurers to use letters of credit meeting certain criteria to fund the required minimum $5.4 million trust fund.
- Clarifies that if a property insurer does not obtain a written rejection from the policyholder for coverage for the additional construction costs of meeting new building codes, commonly called "law and ordinance coverage," the policy is deemed to include such coverage limited to 25 percent of the dwelling limit, not the 50 percent limit that must also be offered. Current law is ambiguous on this point, but the bill conforms to the current interpretation used by OIR.
- Clarifies that the law requiring insurers to offer replacement cost coverage and, if elected, to pay the replacement cost whether or not the policyholder replaces or repairs the damaged property, does not prohibit an insurer from limiting its liability to the lesser of: the cost of repair, the cost to replace, or the limit of liability shown on the policy declarations page.
- Requires OIR to conduct a study and report on the insurability of attached or free standing structures.
- Requires OIR to conduct a study and develop a program that will provide an objective rating system that will allow homeowners to evaluate the relative ability of Florida properties to withstand the wind load from a hurricane.
- Prohibits public adjusters from engaging in conflicts of interest by participating in the repair of damaged property that he adjusted.

- Provides procedures for the cancellation of a property and casualty insurance policy if the policyholder submits a check which is subsequently dishonored by a financial institution. The bill provides that an insurance policy can be cancelled "ab initio" (from the beginning, or back to the first day of coverage) if the insured does not timely cure a dishonored check within 5 days of notice.

If approved by the Governor, these provisions take effect upon becoming law. except as otherwise provided.
*Vote: Senate 22-16; House 77-39*

## HB 217 — Sinkhole Insurance

by Rep. Legg and others (CS/SB 286 by Banking and Insurance Committee and Senators Fasano, Baker, Lynn, Dockery, Crist, and Jones)

This bill revises the laws relating to sinkhole insurance claims.

***Sinkhole Deductibles***
Effective October 1, 2006, the bill permits deductibles of 1, 2, 5, and 10 percent to be applied to residential property insurance policies.

***Direct Payment to Contractor***
The bill permits an insurer, if approved in writing by the policyholder and any lien holders, to make direct payment to the persons selected by the policyholder to perform land and building stabilization and foundation repairs caused by a sinkhole.

***Sinkhole Testing***
Sinkhole testing by a geologist would no longer be required to be conducted in compliance with the Florida Geological Survey Special Publication No. 57 (2005). The standard for sinkhole testing that an insurer must perform after a claim is filed and the insurer is unable to determine the cause of loss, is that the professional geologist or professional engineer must perform such tests that are necessary to determine the presence or absence of sinkhole loss. The sinkhole report is to be filed with the clerk of court, instead of the county property appraiser, and does not create a cloud on the title of real property or create any cause of action.

***Neutral Evaluation of Sinkhole Claims***
The bill provides an alternative dispute resolution process for sinkhole claims. The neutral evaluation process is nonbinding, but mandatory if either the policyholder or insurer files a request with the Department of Financial Services (DFS) for neutral evaluation. Upon receipt of a request for neutral evaluation, the DFS will provide the parties a list of certified neutral evaluators, who must be engineers or geologists who have completed an alternative dispute resolution course designed or approved by the DFS. The parties have 10 days to select a neutral evaluator from this list. If the parties cannot agree, then the neutral evaluator will be assigned by

the DFS. The neutral evaluation must be held within 45 days of the department's receipt of a request for evaluation, using procedures adopted by the department.

For matters not resolved by the parties during the neutral evaluation, the neutral evaluator must prepare a report stating whether the sinkhole loss has been verified or eliminated. If the existence of sinkhole loss is verified, the report must include the evaluator's opinion regarding the need for estimated costs of stabilizing the land and any covered structures as well as appropriate remediation or structural repairs. The evaluator's report must be sent to all parties in attendance at the neutral evaluation and to the DFS. The neutral evaluator's written recommendation is admissible in any subsequent action or proceeding relating to the claim or the cause of action giving rise to the claim. However, evidence of an offer to settle a claim during neutral evaluation is inadmissible regarding liability or claim value. If the neutral evaluator recommends repairs that exceed the insurer's offer to pay, the insurer is liable to the policyholder for up to $2,500 in attorney's fees. If the insurer timely complies with the recommendation of the neutral evaluator, but the policyholder declines to do so, the insurer is not liable for extra-contractual bad faith damages related to issues determined by the neutral evaluation process. Nor is the insurer liable for attorney's fees under s. 627.428, F.S., or other provisions of the Florida Insurance Code, unless the policyholder obtains a judgment that is more favorable than the neutral evaluator's recommendation.

***Illegal Solicitation of Sinkhole Claims***

The bill prohibits a general contractor, subcontractor, or other business providing sinkhole remediation services from soliciting legal business for an attorney. Doing so is a first degree misdemeanor.

***Required Rate Filing***

The bill mandates that the Office of Insurance Regulation (OIR) must calculate a presumed factor to reflect the impact of the changes made by this act and sections 17 through 21 of ch. 2005-111, L.O.F. Each residential property insurer is required to file a rate that takes into account the presumed factor at its first rate filing after October 1, 2006.

