Insurance & Banking Subcommittee

Thursday, March 28, 2013
8:00 AM
404 HOB

Will Weatherford
Speaker

Bryan Nelson
Chair

The Florida House of Representatives

Regulatory Affairs Committee

Insurance & Banking Subcommittee

Will Weatherford
Speaker

Bryan Nelson
Chair

AGENDA
Thursday, March 28, 2013
404 HOB
8:00 a.m. – 10:00 a.m.

I. Call to Order

II. Roll Call

III. HB 433 by *Rep. Richardson*
Agency Inspectors General

IV. HB 493 by *Rep. Fitzenhagen*
Security of Protected Consumer Information

V. HB 581 by *Rep. Renuart*
Dentists

VI. HB 605 by *Rep. Hudson*
Workers' Compensation

VII. CS/HB 833 by *Civil Justice Subcommittee, Rep. Passidomo*
General Assignments

VIII. HB 1107 by *Rep. Hager*
Florida Hurricane Catastrophe Fund

303 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 717-4873 Fax: (850) 413-0419

IX. HB 1157 by *Rep. Powell*
Health Flex Plans

X. HB 1247 by *Rep. Nuñez*
Hurricane Mitigation

XI. HB 1329 by *Rep. Oliva, Nuñez*
Citizens Property Insurance Corporation

XII. PCS for HB 157
Delivery of Insurance Policies

XIII. PCS for HB 909
Property Insurance

XIV. PCS for HB 971
Florida Fire Prevention Code

XV. Adjournment

A bill to be entitled

An act relating to agency inspectors general; amending s. 20.055, F.S.; revising the definition of the term "state agency" to include the Citizens Property Insurance Corporation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (1) of section 20.055, Florida Statutes, is amended to read:

20.055 Agency inspectors general.—

(1) For the purposes of this section:

(a) ~~(b)~~ "Agency head" means the Governor, a Cabinet officer, a secretary as defined in s. 20.03(5), or an executive director as defined in s. 20.03(6). It also includes the chair of the Public Service Commission, the Director of the Office of Insurance Regulation of the Financial Services Commission, the Director of the Office of Financial Regulation of the Financial Services Commission, the board of directors of the Florida Housing Finance Corporation, and the Chief Justice of the State Supreme Court.

(b) ~~(d)~~ "Entities contracting with the state" means for-profit and not-for-profit organizations or businesses having a legal existence, such as corporations or partnerships, as opposed to natural persons, which have entered into a relationship with a state agency as defined in paragraph (a) to provide for consideration certain goods or services to the state agency or on behalf of the state agency. The relationship may be

evidenced by payment by warrant or purchasing card, contract, purchase order, provider agreement, or other such mutually agreed upon relationship. This definition does not apply to entities which are the subject of audits or investigations conducted pursuant to ss. 112.3187-112.31895 or s. 409.913 or which are otherwise confidential and exempt under s. 119.07.

(c) "Individuals substantially affected" means natural persons who have established a real and sufficiently immediate injury in fact due to the findings, conclusions, or recommendations of a final report of a state agency inspector general, who are the subject of the audit or investigation, and who do not have or are not currently afforded an existing right to an independent review process. Employees of the state, including career service, probationary, other personal service, Selected Exempt Service, and Senior Management Service employees, are not covered by this definition. This definition also does not cover former employees of the state if the final report of the state agency inspector general relates to matters arising during a former employee's term of state employment. This definition does not apply to persons who are the subject of audits or investigations conducted pursuant to ss. 112.3187-112.31895 or s. 409.913 or which are otherwise confidential and exempt under s. 119.07.

(d) ~~(a)~~ "State agency" means each department created pursuant to this chapter, and also includes the Executive Office of the Governor, the Department of Military Affairs, the Fish and Wildlife Conservation Commission, the Office of Insurance Regulation of the Financial Services Commission, the Office of

Financial Regulation of the Financial Services Commission, the Public Service Commission, the Board of Governors of the State University System, the Florida Housing Finance Corporation, the Citizens Property Insurance Corporation, and the state courts system.

Section 2. This act shall take effect July 1, 2013.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 433 Agency Inspectors General
SPONSOR(S): Richardson and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Callaway	Cooper
2) Government Operations Appropriations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market.

Current law requires Citizens to have a Chief of Internal Audit. Citizens is not required by law to have an inspector general and Citizens does not have an inspector general. The bill creates an inspector general position in Citizens. The Citizens' Inspector General must comply with current law setting forth the job qualifications, duties, responsibilities, and reporting and auditing requirements of state agency inspector generals. The Citizens' Inspector General will have more extensive duties and responsibilities than the Citizens' Chief of Internal Audit, although some statutory duties and responsibilities of these two positions overlap.

The bill has no fiscal impact on state or local governments. Citizens will incur salary and benefit costs associated with the inspector general position created by the bill.

The bill is effective July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market. Although it operates like a private insurance company, it is not a private insurance company.[1]

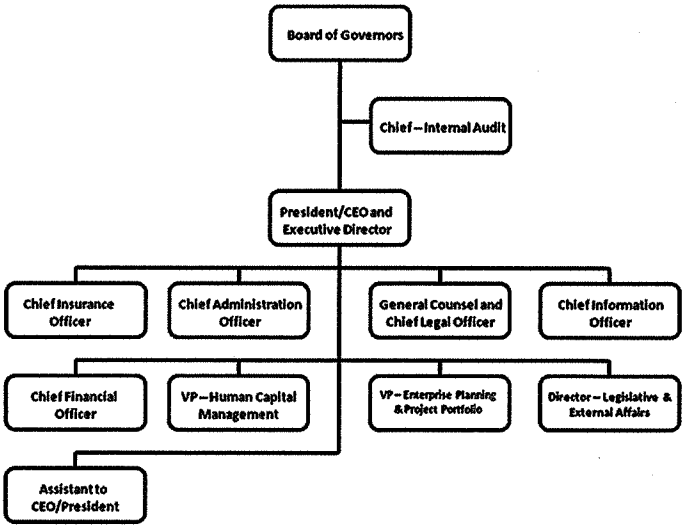
As of December 31, 2012, Citizens is the largest property insurer in Florida with over 1.3 million policies and over $429 billion in exposure. Citizens insures almost 450,000 residential and commercial policies in Florida's coastal areas and over 860,000 residential policies in Florida's non-coastal areas. The remaining 8,000 policies are commercial policies insured in Florida's non-coastal areas.[2]

Citizens operates under the direction of an eight member Board of Governors (Board). The Governor, Chief Financial Officer, Senate President, and Speaker of the House of Representatives each appoint two members of the Board. Board members serve three year staggered terms.[3] At least one of the two board members appointed by each appointing officer must have demonstrated expertise in insurance. The board members are not Citizens' employees and are not paid.