If approved by the Governor, these provisions take effect July 1, 2006.
*Vote: Senate 37-0; House 119-0*

# MOTOR VEHICLE INSURANCE

## CS/CS/CS/SB 2114 — Motor Vehicle Insurance Fraud; Reenactment of No-Fault Law

by Judiciary Committee; Health Care Committee; and Banking and Insurance Committee

***Reenactment and Future Repeal of Florida's No-Fault Law***

This bill reenacts the Florida Motor Vehicle No-Fault Law, by repealing s. 19 of ch. 2003-411, L.O.F., which would have repealed the No-Fault Law, effective October 1, 2007. However, the bill provides for future repeal of the No-Fault Law, effective January 1, 2009, unless reviewed and reenacted by the Legislature prior to that date.

***Motor Vehicle Insurance Fraud***

This bill amends s. 817.234, F.S., to provide that it is a second degree felony (with a two year minimum mandatory term of imprisonment) to plan or organize a scheme to create documentation of a motor vehicle crash that did not occur for purposes of a claim for personal injury protection (PIP) benefits or a motor vehicle tort claim. This penalty currently applies to staged or intentional motor vehicle accidents. The bill expands the applicability of the motor vehicle insurance fraud statute under s. 817.2361, F.S., to provide that any person who creates or presents false or fraudulent "proof" of motor vehicle insurance commits a third degree felony.

The bill specifies information that must be contained in a motor vehicle crash report form under s. 316.068, F.S., to include the time, date and location of the crash; description of the vehicles involved; names and addresses of all drivers, passengers, witnesses and parties involved; name, badge number, and law enforcement agency of the officer investigating the crash; and the names of the insurance companies for the respective parties involved in the crash. The bill states that the absence of information in a crash report regarding the existence of passengers in the vehicles involved in a crash constitutes a "rebuttable presumption" that no such passengers were involved in the reported crash. The bill amends s. 322.26, F.S., to require the Department of Highway Safety and Motor Vehicles to revoke the driver's license of any person convicted of these specified offenses: soliciting any business from a person involved in a motor vehicle accident for the purpose of making, adjusting or settling a vehicle tort claim under s. 817.234(8), F.S.; participating in a staged motor vehicle accident under s. 817.234(9), F.S., or for brokering health care patients under s. 817.505, F.S.

***Funding for the Division of Insurance Fraud***

The bill appropriates for FY 2006-07, the sums of $510,276 in recurring funds and $111,455 in nonrecurring funds from the Insurance Regulatory Trust Fund to the Division of Insurance Fraud within the Department of Financial Services for the purpose of providing a new fraud unit within the division consisting of six sworn law enforcement officers, one non-sworn investigator, one crime analyst, and one clerical position. A total of nine FTEs and associated salary rate of $381,500 are authorized. The legislation also appropriates for FY 2006-07, the sums of $415,291 in recurring funds and $52,430 in nonrecurring funds from the Insurance Regulatory Trust Fund

to the Division of Insurance Fraud for ten FTE positions and associated salary rate of $342,500. Both appropriations are for the purposes of deterring insurance fraud under s. 626.989, F.S.

If approved by the Governor, these provisions take effect October 1, 2006.
*Vote: Senate 38-0; House 118-1*

### HB 7035 — Motor Vehicle Crash Reports (Public Records)

by Governmental Operations Committee and Rep. Rivera (CS/SB 2116 by Governmental Oversight and Productivity Committee and Banking and Insurance Committee)

The bill reenacts and reorganizes the public records exemption contained in s. 316.066(3), F.S., related to motor vehicle crash reports. This law requires law enforcement officers to file written reports of motor vehicle crashes, which are public records. However, s. 316.066(3)(c), F.S., provides that crash reports that identify the parties to a car crash by revealing the identity, the home or employment telephone number, the home or employment address, or other personal information, concerning the parties to motor vehicle crashes that are received or prepared by any agency which regularly receives or prepares information concerning the parties to motor vehicle crashes are confidential and exempt from public disclosure. This information is to remain confidential and exempt for 60 days after the date the report is filed. The primary policy reason for closing access to these crash reports for 60 days to persons or entities not specifically listed is to protect crash victims and their families from illegal solicitation by "runners" for attorneys or medical providers, who may entice the victims to file fraudulent or inflated insurance claims.

If approved by the Governor, these provisions take effect October 1, 2006.
*Vote: Senate 39-0; House 91-26*

## INSURANCE

### HB 947 — Long-Term Care Coverage

by Rep. Legg and others (CS/SB 2290 by General Government Appropriations Committee, Senators Fasano, Atwater, Pruitt, and Crist)

The bill amends laws governing long-term care insurance to:

- Provide that a long-term care policy is incontestable after being in force for two years, except in instances of non-payment of premium. Currently, the insurer may not contest claims based on the application for coverage for a period of two years, unless there is a fraudulent misrepresentation in the application.
- Prohibit an insurer from imposing a new waiting period when a policy is replaced through an affiliated insurer.