Only the Citizens' President/CEO/Executive Director and the Chief of Internal Audit report directly to the Citizens' Board. The following senior managers report directly to the President/CEO/Executive Director:

- Chief Insurance Officer,
- Chief Administration Officer,
- General Counsel and Chief Legal Officer,
- Chief Information Officer,
- Chief Financial Officer,
- Vice President of Human Capital Management,
- Vice President of Enterprise Planning and Project Portfolio, and
- Director of Legislative and External Affairs.

An organizational chart of the senior managers at Citizens is as follows:



[1] s. 627.351(6)(a)1., F.S.

[2] https://www.citizensfla.com/about/corpfinancials.cfm (last viewed February 1, 2013)

[3] s. 627.351 (6)(c)4., F.S.

Citizens does not currently have an inspector general and is not required by law to have one. Current law, however, requires Citizens to have a Chief of Internal Audit. The Chief of Internal Audit position was created in Citizens in 2006.[4] Citizens' first Chief of Internal Audit started in January, 2007. The position has been filled almost continuously since that time, with Citizens employing four Chiefs of Internal Audit since 2007.[5]

Generally, the duties of the Chief of Internal Audit include: fostering and promoting accountability and integrity in Citizens; holding the Citizen's leadership, management and staff accountable for efficient, cost-effective operation; and preventing, identifying, and eliminating fraud, waste, corruption, illegal acts, and abuse. Specific duties and responsibilities for the position are contained in s. 627.351(6)(i), F.S. The Chief of Internal Audit carries out his duties primarily through audits, management reviews and investigations.

From December 2010 until October 2012, Citizens also had an Office of Corporate Integrity (Office).[6] The Office handled employee complaints, particularly those that could indicate ethics violations and internal fraud. From December 2010 until July 2012, the employees in this office reported to Citizens' General Counsel and Chief Legal Officer. Thereafter, they reported to the Citizens' Chief of Internal Audit. The Office was disbanded by Citizens' Board in October 2012, but its functions were absorbed by other Citizens' staff, including the Office of Internal Audit, the Ethics Officer, and the Employee Relations Office.[7]

Governor's Inspector General Report

In September 2012, Governor Rick Scott asked his Office of the Chief Inspector General (Inspector General) to review travel expenses incurred by Citizens' Board members, Senior Managers, and employees to determine whether the expenses were incurred in accordance with Citizens' travel policies.[8] The Governor requested the review after newspapers published articles relating to Citizens' employees' travel expenses.[9] The Inspector General issued a report on January 15, 2013.[10] The report found travel expenses incurred by Citizens' Board and staff were generally compliant with the Citizens' travel policies in effect when the travel was incurred. But, the Inspector General also found Citizens' travel policies were ambiguous and lacked specific requirements to ensure travel was necessary and conducted in the most economical manner. Additionally, the report noted the policies allowed for travel expenses in excess of the State of Florida travel guidelines. The Inspector General recommended Citizens be required to follow state travel laws and that Citizens' travel policies be updated to reflect that state travel laws apply to Board Members, Senior Managers, and all employees. The Inspector General also recommended Citizens enhance their internal controls to address the findings in the report.

---

[4] See Section 15, Ch. 2006-12, L.O.F.

[5] The Chief of Internal Audit position was not filled between 6/9/2007 and 11/4/2007 due to a lapse between the resignation of one Chief and the hiring of a replacement.

[6] The Office of Corporate Integrity began as the Office of Corporate Compliance within the Administration/Human Resources Department in Citizens. The Office of Corporate Compliance was established in June 2008.

[7] Press Release from Citizens dated October 18, 2012, available at https://www.citizensfla.com/about/pressreleases.cfm?show=text&link=/shared/press/articles/new/10_18_2012.cfm&showyear=2012 (last viewed January 22, 2013). The Office was disbanded by the Citizens' Board upon a recommendation of the Audit Committee of the Board.

[8] The Inspector General reviewed approximately 350 expense reports of travel and travel related expenses for Citizens' eight Board members, 13 Senior Managers and 18 other employees.

[9] "Expense reports for Citizens Property Insurance's top executives how lavish spending," August 26, 2012, available at http://www.tampabay.com/news/business/banking/expense-reports-for-citizens-property-insurances-top-executives-show/1247636 (last viewed January 22, 2013); "Citizens Property Insurance interim president chalks up almost $10,000 in travel expenses in two months," June 20, 2012, available at http://www.tampabay.com/news/business/banking/citizens-property-insurance-interim-president-chalks-up-almost-10000-in/1236203 (last viewed January 22, 2013).

[10] Chief Inspector General Report No. 2013-10, available at http://www.flgov.com/2013/01/17/statement-from-governor-rick-scott-regarding-inspector-general-report-on-citizens-corporate-travel/ (last viewed January 22, 2013).

Governor's Response to the Inspector General Report
In response to the Inspector General Report on Citizens' travel expenses, Governor Scott proposed four reforms.[11] First, the Governor recommended Citizens immediately change their travel guidelines to comply with official state travel restrictions. Second, he recommended Citizens' Board members to change their travel policy to prohibit any international travel. Third, he suggested Citizens' travel policy be further tightened to allow only essential employees to attend board meetings. Lastly, the Governor recommended Citizens have its own independent statutory Inspector General to enforce existing rules and any additional reforms needed. On January 18, 2013, Citizens' President/CEO/Executive Director publically provided support for an Inspector General at Citizens.[12]

Effect of Proposed Changes

Section 20.055, F.S., establishes the Office of Inspector General in each state agency and specifies the duties and responsibilities of that office. This law also outlines who appoints each state agency's inspector general and the chain of command, job qualifications, auditing requirements and reporting requirements for an agency's inspector general.

The definition of "state agency" in the inspector general statute does not include Citizens and the bill changes that definition to include Citizens as a state agency. Thus, current law establishing the Office of Inspector General in each state agency would apply to Citizens and require Citizens to have an inspector general. In addition, all the duties, responsibilities, qualifications, and auditing and reporting requirements required of state agency inspector generals would also apply to the Citizens' Inspector General. The Citizens' Inspector General will have more extensive duties and responsibilities than the Citizens' Chief of Internal Audit, although some statutory duties and responsibilities of these two positions overlap.