- Eliminate the current minimum nursing home benefit of 24 months of coverage.
- Require all existing policyholders to be given an option to receive contingent benefit options upon lapse in the event of a significant rate increase. These options include a reduced benefit plan for the existing premium amount, a paid-up policy equal to the sum of premiums paid to date, or continuation of the current policy if the increased premiums are paid.
- Prohibit existing policyholders from being charged premiums that exceed the premiums the insurer is charging to new policyholders.
- Require insurers to pool the claims experience of all affiliated carriers when calculating rates, rather than only the policy forms providing similar benefits of the insured.
- Require the Agency for Health Care Administration (AHCA) to establish a qualified state Long-term Care Partnership Program in Florida, in compliance with the requirements of the Social Security Act as amended by the federal Deficit Reduction Act of 2005, and in consultation with the Office of Insurance Regulation (OIR) and the Department of Children and Family Services.
- Provide certain regulatory and administrative requirements for AHCA and OIR for the Long-term Care Partnership Program.
- Require that, for purposes of determining Medicaid eligibility, assets in an amount equal to the insurance benefit payments made to, or on behalf of, an individual who is a beneficiary under an approved qualified state Long-term Care Partnership Program policy shall be disregarded.

If approved by the Governor, these provisions take effect upon becoming a law, except as otherwise expressly provided.
*Vote: Senate 38-0; House 114-0*

## HB 561 — Insurance Fraud and Other Offenses Involving Insurance

by Rep. Rivera and others (CS/SB 1596 by Criminal Justice Committee and Senators Alexander and Posey)

This bill amends provisions of the Insurance Code pertaining to insurance fraud. The legislation includes the following:

- Provides that it is a second degree felony (with a two year minimum mandatory term of imprisonment) to plan or organize a scheme to create documentation of a motor vehicle crash that did not occur (i.e., a “paper” accident) for purposes of a claim for personal injury protection (PIP) benefits or a motor vehicle tort claim. This penalty currently applies only to “staged” accidents.

- Expands the applicability of the motor vehicle insurance fraud statute to provide that any person who creates or presents false or fraudulent "proof" of motor vehicle insurance commits a third-degree felony.
- Provides that it is a third-degree felony for insurance agents, adjusters, customer representatives, and others to transact insurance without a license.
- Provides that it is a third-degree felony to solicit or receive a commission, bonus, rebate, kickback, or bribe, in cash or in kind, or engage in any split-fee arrangement, in return for accepting treatment from a health care provider or health care facility. Clarifies that a health care provider or facility means any person or entity required to be licensed or lawfully exempt from licensure.
- Specifies information that must be contained in a motor vehicle crash report to include the time, date and location of the crash; description of the vehicles involved; names and addresses of all drivers, passengers, witnesses and parties involved; name, badge number, and law enforcement agency of the officer investigating the crash; and the names of the insurance companies for the respective parties involved in the crash. The absence of information in a crash report regarding the existence of passengers in the vehicles involved in a crash constitutes a "rebuttable presumption" that no such passengers were involved in the reported crash.
- Requires the Department of Highway Safety and Motor Vehicles to revoke the driver's license of any person convicted of these specified offenses: soliciting any business from a person involved in a motor vehicle accident for the purpose of making, adjusting or settling a vehicle tort claim under s. 817.234(8), F.S.; participating in a staged motor vehicle accident under s. 817.234(9), F.S., or for brokering health care patients under s. 817.505, F.S. Mandates a fee of $180 to be imposed against drivers who have their revoked or suspended licenses reinstated due to convictions of the above offenses.
- Provides that it is a third-degree felony for any person to willfully violate an "emergency" rule or order of the Department of Financial Services, the Office of Insurance Regulation, or the Financial Services Commission (Governor and Cabinet). However, such penalties would not apply to licensees or affiliated parties of licensees.
- Provides that it is a second-degree misdemeanor for any person to willfully violate a rule of the Department of Financial Services, the Office of Insurance Regulation, or the Financial Services Commission.
- Provides that falsely personating an officer of the Department of Financial Services is a third-degree felony.
- Authorizes the Division of Insurance Fraud to deposit revenues received from criminal proceedings or forfeiture proceedings into the Insurance Regulatory Trust Fund to be used to carry out the division's responsibilities.