B. SECTION DIRECTORY:

Section 1: Amends s. 20.055, F.S., relating to agency inspector generals.

Section 2: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[11] http://www.flgov.com/2013/01/17/statement-from-governor-rick-scott-regarding-inspector-general-report-on-citizens-corporate-travel/ (last viewed January 22, 2013).

[12] https://www.citizensfla.com/about/pressreleases.cfm?show=text&link=/shared/press/articles/new/01_18_2013.cfm (last viewed January 22, 2013).

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Citizens will incur salary and benefit costs associated with the Inspector General position created by the bill.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The definition of "agency head" in the inspector general governing statute is not amended by the bill to include an agency head for the Citizens' Inspector General. Thus, under the bill, the Citizens' Inspector General has no agency head to report to.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to security of protected consumer information; creating s. 501.0051, F.S.; providing definitions; authorizing the representative of a protected consumer to place a security freeze on the protected consumer's consumer record; requiring a consumer reporting agency to establish a record if the protected consumer does not have an existing consumer report; requiring a consumer reporting agency to provide written confirmation of a security freeze within a specified period; prohibiting a consumer reporting agency from stating or implying that a security freeze reflects a negative credit history or rating; requiring a consumer reporting agency to remove a security freeze under specified conditions; providing for applicability; authorizing a consumer reporting agency to charge a fee for placing or removing a security freeze and for reissuing personal identification information; prohibiting a fee under certain circumstances; requiring written notification to change specified information in a protected consumer's record; providing exemptions; requiring a consumer reporting agency to notify a representative and provide specified information if the consumer reporting agency violates a security freeze; providing penalties and civil remedies; amending s. 501.005, F.S.; revising written disclosure requirements for consumer reporting agencies pertaining to consumer

rights associated with a security freeze; conforming a cross-reference; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 501.0051, Florida Statutes, is created to read:

501.0051 Protected consumer security freeze.—

(1) As used in this section, the term:

(a) "Consumer reporting agency" has the same meaning as provided in 15 U.S.C. s. 1681a(f).

(b) "Consumer report" has the same meaning as provided in 15 U.S.C. s. 1681a(d).

(c) "Protected consumer" means a person younger than 16 years of age at the time a security freeze request is made or a person represented by a guardian or other advocate pursuant to chapter 39, chapter 393, or chapter 744.

(d) "Record" means a compilation of information that:

1. Identifies a protected consumer;

2. Is created by a consumer reporting agency exclusively for the purpose of complying with this section; and

3. May not be created or used to consider the protected consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or eligibility for other financial services.

(e) "Representative" means the custodial parent or legal guardian of a protected consumer, including a guardian appointed pursuant to s. 914.17.

(f) "Security freeze" means:

1. A notice that is placed on the protected consumer's consumer report that prohibits a consumer reporting agency from releasing the consumer report, credit score, or any information contained within the consumer report to a third party without the express authorization of the representative; or

2. A notice that is placed on the protected consumer's record that prohibits the consumer reporting agency from releasing the protected consumer's record except as provided in this section, if a consumer reporting agency does not have a file pertaining to the protected consumer.

(g) "Sufficient proof of authority" means documentation that shows that a representative has authority to act on behalf of a protected consumer. Sufficient proof of authority includes, but is not limited to, a court order, valid power of attorney, or a written notarized statement signed by a representative that expressly describes the authority of the representative to act on behalf of the protected consumer.

(h) "Sufficient proof of identification" means documentation that identifies a protected consumer or a representative of a protected consumer. Sufficient proof of identification includes, but is not limited to, a copy of a social security card, a certified or official copy of a birth certificate, a copy of a valid driver license, or a government-issued photo identification.

(2) A representative may place a security freeze on a protected consumer's consumer record by:

(a) Submitting a request to a consumer reporting agency in

the manner prescribed by that agency;

(b) Providing the agency with sufficient proof of authority and sufficient proof of identification; and

(c) Paying the agency a fee as authorized under this section.

(3) If a consumer reporting agency does not have a consumer report pertaining to a protected consumer when the consumer reporting agency receives a request for a security freeze under subsection (2), the consumer reporting agency shall create a record for the protected consumer and place a security freeze on the record.

(4) A consumer reporting agency shall place a security freeze on a consumer record within 30 days after confirming the authenticity of a security freeze request made in accordance with this section.

(5) The consumer reporting agency shall send a written confirmation of the security freeze to the representative within 10 business days after instituting the security freeze and shall provide the representative with instructions for removing the security freeze and a unique personal identifier to be used by the representative when providing authorization for removal of a security freeze.

(6) A consumer reporting agency may not state or imply to any person that a security freeze on a protected consumer's consumer record reflects a negative credit score, negative credit history, or a negative credit rating.

(7) A consumer reporting agency shall remove a security freeze placed on a consumer record of a protected consumer only

in the following instances:

(a) Upon request of a representative pursuant to paragraph (8)(a).

(b) Upon request of a protected consumer pursuant to paragraph (8)(b).

(c) If the security freeze was instituted due to a material misrepresentation of fact by a representative. If a consumer reporting agency intends to remove a security freeze pursuant to this paragraph, the consumer reporting agency shall notify the representative in writing before removing the security freeze.

(8) A security freeze placed in accordance with this section shall remain in place until a representative or protected consumer requests that it be removed. A consumer reporting agency shall remove a security freeze within 30 days after receiving a request for removal from a protected consumer or representative.

(a) A representative submitting a request for removal must provide the following:

1. Sufficient proof of identification and sufficient proof of authority as determined by the consumer reporting agency.

2. The unique personal identifier provided by the consumer reporting agency pursuant to subsection (5).

3. Payment of a fee as authorized by this section.

(b) A protected consumer submitting a request for removal must provide the following:

1. Sufficient proof of identification as determined by the consumer reporting agency.

2. Documentation that the sufficient proof of authority for the protected consumer's representative to act on behalf of the protected consumer is no longer valid.

(9) This section does not apply to use of a consumer record by the following persons or for the following reasons:

(a) A state agency acting within its lawful investigative or regulatory authority.

(b) A state or local law enforcement agency investigating a crime or conducting a criminal background check.

(c) Any person administering a credit file monitoring subscription service to which the protected consumer has subscribed.

(d) Any person for the purpose of providing the protected consumer's consumer report upon the representative's request.

(e) Any person with a court order lawfully entered.