- Requires health care clinics to post anti-fraud reward signs in conspicuous locations and allows full and complete access to such clinics by authorized employees of the Division of Insurance Fraud to make unannounced inspections to ensure compliance. Prohibits a medical or clinic director from referring patients to the clinic if the clinic performs magnetic resonance imaging or similar tests. Violating this prohibition constitutes a third-degree felony.
- Clarifies what is meant by independent procurement of insurance coverage to state that independent procurement of coverage is coverage by an unauthorized insurer legitimately licensed in another state or country.
- Requires insurers, upon receiving notice of a personal injury protection claim, to notify those insureds or persons for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed, that the Department of Financial Services may pay rewards of up to $25,000 for information leading to the arrest and conviction of persons committing specified crimes investigated by the Division of Insurance Fraud. Requires the Financial Services Commission to include specific anti-fraud information in a notification form to insurerds regarding personal injury protection benefits.
- Requires insurers to timely submit acceptable anti-fraud plans or anti-fraud investigative descriptions to the Division of Insurance Fraud and imposes an administrative fine for failure to comply.
- Provides that the law relating to fraudulently obtaining goods or services does not apply to investigative actions by law enforcement officers.
- Clarifies that kickbacks for patient referrals are illegal whether the patient is being referred to or from a health care provider or facility. Clarifies the definition of "kickback" to mean payments by or on behalf of a health care provider to any person as an incentive to refer patients for past or future services.
- Provides that the Office of Insurance Regulation may adjust fines imposed against specified insurers by considering the financial condition of the licensee, premium volume written, ratio of violations to compliancy, and other mitigating factors.
- Eliminates a misdemeanor penalty for the violation of a stop work order under the workers' compensation law to clarify that the offense is a third-degree felony. Provides that the retroactive assumption of coverage and liabilities under a policy providing workers' compensation and employer's liability insurance may not exceed 21 days.

If approved by the Governor, these provisions take effect July 1, 2006.
*Vote: Senate 40-0; House 112-1*

## HB 1361 — Debt Cancellation Products and Other Insurance Matters

by Rep. Brown (CS/SB 2522 by Banking and Insurance Committee and Senator Posey)

***Debt Cancellation Products***

The bill authorizes insurers to sell debt cancellation and debt suspension agreement contractual liability insurance to creditors such as a bank or credit union, or an entity entering into retail installment contracts. The product would serve to insure a creditor from losses experienced pursuant to debt cancellation contracts, debt suspension agreements, or retail installment contracts that the creditor has executed with its customers. The debt cancellation product is not insurance, but instead is classified as a loan or lease contract term, or a contractual agreement. The financial services commission is given rulemaking authority to administer the sale of debt cancellation products by motor vehicle retail installment sellers.

The bill also eliminates the $50,000 limit on insurance that may be procured on the life of a debtor under a debtor group contract or via credit life insurance. The change would allow the amount of insurance procured under a debtor group contract or credit life insurance on the life of a debtor to be up to the amount of his or her indebtedness to the creditor. The bill allows for the term of credit disability insurance to extend for the term of the indebtedness, rather than the current 10 year limitation.

***Free Insurance Exception***

The bill creates an exception to the general prohibition against offering or providing free insurance. Such insurance covering property other than real property or motor vehicles may be offered or sold if the person paying for the insurance has an ongoing contractual or economic interest in the property or requires the property to deliver its services.

***Health Identification Cards***

Health insurance companies and health maintenance organizations are required to provide identification cards to policyholders and subscribers, which contain specified information that can be used to estimate the financial responsibility of the covered person and contact information for the insurer or HMO. This information will assist hospitals and other providers in determining coverage and the financial responsibility of the covered person.

***Discount Medical Plan Organizations***

A discount medical plan organization (DMPO) applicant is permitted to submit, rather than petition OIR to accept, audited financials of the parent company, in lieu of the DMPO's financials. Additionally, the DMPO is allowed to certify that minimum capitalization requirements are satisfied rather than submit annual, audited financials. The bill states that a market investigation by the Office of Insurance Regulation (OIR) of a DMPO may only be conducted "for cause." A DMPO is authorized to require a waiting period for accessing hospital services and charge up to $60 dollars per month for a plan that covers physician or hospital services without prior approval from the OIR. A DMPO plan that does not include access to

physician or hospital services may continue to charge up to $30 per month the plan without prior approval from the OIR.

***Non-Profit Worker's Compensation Self-Insurance Funds***
The bill authorizes any two or more not for profit corporations located in Florida and organized under Florida law to form a self-insurance fund for pooling liabilities of its members for any property, casualty, or surety risk, provided that the fund has annual normal premiums in excess of $5 million and has only members who each receive at least 75 percent of its revenue from local, state, or federal government sources. The self-insurance fund must use a qualified actuary to determine rates and establish reserves and annually submit to the Office of Insurance Regulation (OIR) a certification that the rates are actuarially sound and are not inadequate. The fund must maintain excess insurance, with a retention that does not exceed $350,000 per occurrence. Annual audited financial statements must be submitted to the OIR. The governing body of the self-insurance fund must be comprised entirely of corporation not for profit officials and the fund must use knowledgeable personnel to administer the fund with a minimum of 5 years' experience with commercial self-insurance funds, group self-insurance funds, or domestic insurers, with such persons meeting all licensure requirements. The self-insurance fund must submit to the OIR contracts used for its members which clearly establish the liability of each member for obligations of the fund. The fund must annually submit to the OIR a certification by the governing body that, to the best of its knowledge, the requirements under this law are met. The bill also states that a worker's compensation policy issued by a worker's compensation self-insurance fund covered by the Workers' Compensation Insurance Guaranty Association cannot be rejected pursuant to a construction contract if the rejection is because the self-insurance fund is not rated by a nationally recognized rating service.

The bill revises provisions relating to security deposits by domestic insurers to allow such deposits to be held by broker/dealers, to conform to Florida law to the model law and rules enacted by the National Association of Insurance Commissioners.

If approved by the Governor, these provisions take effect upon becoming law.
*Vote: Senate 39-0; House 116-1*

## CS/SB 1506 — Insurance; Electronic Statements
by Banking and Insurance Committee and Senator Alexander

This legislation provides the Office of Insurance Regulation (OIR) with the authority to collect electronic financial statements or other information from viatical settlement providers, life expectancy providers, premium finance companies, and continuing care retirement communities. Currently, such entities submit these statements or filings only by hard copy. The bill also authorizes OIR to require that records of a particular transaction of stock and mutual insurers be submitted by remote electronic access.

The bill authorizes the Financial Services Commission (Governor and Cabinet) to require by rule that financial statements or other filings be submitted to the OIR by electronic means in a computer-readable form, compatible with the electronic data format specified by the Commission.

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

## CS/SB 2432 — Medical Travel Insurance

by Health Care Committee and Senator Constantine

The bill is cited as the "John F. Cosgrove Act" and applies to prepaid limited health service contracts regulated by the Office of Insurance Regulation under ch. 636, F.S.

The legislation provides that a person registered as a seller of travel with the Department of Agriculture and Consumer Services under s. 559.928, F.S., is not required to be licensed as a health insurance agent in order to sell prepaid limited health service contracts that cover the cost of air ambulance transportation. Air ambulance transportation services are licensed by the Department of Health under s. 401.251, F.S. However, the prepaid limited health service contract for such coverage is subject to all applicable provisions of ch. 636, F.S.

If approved by the Governor, these provisions take effect July 1, 2006.
*Vote: Senate 39-0; House 119-0*

## HB 299 — Travel-Limited Life Insurance

by Reps. Sobel, Hasner, and others (CS/SB 764 by Banking and Insurance Committee and Senators Aronberg, Alexander, Margolis, Atwater, and Rich)

The bill is cited as the "Freedom to Travel Act." The legislation creates a new unfair or deceptive trade practice provision under the Insurance Code (s. 626.9541, F.S.) which would prohibit life insurers from refusing coverage or otherwise discriminating against an individual solely on the basis of that individual's past lawful foreign travel experiences. The bill further prohibits life insurers from refusing coverage or otherwise discriminating against an individual solely on the basis of that individual's future lawful foreign travel plans, unless life insurers demonstrate, and the Office of Insurance Regulation determines, that: 1) individuals who intend to travel are a separate actuarially supportable class whose risk of loss is different from those individuals who do not intend to travel; and 2) such risk classification is based on sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination.

The bill authorizes the Financial Services Commission to adopt rules to implement these provisions and to allow for limited exceptions based on national or international emergency conditions affecting public health, safety and welfare and that are consistent with public policy.

The bill provides enforcement authority to the Office of Insurance Regulation to require that each market conduct examination of a life insurer include a review of every application under which an insurer refused to issue life insurance, refused to continue life insurance, or limited the amount, extent, or kind of life insurance issued, based upon future lawful travel plans. The administrative fines provided under s. 624.4211, F.S., are trebled for violations of these provisions. Finally, the Office of Insurance Regulation must annually report to the President of the Senate and Speaker of the House of Representatives as to the nature and extent of denials or limitations by life insurers based upon an insured's future travel plans.

If approved by the Governor, these provisions take effect July 1, 2006.
*Vote: Senate 38-0; House 116-0*

## HB 1113 — Insurance Agents

by Rep. Lopez-Cantera and others (CS/SB 2526 by Banking and Insurance Committee and Senator Posey)

This bill makes various changes to insurance agent licensing provisions under the Insurance Code. Specifically, the bill does the following:

- Provides that insurance agents, customer representatives, adjusters, service representatives, managing general agents, or reinsurance intermediaries may voluntarily disclose their race or ethnicity, gender or native language on license applications to the Department of Financial Services which will use the information exclusively for research and statistical purposes and to improve the quality and fairness of the license examination. This provision is to take effect on January 1, 2007.
- Mandates that the Department of Financial Services must provide fingerprint processing services at all its designated license examination centers in order to take an applicant's fingerprints. The department is prohibited from approving a license application if fingerprints have not been submitted**.** This provision is to take effect on January 1, 2007.
- Removes the prohibition against the Department of Financial Services denying, delaying or withholding approval of applications due to the fact that it has not received a criminal history report based on the applicant's fingerprints. Revises circumstances under which the department must notify an applicant about license examinations. This provision is to take effect on January 1, 2007.
- Exempts from the examination requirement an adjuster applicant who has the designation of a Professional Property Insurance Adjuster (PPIA) from the HurriClaim Training

Academy or a Certified Claims Adjuster (CCA) from the Association of Property and Casualty Claims Professionals.