(f) Any insurance company for use in setting or adjusting a rate, adjusting a claim, or underwriting for insurance purposes.

(g) A consumer reporting agency's database or file which consists entirely of information concerning, and is used exclusively for, one or more of the following:

1. Criminal record information.

2. Personal loss history information.

3. Fraud prevention or detection.

4. Tenant screening.

5. Employment screening.

6. Personal insurance policy information.

7. Noncredit information used for insurance purposes.

(h) A check services company that issues authorizations for the purpose of approving or processing negotiable instruments, electronic funds transfers, or similar methods of payment.

(i) A deposit account information service company that issues reports regarding account closures due to fraud, substantial overdrafts, automatic teller machine abuse, or similar negative information regarding a protected consumer to an inquiring financial institution, as defined in s. 655.005 or in federal law, for use only in reviewing a representative's request for a deposit account for the protected consumer at the inquiring financial institution.

(j) A consumer reporting agency that acts only as a reseller of credit information by assembling and merging information contained in the database of another consumer reporting agency or multiple consumer reporting agencies and does not maintain a permanent database of credit information from which new consumer reports are produced. However, a consumer reporting agency shall honor any security freeze placed or removed by another consumer reporting agency.

(k) A fraud prevention services company issuing reports to prevent or investigate fraud.

(10)(a) A consumer reporting agency may charge a reasonable fee, not to exceed $10, to a representative who elects to place or remove a security freeze.

(b) A consumer reporting agency may charge a reasonable fee, not to exceed $10, if the representative fails to retain the original personal identifier provided by the consumer

reporting agency and the agency must reissue the personal identifier or provide a new personal identifier to the representative.

(c) A consumer reporting agency may not charge any fee under this section to a representative of a protected consumer who is a victim of identity theft if the representative submits, at the time the security freeze is requested, a copy of a valid investigative report or incident report or complaint with a law enforcement agency about the unlawful use of the protected consumer's identifying information by another person.

(11) If a security freeze is in effect, a consumer reporting agency may not change any of the following official information in the consumer record without sending a written confirmation of the change to the representative within 30 days after the change is posted to the protected consumer's record:

(a) The protected consumer's name.

(b) The protected consumer's address.

(c) The protected consumer's date of birth.

(d) The protected consumer's social security number.

Written confirmation is not required for technical corrections of a protected consumer's official information, including name and street abbreviations, complete spellings, or transposition of numbers or letters. In the case of an address change, the written confirmation must be sent to both the new address and the former address.

(12) If a consumer reporting agency violates a security freeze placed in accordance with this section by releasing

information subject to a security freeze without proper authorization, the consumer reporting agency shall, within 5 business days after discovering or being notified of the release of information, notify the representative of the protected consumer in writing. The notice shall state the specific information released, and provide the name, address, and other contact information of the recipient of the information.

(13)(a) Any consumer reporting agency that willfully fails to comply with any requirement imposed under this section with respect to any representative or protected consumer is subject to an administrative fine in the amount of up to $500 issued pursuant to the administrative procedures established in chapter 120 by the Department of Agriculture and Consumer Services.

(b) Any individual who obtains a record under false pretenses or knowingly without a permissible purpose is liable to the representative and protected consumer for actual damages sustained by the protected consumer as a result of the failure of at least $100 but not more than $1,000.

(c) Any person who obtains a record from a consumer reporting agency under false pretenses or knowingly without a permissible purpose is liable to the consumer reporting agency for actual damages sustained by the consumer reporting agency or $1,000, whichever is greater.

Section 2. Subsection (17) of section 501.005, Florida Statutes, is amended to read:

501.005 Consumer report security freeze.—

(17) Any written disclosure by a consumer reporting agency, pursuant to 15 U.S.C. s. 1681g, to any consumer residing

in this state shall include a written summary of all rights the consumer has under this section and s. 501.0051, and, in the case of a consumer reporting agency which compiles and maintains consumer reports on a nationwide basis, a toll-free telephone number which the consumer can use to communicate with the consumer reporting agency. The information set forth in paragraph (c) ~~(b)~~ of the written summary of rights must be in at least 12-point boldface type. The written summary of rights required under this section is sufficient if it is substantially in the following form:

(a) You have a right to place a "security freeze" on your consumer report, which will prohibit a consumer reporting agency from releasing any information in your consumer report without your express authorization. A security freeze must be requested in writing by certified mail to a consumer reporting agency. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent.

(b) If you are the custodial parent or legal guardian of a minor younger than 16 years of age or a guardian or advocate of an incapacitated, disabled, or protected person under chapter 39, chapter 393, chapter 744, or chapter 914 Florida Statutes, you have a right to place a security freeze on the consumer report of the person you are legally authorized to care for. If no consumer report exists, you have a right to request a record to be created and a security freeze to be placed on the record. A record with a security freeze is intended to prevent the opening of credit accounts until the security freeze is removed.

(c) ~~(b)~~ YOU SHOULD BE AWARE THAT USING A SECURITY FREEZE TO

CONTROL ACCESS TO THE PERSONAL AND FINANCIAL INFORMATION IN YOUR CONSUMER REPORT MAY DELAY, INTERFERE WITH, OR PROHIBIT THE TIMELY APPROVAL OF ANY SUBSEQUENT REQUEST OR APPLICATION YOU MAKE REGARDING A NEW LOAN, CREDIT, MORTGAGE, INSURANCE, GOVERNMENT SERVICES OR PAYMENTS, RENTAL HOUSING, EMPLOYMENT, INVESTMENT, LICENSE, CELLULAR PHONE, UTILITIES, DIGITAL SIGNATURE, INTERNET CREDIT CARD TRANSACTION, OR OTHER SERVICES, INCLUDING AN EXTENSION OF CREDIT AT POINT OF SALE.

(d) ~~(c)~~ When you place a security freeze on your consumer report, you will be provided a personal identification number or password to use if you choose to remove the freeze on your consumer report or authorize the release of your consumer report for a designated period of time after the security freeze is in place. To provide that authorization, you must contact the consumer reporting agency and provide all of the following:

1. The personal identification number or password.

2. Proper identification to verify your identity.

3. Information specifying the period of time for which the report shall be made available.

4. Payment of a fee authorized by this section.

(e) ~~(d)~~ A consumer reporting agency must authorize the release of your consumer report no later than 3 business days after receiving the above information.