- Clarifies that no person is permitted to take a license examination until his or her application for examination has been approved. Allows a license applicant to take the license examination prior to submitting a license application by submitting an examination application through the Internet website of the Department of Financial Services. Specifies information the applicant must provide the department including voluntarily reporting race or ethnicity, gender or native language information. The application must state that an applicant is not required to disclose information as to race or ethnicity, gender or native language and will not be penalized for not doing so, and that the department will use the data exclusively for research and statistical purposes and to improve the quality and fairness of the examination. Each application must be accompanied by an examination fee. This provision is to take effect on January 1, 2007.
- Provides that the license examination provisions for an agent, customer representative or adjuster apply to any person who submits a license application and to any person who submits an examination application prior to filing an application for a license.
- Requires the Department of Financial Services to annually prepare and publish an annual report (by May 1st) that summarizes statistical information relating to life insurance agent examinations administered during the preceding calendar year. The report must include information for all examinees, combined and separately, by race or ethnicity, gender, race or ethnicity within gender, education level and native language according to specified criteria which includes the total number of examinees; the percentage and number of examinees who passed the examination; the mean scaled scores and the standard deviation of scaled scores on the examination. The department must make available upon request a statistical summary relating to each life insurance test form administered during the proceeding year which indicates for each test form specified ethnic and racial information. The department is authorized to provide application information under contact with a testing service.
- Requires the department to provide the time and place of the examination to each applicant for an examination.
- Provides that an applicant for license examination must appear in person and personally take the examination. This provision is to take effect on January 1, 2007.
- Provides that an applicant for examination may take additional examinations.
- Requires the Department of Financial Services to promptly issue a license as soon at it approves such license for those applicants who have completed the examination and received a passing grade. The bill provides that a passing grade is valid for 1 year and that the department may not issue a license based on an examination taken more than 1 year prior to the date the application for license is filed. This provision is to take effect on January 1, 2007.

- Appropriates for FY 2006-07, $158,995 in recurring funds and $120,069 in nonrecurring funds from the Insurance Regulatory Trust Fund in the Department of Financial Services for the purposes of funding the act and provides for three full-time equivalent positions with $103,285 in associated salary rate.

If approved by the Governor, these provisions take effect July 1, 2006, except as otherwise expressly provided in this act.
*Vote: Senate 39-0; House 120-0*

## SB 1256 — Continuing Care Providers

by Banking and Insurance Committee and Senators Saunders, King, Baker, and Crist

Present law provides for the licensure and regulation of Continuing Care Retirement Communities (CCRCs) by the Office of Insurance Regulation (OIR) under ch. 651, F.S. Currently, a CCRC must maintain in escrow a statutorily established minimum liquid reserve for the benefit of facility residents. A component of the minimum liquid reserve is property insurance premiums that are used in calculating a CCRCs "debt service" reserve. For purposes of calculating this reserve, the property insurance premiums are capped at the amount paid in calendar year 1999. However, the 1999 premium cap expires on January 1, 2006. On that date, a CCRC must increase its property insurance premiums by 10 percent of the premium paid that year until attributable premium equals 100 percent of the actual premiums.

This bill provides the following changes to the calculation of minimum liquid reserve provisions by:

- Restructuring the treatment of property insurance premiums in the calculation of minimum liquid reserve requirements by removing property insurance premiums from the "debt service" reserve and placing such premiums into the calculation of the "operating" reserve of a CCRC;
- Deletes the provision capping property insurance premiums at the 1999 level; and
- Deletes the January 1, 2006, provision mandating increases in reserves for property insurance premiums by 10 percent per year.

The effect of these changes will generally require that 30 percent of the property insurance premiums be reserved. This percentage is lower than the increase that would occur under current law (due to the 1999 cap expiring). But, the bill will result in gradual premium increases compared to the 1999 cap.

If approved by the Governor, these provisions take effect July 1, 2006.
*Vote: Senate 38-0; House 120-0*

## CS/SB 1620 — Warranty Associations

by Banking and Insurance Committee and Senator Haridopolos

Chapter 634, F.S., regulates warranty associations, including motor vehicle service agreement companies, home warranty associations, and service warranty associations. The bill provides the following changes to laws governing warranty associations:

- Prohibits an association from investing or lending association funds to any officer, director, or controlling shareholder;
- Allows home warranty contract holders to cancel the contract within 10 days, with a refund of at least 95 percent of the premium and to cancel at any time, after the 10 days, with a refund of at least 90 percent of the unearned pro rata premium. Current law allows for cancellation within 10 days without penalty, but only for contracts offered in connection with a home equity loan; not contracts offered in connection with the sale of a home;
- Provides that if a home warranty association elects to use a contractual liability insurance policy in lieu of establishing an unearned premium reserve, the policy must cover all home warranty contracts issued during the policy period whether or not the premium has been remitted to the insurer;
- Allows a service warranty association to sell a warranty in connection with the sale of a home, without also being licensed as a home warranty association, if the warranty only covers systems and appliances and no structural component of a home;
- Allows a home warranty association to renew a home warranty more than nine times, the current statutory limit, and charge a higher rate to renew a warranty than the current cost to purchase a new warranty for the same home, which is currently prohibited; and
- Exempts from licensure, as a motor vehicle service agreement company, an affiliate of a licensed motor vehicle service agreement company which is domiciled in Florida and uses contractual liability insurance to meet reserve requirements, if the affiliate does not issue or market motor vehicle service agreements to Florida residents and does not administer such agreements originally issued to Florida residents.