(f) ~~(e)~~ A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account, that requests information in your consumer report for the purposes of reviewing or collecting the account. Reviewing

the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

(g) ~~(f)~~ You have the right to bring a civil action against anyone, including a consumer reporting agency, who fails to comply with the provisions of s. 501.005, Florida Statutes, which governs the placing of a consumer report security freeze on your consumer report.

Section 3. This act shall take effect September 1, 2013.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 493 Security of Protected Consumer Information
SPONSOR(S): Fitzenhagen
TIED BILLS: **IDEN./SIM. BILLS:** SB 566

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Business & Professional Regulation Subcommittee	10 Y, 0 N	Collins	Luczynski
2) Insurance & Banking Subcommittee		Bauer	Cooper
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

Currently, Section 501.005, F.S. provides consumers with procedures to request "security freezes" on consumer records that may have been compromised as a result of identity theft. Security freezes prohibit consumer reporting agencies (Equifax, Experian, and TransUnion) from releasing a credit report, subject to specified exemptions. However, this procedure presumes that the consumer has an existing credit file and history, and may not address the issue of identity theft committed against minors and other persons who may be represented by a guardian, and who do not have a credit history or are unable to request security freezes on their own. While parents typically apply for a Social Security number for their child shortly after birth, a credit reporting agency does not create a credit report or history until an application for credit is received. An identity thief will typically apply for credit with a child's Social Security number, but with a different name and date of birth. As a result, the identity theft may go undetected for years. A recent study estimated that 142,000 instances of identity fraud are perpetrated on minors in the United States each year.

The bill creates s. 501.0051, F.S., to provide a mechanism to protect the personal information of protected consumers, which is an individual less than sixteen years of age or a person represented by a guardian or other advocate pursuant to chs. 39, 393, or 744, F.S. The newly-created section provides definitions, procedures, requirements, damages, and limitations regarding security freezes on a protected consumer's credit record.

The bill also amends s. 501.005, F.S., to require consumer reporting agencies to provide consumers with a written summary of all rights under both s. 501.005 and the newly created s. 501.0051, F.S.

The bill has no fiscal impact on state or local funds. The bill may have a positive impact on the private sector by providing additional safeguards for minors under age 16 and other persons represented by a guardian or advocate.

The bill has an effective date of September 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Credit reports and credit reporting agencies

Credit reporting agencies (also known as credit bureaus) are entities that collect and disseminate information about consumers to be used for credit evaluation and other permissible purposes, such as employment or background checks for professional licenses. The three major credit reporting companies in the U.S. are Equifax, TransUnion, and Experian.

Current federal law and security freezes

In 1970, Congress enacted the federal Fair Credit Reporting Act (FCRA), which regulates the collection, dissemination, and use of consumer credit information, is enforced by the Federal Trade Commission, and provides a private cause of action for consumers. The FCRA was enacted to (1) prevent the misuse of sensitive consumer information by limiting recipients to those who have a legitimate need for it; (2) improve the accuracy and integrity of consumer reports; and (3) promote the efficiency of the nation's banking and consumer credit systems.

Consumer reports are used by financial institutions, insurance companies, employers, and other entities in making eligibility decisions affecting consumers. Information included in consumer reports generally may include consumers' credit history and payment patterns, as well as demographic and identifying information, and public record information (e.g., arrests, judgments, and bankruptcies).

In 2003, Congress passed the Fair and Accurate Credit Transactions Act (FACTA) to enhance FCRA and to require credit bureaus to provide one free report every 12 months. FCRA (as amended by FACTA) also states that a consumer, or any individual acting on behalf of or as a personal representative of a consumer, may assert a good-faith suspicion that he or she has been a victim of identity theft. This requires the credit bureau to place an "initial fraud alert" on the consumer's credit file for at least 90 days and for no charge.[1] According to the FTC, this initial fraud alert makes it harder for identity thieves to open more accounts in a consumer's name, since the existence of a fraud alert requires businesses to verify a consumer's identity before issuing credit.[2] In addition, FCRA requires credit bureaus to block the reporting of information contained in a credit file resulting from an alleged identity theft.[3] Consumers can also file an identity theft report (which consists of an affidavit and a police report) to the 3 credit bureaus in order to obtain an extended fraud alert placed on the credit report.

Both FCRA and FACTA provide that states may enact laws with respect to the collection, distribution, or use of any information on consumer, or for the prevention or mitigation of identity theft, so long as these state laws are not inconsistent with the federal acts.[4] Security freeze legislation, which goes beyond fraud alerts by blocking access to a consumer's credit file, is one example of allowable state laws.[5]

---

[1] 15 U.S.C. §1681c-1.
[2] FTC Consumer Information: Place a Fraud Alert, http://www.consumer.ftc.gov/articles/0275-place-fraud-alert (last accessed on March 4, 2013).
[3] 15 U.S.C. §1681c-2.
[4] 15 U.S.C. §1681t(1).
[5] After the FACT Act: What States Can Still Do to Prevent Identity Theft, http://www.consumersunion.org/pub/core_financial_services/000756.html (last accessed March 4, 2013).

As of October 16, 2011, forty-seven states (including Florida) and the District of Columbia have enacted laws requiring credit bureaus to provide consumers the option to place security freezes on their credit reports.[6] A security freeze restricts a consumer-reporting agency from releasing a credit report or any information from the report without authorization from the consumer. A freeze also requires authorization to change information—such as the consumer's name, date of birth, Social Security number, and address—in a consumer report. A security freeze remains on a credit report until the consumer removes it. Generally, a person can "thaw" or temporarily remove the freeze to open a new credit account or a new loan. To do this, a consumer provides the consumer-reporting agency with special personal identifying number (PIN), which is required to verify the consumer's identity. States have created exemptions for specified organizations that still can access credit report information even if a freeze is in place. Typically, these organizations include law enforcement agencies, child support enforcement, insurance, and subsidiaries and affiliates of companies that have existing accounts with the consumer.

Current Florida law

Florida consumers have a statutory right to have security freeze placed on their consumer reports by sending a written request by certified mail to a credit reporting agency.[7] A "security freeze" is a notice placed in a consumer report that prohibits a consumer reporting agency from releasing the consumer report, credit score, or any information contained in the report to a third party without the express authorization of the consumer.[8] Any disclosure by a consumer reporting agency to a resident of the state must include a written summary of all rights the consumer has, including the right to place a security freeze on his or her consumer report.[9] A credit reporting agency may charge a fee, not to exceed $10, when a consumer elects to temporarily lift or remove a security freeze on his or her credit report. However, the law prohibits a consumer-reporting agency from charging a fee to a consumer age 65 or older or to a victim of identity theft for the placement or removal of a security freeze.