If approved by the Governor, these provisions take effect July 1, 2006.
*Vote: Senate 40-0; House 110-1*

# FINANCIAL ENTITIES, CREDIT COUNSELING, AND SECONDHAND DEALERS

## HB 7153 — Financial Entities and Transactions

by Economic Development, Trade and Banking Committee and Rep. Detert (CS/SB 2744 by Banking and Insurance Committee and Senators Atwater and Crist)

The Office of Financial Regulation is responsible for the regulation of financial entities, including financial institutions, consumer finance companies, mortgage brokers and lenders, money transmitters, securities dealers and agents, deferred presentment providers, and title loan companies. The bill amends statutory provisions relating to mortgage brokerage and mortgage lending ch. 494, F.S.), mortgage lenders duties related to escrow funds (ch. 501, part I, F.S.), the Florida Consumer Finance Act (ch. 516, F.S.), the Florida Securities and Investor Protection Act (ch. 517, F.S.), the Retail Installment Sales (ch. 520, F.S.), the Florida Title Loan Act (ch. 537, F.S), the Money Transmitters' Code (ch. 560 F.S), and provisions related to safe deposit boxes (chs. 655 and 733, F.S.). The bill provides for:

- Mandated electronic filing of required forms, documents, or files with a provision for hardship situations;
- Clarification that receipt of the appropriate fee is a condition of new and renewal license application completion and that grounds for disciplinary action exists if the payment of the fee fails to clear;
- Revision of fingerprint card processing;
- Clarification of when a change in licensee control will trigger the need for a new license;
- Revision of mortgage broker and lender examination procedures and authority to charge an examination fee of up to $100 for the administration of the test by a third party vendor;
- Increase in the fee cap for a credit check of a loan applicant from $10 to $25 for consumer finance loans;
- Elimination of the registration fee ($30) for Canadian agents if the Canadian Dealer is registered and the requirement of a notice filing;
- Registration and imposition of additional fees for investment advisers through the national Investment Adviser Registration Depository;
- Elimination of reporting requirements in the renewal process for registration to sell or issue payment instruments or act as a funds transmitter under part II of ch. 560, F.S.;

- Extension of time that a financing statement filed is effective for purposes of satisfying the requirements for perfecting a security interest under the provisions of the Uniform Commercial Code; and
- An award of attorney's fees and costs if, as the result of neglect, a mortgage lender fails to pay any tax or insurance premium and subsequently refuses to pay the difference in premiums between a lapsed insurance policy and a new policy required by law.

If approved by the Governor, these provisions take effect October 1, 2006, except as otherwise expressly provided.
*Vote: Senate 40-0; House 119-0*

## HB 825 — Financial Literacy Council

by Rep. Altman and others (CS/CS/SB 1368 by Governmental Oversight and Productivity Committee; Banking and Insurance Committee; and Senator Atwater)

The bill creates the Financial Literacy Council (council) within the Department of Financial Services. The council is designed to provide basic financial information to consumers and small businesses from a single state source and to provide recommendations to the department. The council is comprised of nine members appointed by the Chief Financial Officer. The bill provides for membership requirements, council meetings, and reports and authorizes the council to seek funding from the state and federal government and other sources.

The bill requires any funds received by the council to be deposited into the Administrative Trust Fund of the Department of Financial Services. The bill appropriates $50,000 in non-recurring funds from the Administrative Trust Fund to the council to fund its activities, contingent upon prior receipt of grant funds or contributions by the council. The bill abolishes the council on December 31, 2011, and provides for the appropriation of any council funds to the department for funding activities that the department has implemented pursuant to the council's recommendations.

If approved by the Governor, these provisions take effect July 1, 2006.
*Vote: Senate 40-0; House 117-1*

## SB 704 — ATM Transaction Charges

by Senator Alexander

The bill allows an operator of an automated teller machine (ATM) in Florida to charge a fee or surcharge, not otherwise prohibited under state or federal law, to a customer accessing funds from an account held by a financial institution located outside of the United States. Currently, such fees or surcharges are not prohibited under current state law. However, such surcharges are

prohibited by internal policies of the electronic funds networks, Visa, and MasterCard for the United States region, unless expressly authorized by state law.