In addition to any other penalties or remedies provided under law, a person who is aggrieved by a violation of the provisions of s. 501.005, F.S., may bring a civil action as authorized by s. 501.005(16), F.S. Any person who willfully fails to comply with any requirement imposed under s. 501.005, F.S., with respect to any consumer is liable to that consumer for actual damages sustained by the consumer as a result of the failure of not less than $100 and not more than $1,000, plus the cost of the action together with reasonable attorney's fees. Any person who is negligent in failing to comply with any requirement imposed under this s. 501.005, F.S., with respect to any consumer is liable to that consumer for any actual damages sustained by the consumer because of the failure of not less than $100 and not more than $1,000.

Also, s. 501.005, F.S., provides that any individual who obtains a consumer report under false pretenses or knowingly without a permissible purpose is liable to the consumer for actual damages sustained by the consumer as a result of the failure or damages of not less than $100 and not more than $1,000, whichever is greater. Any person who obtains a consumer report from a consumer reporting agency under false pretenses or knowingly without a permissible purpose is liable to the consumer reporting agency for actual damages sustained by the consumer reporting agency or $1,000, whichever is greater. Section 501.005(16), F.S., allows for the assessment of punitive damages for willful violations of s. 501.005, F.S. Upon a finding by the court that an unsuccessful pleading, motion was filed in bad faith or for purposes of harassment, the court shall award to the prevailing party

---

[6] Consumers Union's Guide to Security Freeze Protection, at http://www.consumersunion.org/campaigns/learn_more/003484indiv.html (last accessed March 4, 2013).

[7] Section 501.005, F.S.

[8] Section 501.005(1), F.S. Additionally, Section 501.005(12), F.S., allows for the release of information that would otherwise be protected by a security freeze to the existing creditors of the consumer, persons who have been granted access to the information according to law, state agencies acting within their lawful investigatory or regulatory authority, law enforcement agencies, persons maintaining credit monitoring services or who provide credit reports to consumers on their request, to persons designated by court order, for credit prescreening or insurance underwriting purposes, and to certain other specified entities.

[9] See, generally: s. 501.005(17), Florida Statutes.

attorney's fees that are reasonable in relation to the work performed in responding to the pleading, motion, or other paper.

Identity Theft & Children

A recent study by AllClear ID, based on 27,000 American children, found that more than 10% of children are victims of identity theft, mostly among children ages 5 and younger.[10] While the current statutory security freeze process may be commonly used by adults, it is often not able to be utilized by minor consumers and consumers who are represented by a guardian or other advocate. Unlike the average adult, most minors and consumers represented by a guardian or other advocate do not have existing credit files. While parents typically apply for a Social Security number for their child shortly after birth, credit bureaus do not create credit files until an individual uses his or her Social Security number to apply for credit for the first time. When a credit file is created for a first-time credit applicant, the credit bureaus will verify the Social Security number, but not the name and date of birth assigned to it when issued. An identity thief will typically apply for credit with a child's Social Security number, but with a different name and date of birth. As a result, the identity theft may go undetected for years.[11] In addition, even when parents do detect that their child's identity has been compromised, consumer reporting agencies generally do not administer security freezes for consumers who do not have existing credit files. As a spokesman for TransUnion and Equifax explained, a security freeze "applies to a credit file, not a social security number."[12]

In addition, s. 817.568, F.S., addresses criminal use of personal identification and includes a provision specifically addressing minors:

> (6) Any person who willfully and without authorization fraudulently uses personal identification information concerning an individual who is less than 18 years of age without first obtaining the consent of that individual or of his or her legal guardian commits a felony of the second-degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
> (7) Any person who is in the relationship of parent or legal guardian, or who otherwise exercises custodial authority over an individual who is less than 18 years of age, who willfully and fraudulently uses personal identification information of that individual commits a felony of the second-degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Effect of Proposed Changes

The bill creates s. 501.0051, F.S., to authorize a representative of a minor consumer younger than sixteen years of age, or a guardian or other advocate of a consumer pursuant to chs. 39, 393, or 744, F.S., to place a security freeze on that consumer's credit report.

The bill also directs credit reporting agencies to create a credit record for the protected consumer in the event that the consumer does not yet have a credit report file. Similarly, a representative of a minor consumer less than sixteen years of age, or a guardian or other advocate of a consumer pursuant to chs. 39, 393, or 744, F.S., is provided the ability to place a security freeze on that consumer's newly-created credit record.

Definitions

The bill defines the terms: "consumer reporting agency," "consumer report," "protected consumer," "record," "representative," "security freeze," sufficient proof of authority," and "sufficient proof of

[10] AllClear ID Alert Network, Child Identity Theft: Report 2012, available on https://www.allclearid.com/child/child-id-theft-statistics-2012 (last accessed March 4, 2013).
[11] *Id.*
[12] http://bucks.blogs.nytimes.com/2011/09/21/why-its-not-easy-to-freeze-your-childs-credit-file/ (Last accessed on February 7, 2013).

identification." Except as noted below, the following definitions are identical to the current definitions in s. 501.005, F.S.

- "Consumer reporting agency" is defined as any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties, and which uses any means or facility of interstate commerce for the purpose of preparing or furnishing consumer reports.
- "Consumer report" is defined as any written, oral or other communication by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing a consumer's eligibility for credit or insurance, employment, or any other purpose authorized under 15 U.S.C. 1681(b).
- "Protected consumer" is defined as a person less than sixteen years of age at the time a security freeze request is made, or a person represented by a guardian or other advocate pursuant to chs. 39, 393, or 744, F.S.
- "Record" is defined as a compilation of information that 1) identifies a protected consumer, 2) is created by a consumer reporting agency for the purpose of complying with credit reporting requirements and 3) may *not* be created or used to consider the protected consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or eligibility for other financial services.
- "Representative" is defined as the custodial parent or legal guardian of a protected consumer, including a guardian ad litem.
- "Security freeze" is defined as a notice that may be placed on either 1) the protected consumer's consumer report, which prohibits a consumer reporting agency from releasing the consumer report, credit score, or any information contained within the consumer report to a third party without the express authorization of the representative, or 2) the protected consumer's record, which prohibits the consumer reporting agency from releasing the protected consumer's record, in the event that a consumer reporting agency does not have an existing consumer report file pertaining to the protected consumer.
- "Sufficient proof of authority" is defined as documentation that shows that a representative has authority to act on behalf of a protected consumer, such as a court order, valid power of attorney, or a written notarized statement signed by a representative that expressly describes the authority of the representative to act on behalf of the protected consumer.
- "Sufficient proof of identification" is defined as documentation that identifies a protected consumer or a representative of a protected consumer, such as a social security card, a certified or official copy of a birth certificate, a copy of a valid driver license, or government-issued photo identification.

Creating a Security Freeze

The bill provides the procedure to be used in the event that a representative, guardian or other advocate wants to place a security freeze on a protected consumer's consumer record. Specifically, to place a security freeze on a consumer record, the representative must:

- Submit a request to the consumer reporting agency in the manner prescribed by that agency;
- Provide the agency with sufficient proof of authority and identification; and
- Pay the agency a fee.

If a consumer reporting agency doesn't have a consumer report pertaining to a protected consumer when it receives the security freeze request, the agency must create a record for the protected consumer and place a security freeze on that newly-created record.

The security freeze must be placed within thirty days after the consumer reporting agency confirms the authenticity of the security freeze request.

Moreover, within ten days of the consumer reporting agency placing the security freeze, it is required to send the representative written confirmation of the implementation of the security freeze. It must also provide the representative with a unique personal identifier and instructions for removing the security freeze.

Removing a Security Freeze

The bill also provides procedures to be used in the event that a representative wants to remove the security freeze. A consumer reporting agency may only remove a security freeze:

- Upon request of a representative;
- Upon request of a protected consumer; or
- If the security freeze was instituted due to a material misrepresentation of fact by a representative; however, the consumer reporting agency must first notify the representative in writing before removing the security freeze.

If the removal of a security freeze is requested by the representative, he or she must provide the consumer reporting agency with the following:

- Sufficient proof of identification and authority;
- The unique personal identifier; and
- Payment of a fee.

If the removal of a security freeze is requested by the protected consumer, he or she must provide the consumer reporting agency with the following:

- Sufficient proof of identification; and
- Documentation that the authority for the protected consumer's representative to act on behalf of the protected consumer is no longer valid.

The security freeze must be removed within thirty days after receiving the request for removal.

Exemptions from Section

The bill provides that the provisions of s. 501.0051, F.S., do not apply to the use of consumer credit information by:

- A state agency acting within its lawful investigative or regulatory authority;
- A state or local law enforcement agency investigating a crime or conducting a criminal background check;
- Any person administering a credit file monitoring subscription, to which the protected consumer has subscribed;
- Any person, for the purpose of providing the protected consumer's consumer report upon the representative's request;
- Any person with a court order;
- An insurance company, for the purpose of settling or adjusting a rate, adjusting a claim, or underwriting for insurance purposes;
- A consumer reporting agency's database or file which consists entirely of information concerning, and is used exclusively for: 1) criminal record information, 2) personal loss history information, 3) fraud prevention or detection, 4) tenant screening, 5) employment screening, 6) personal insurance policy information, or 7) noncredit information used for insurance purposes;
- A check services company that issues authorizations, for the purpose of approving or processing checks, electronic funds transfers, or similar methods of payment;

- A deposit account information service company that issues reports regarding account closures due to fraud, substantial overdrafts, automatic teller machine abuse, or other negative information regarding a protected consumer to an inquiring financial institution, for limited purposes;
- A consumer reporting agency that acts only as a reseller of credit information by assembling and merging information contained in the database of another consumer reporting agency; or
- A fraud prevention services company issuing reports to prevent or investigate fraud.

Fees

The bill authorizes consumer reporting agencies to charge a representative who elects to place or remove a security freeze a "reasonable fee," which may not exceed ten dollars.

Additionally, consumer reporting agencies are granted the ability to charge a representative a "reasonable fee," not to exceed ten dollars, to be imposed if the representative fails to retain the original personal identifier granted when the security freeze was placed, and the agency has to reissue that original personal identifier.

However, the bill does not allow for a consumer reporting agency to charge the representative any fee if the representative submits a copy of an investigative report, incident report, or other complaint with a law enforcement agency about the unlawful use of the protected consumer's identifying information by another person. The documentation must be submitted at the time the security freeze is requested.

The bill does not provide a consumer reporting agency the ability to charge a protected consumer directly, for any reason.

Changes to a Protected Consumer's Consumer Record

If a security freeze is in effect, the bill prohibits a consumer reporting agency from changing the protected consumer's name, address, date of birth, or social security number in his or her consumer record, unless the agency first sends a written confirmation of the change to the representative within thirty days after the change is posted to the consumer record.

However, written confirmation is not required to be made regarding technical corrections of a protected consumer's information. Technical corrections include name and street abbreviations, complete spellings, or transposition of numbers or letters.

Violations of the Security Freeze

In the event that a consumer reporting agency violates the security freeze by releasing credit information without proper authorization, the bill provides that the consumer reporting agency is required to notify the representative, in writing, within five business days after discovering or being notified of the release of information.

Moreover, the bill provides for fines and damages, in certain circumstances. Specifically:
- A credit reporting agency that willfully fails to comply with the security freeze provisions is subject to a maximum $500 administrative fine, issued pursuant to ch. 120, F.S., by the Department of Agriculture and Consumer Services.
- Anyone who obtains a record under false pretenses, or knowingly without a permissible purpose, is liable to: 1) the representative and the protected consumer for actual damages of $100 to $1,000, and 2) the consumer reporting agency for actual damages or $1,000, whichever is greater.

Effects on Credit Score, Credit History, and Credit Rating

The bill also provides that a consumer reporting agency may not state or otherwise imply that a security freeze reflects a negative credit score, history, or rating.

Written Summary of Rights

The bill provides that the written summary of rights required under s. 501.005, F.S., also applies to s. 501.0051, F.S. Additionally, the bill amends the terms of the summary of rights to include that a representative has a right to place a security freeze on the consumer report of the person that he or she is legally authorized to care for, pursuant to the provisions in s. 501.0051, F.S.

Moreover, the summary of rights must indicate that if no consumer report exists for the protected consumer, that the representative has a right to request that a record be created and that a security freeze be placed on that consumer record.