If approved by the Governor, these provisions take effect July 1, 2006.
*Vote: Senate 39-0; House 118-2*

## HB 667 — Credit Counseling Services

by Rep. Hasner and others (CS/SB 1954 by Banking and Insurance Committee and Senator Aronberg)

Credit counseling agencies were initially established to assist persons in financial difficulty gain control of their finances, repay their credit card debts, and avoid bankruptcy. In 2004, Florida enacted legislation that established the framework for the regulation of the relationship between a consumer and a credit counseling agency that provides credit counseling or debt management services. This bill provides the following changes to the laws governing consumer counseling services and debt management services:

- Provides that the fee caps that currently apply to credit counseling services apply only to debtors residing in Florida. Therefore, the fee cap would not apply to a credit counseling agency located in Florida and providing services to a resident of another state.
- Creates a definition of the term, "creditor contribution," meaning a sum that a creditor, such as a financial institution, agrees to contribute to the credit counseling agency or otherwise setoff against the debt payable by the agency on behalf of debtors.
- Requires a debt management or credit counseling service to deduct and retain the voluntary, creditor's contribution from the debtor's payment. As a result, the debtor's account would be credited for the amount remitted by the debtor, less any fees authorized by law. However, the bill prohibits these creditor contributions from reducing any amounts to be credited to the account of the debtor for further payment to the creditor. Currently, the law requires that all funds received from the debtor, less any fees allowed by s. 817.802 F.S., must be remitted to the creditors.
- Allows credit counseling agencies to establish a single trust account for funds received from each debtor rather than establishing a separate trust account for each debtor's payments.
- Allows certified public accountants licensed in other states to conduct annual audits of the accounts of a credit counseling or debt management service.

If approved by the Governor, these provisions take effect July 1, 2006.
*Vote: Senate 39-0; House 114-0*

### SB 694 — Secondhand Dealers

by Senators Crist, Fasano, Baker, Bennett, Sebesta, and Lynn

A secondhand dealer engages in the business of buying, reselling, or consigning certain types of used personal property. Secondhand dealers are required to register with the Department of Revenue (department). Pawnbrokers were formerly regulated as secondhand dealers, but are now separately regulated under the provisions of ch. 539, F.S. The bill provides the following changes relating to the regulation of secondhand dealers, which are intended to assist law enforcement efforts related to stolen property:

- The categories of goods regulated and the types of secondhand dealers regulated are expanded to include mail order and computer-assisted (Internet) shopping. However, Internet shopping and businesses primarily engaged in the rental, sale, or trade of motion picture videos and video games are exempted from regulation if certain conditions are met.
- Criminal penalty provisions are increased for persons knowingly giving false verification that the seller is the rightful owner of goods or is authorized to sell, trade, or consign the goods.
- The bill revises the registration requirements for a principal of a secondhand dealer by allowing the denial, suspension, or revocation of a registration if the department determines that an applicant or registrant has been convicted of certain crimes within the last 10 years rather than the last 5 years.
- Recordkeeping requirements are revised by decreasing the retention time for transaction records from 5 to 3 years.

If approved by the Governor, these provisions take effect October 1, 2006.
*Vote: Senate 38-0; House 119-0*

## INSURANCE PUBLIC RECORDS ISSUES

### HB 7061 — Deferred Presentment Providers

by Governmental Operations Committee and Rep. Rivera (CS/SB 1584 by Governmental Oversight and Productivity Committee and Banking and Insurance Committee)

The bill reenacts the public records exemption for the deferred presentment provider database that is maintained by the Office of Financial Regulation of all deferred presentment transactions.

Deferred presentment providers, more commonly known as “pay-day lenders,” are businesses that charge a fee for cashing a check from a customer (“drawer”) and agreeing to hold that check for a certain number of days prior to depositing or redeeming the check. A deferred presentment

provider is prohibited from entering into a transaction with a person who has an outstanding transaction with any other provider, or with a person whose previous transaction with any provider has been terminated for less than 24 hours. To verify such information, the provider must access a database established by OFR. The OFR is required to establish this database of all deferred presentment transactions in the state and give providers real-time access through an Internet connection.

The bill clarifies the exemption by providing that information that identifies a drawer or a deferred presentment provider is confidential and exempt. Further, the bill expressly permits a deferred presentment provider to access the information that it has entered into the database. The bill also clarifies that the deferred presentment provider may obtain an eligibility determination for a particular individual (drawer) based on information in the database

If approved by the Governor, these provisions take effect October 1, 2006.
*Vote: Senate 39-1; House 120-0*

## HB 7049 — Surplus Lines Insurance

by Governmental Operations Committee and Rep. Rivera (CS/SB 1586 by Banking and Insurance Committee)

This bill reenacts s. 626.921(8) F.S., which contains a public records exemption for certain information concerning surplus lines insurance, which is specific to a particular policy or policyholder and is submitted to the Florida Surplus Lines Service Office (FSLSO) or the Department of Financial Services (DFS) or which is available for inspection by the department. The bill also makes technical and clarifying changes to the exemption.

Surplus lines insurance is insurance coverage provided by a company that is not licensed in Florida, but is allowed to transact insurance in the state as an "eligible" surplus lines insurer. The purpose of the surplus lines law is to provide the insurance purchasing public with access to insurers that are not authorized to transact business in Florida when certain insurance coverages cannot be obtained from Florida-authorized insurers. Surplus lines agents are authorized to handle the placement of insurance coverages with surplus lines insurers, and are required to report and file with the FSLSO, a copy of, or information on, each surplus lines insurance policy.

If approved by the Governor, these provisions take effect October 1, 2006.
*Vote: Senate 40-0; House 117-3*