Differences between HB 493 and current law

The following differences are noted between the bill and current s. 501.005, F.S.:

- Current law allows adults to temporarily lift a security freeze, but the bill does not.
  - According to the industry proponents, this is because minors generally do not have the same need to temporarily lift a security freeze as adults do. An adult may request to temporarily lift a security freeze to open a new credit account or loan.[13]
- Current law requires credit reporting agencies to *place a freeze* within 5 days of confirming that a request for a freeze is valid. However, the bill requires credit reporting agencies to place a freeze on a protected consumer's record within 30 days after confirming that a request for a freeze is valid.
- Current law requires credit reporting agencies to *remove* a freeze within 3 days of confirming the validity of a request. However, the bill requires credit reporting agencies to remove a freeze on a protected consumer's record within 30 days after confirming that request to remove a freeze is valid.
  - According to industry proponents, the difference in the time periods to place or to remove security freezes for adults and for protected consumer is due to the additional time needed to verify the proof of authority of a protected consumer's representative.[14]
- Current law requires a request for a security freeze to be submitted to a credit reporting agency in writing by certified mail. The bill requires that a protected consumer's representative to submit the request in the manner prescribed by the agency.
  - According to industry proponents, not all credit reporting agencies currently have the capability to accept requests for security freezes electronically, although those capabilities are in development. As a practical matter and for the time being, credit reporting agencies will likely require requests for to be submitted by certified mail.[15]
- Current law provides civil remedies for punitive damages, attorney's fees, and actual damages for a credit reporting agency's negligent failure to comply with the section. The bill only provides for a recovery of actual damages of at least $100 but not more than $1,000 when an individual obtains a record under false pretenses or knowingly without a permissible purpose.[16]

[13] Meeting with industry proponents and DOACS, on March 25, 2013.
[14] *Id.*
[15] *Id.*
[16] *See* Drafting Comments below.

B. SECTION DIRECTORY:

Section 1: creates s. 501.0051, F.S., to provide definitions, procedures, requirements, exemptions enforcement and damages, and limitations regarding security freezes on a protected consumer's credit record.

Section 2: amends s. 501.005, F.S., to revise written disclosure requirements for consumer reporting agencies pertaining to consumer rights associated with a security freeze, and to include a disclaimer involving protected consumer security freezes.

Section 3: provides an effective date of September 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None. The Department of Agriculture and Consumer Services anticipates using existing resources to investigate alleged violations of the provisions of this bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will expand consumer protections to individuals under the age of sixteen and certain protected adults, specifically helping to protect these groups from identity theft and fraudulent credit card use.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of sales tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides that a credit reporting agency that willfully fails to comply with the security freeze is subject to an administrative fine of *up to* $500. This provision will require agency rulemaking authority and rulemaking in order to determine the exact amount of the administrative fine. An amendment is anticipated to set the administrative remedy at $500.

C. DRAFTING ISSUES OR OTHER COMMENTS:

An amendment is anticipated to provide an affirmative right to a civil action under the new statute, and to increase the civil remedy in the new statute against identity thieves, so that an individual who obtains a record under false pretenses or knowingly without a permissible purpose is liable to a representative and protected consumer for the greater of actual damages of at least $1000 or the actual damages sustained by the protected consumer as a result of the failure.

Currently, consumer reporting agencies are required to provide consumers with written summaries of their rights under the current statute, including their right to bring a civil action. It may be beneficial for consumers to receive a written summary of rights that notifies of them of their right to bring a civil action under the new statute as well.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to dentists; amending s. 627.6474, F.S.; prohibiting a contract between a health insurer and a dentist from requiring the dentist to provide services at a fee set by the insurer under certain circumstances; providing that covered services are those services listed as a benefit that the insured is entitled to receive under a contract; prohibiting an insurer from providing merely de minimis reimbursement or coverage; requiring that fees for covered services be set in good faith and not be nominal; prohibiting a health insurer from requiring as a condition of a contract that a dentist participate in a discount medical plan; amending s. 636.035, F.S.; prohibiting a contract between a prepaid limited health service organization and a dentist from requiring the dentist to provide services at a fee set by the organization under certain circumstances; providing that covered services are those services listed as a benefit that a subscriber of a prepaid limited health service organization is entitled to receive under a contract; prohibiting a prepaid limited health service organization from providing merely de minimis reimbursement or coverage; requiring that fees for covered services be set in good faith and not be nominal; prohibiting the prepaid limited health service organization from requiring as a condition of a contract that a dentist participate in a discount

medical plan; amending s. 641.315, F.S.; prohibiting a contract between a health maintenance organization and a dentist from requiring the dentist to provide services at a fee set by the organization under certain circumstances; providing that covered services are those services listed as a benefit that a subscriber of a health maintenance organization is entitled to receive under a contract; prohibiting a health maintenance organization from providing merely de minimis reimbursement or coverage; requiring that fees for covered services be set in good faith and not be nominal; prohibiting the health maintenance organization from requiring as a condition of a contract that a dentist participate in a discount medical plan; providing for applicability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.—

(1) A health insurer may ~~shall~~ not require a contracted health care practitioner as defined in s. 456.001(4) to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or health maintenance organization, under common management and control with the insurer, including Medicare and Medicaid practitioner contracts

and those authorized by s. 627.6471, s. 627.6472, s. 636.035, or s. 641.315, except for a practitioner in a group practice as defined in s. 456.053 who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this section is void. A violation of this subsection ~~section~~ is not subject to the criminal penalty specified in s. 624.15.

(2)(a) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not contain any provision that requires the dentist to provide services to the insured at a fee set by the health insurer unless such services are covered services under the applicable contract.

(b) Covered services are those services that are listed as a benefit that the insured is entitled to receive under the contract. An insurer may not provide merely de minimis reimbursement or coverage in order to avoid the requirements of this section. Fees for covered services shall be set in good faith and must not be nominal.

(c) A health insurer may not require as a condition of the contract that the dentist participate in a discount medical plan under part II of chapter 636.

Section 2. Subsection (13) is added to section 636.035, Florida Statutes, to read:

636.035 Provider arrangements.—

(13)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466

for the provision of services to a subscriber of the prepaid limited health service organization may not contain any provision that requires the dentist to provide services to the subscriber of the prepaid limited health service organization at a fee set by the prepaid limited health service organization unless such services are covered services under the applicable contract.

(b) Covered services are those services that are listed as a benefit that the subscriber is entitled to receive under the contract. A prepaid limited health service organization may not provide merely de minimis reimbursement or coverage in order to avoid the requirements of this subsection. Fees for covered services shall be set in good faith and must not be nominal.

(c) A prepaid limited health service organization may not require as a condition of the contract that the dentist participate in a discount medical plan under part II of this chapter.

Section 3. Subsection (11) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.—

(11)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not contain any provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract.

(b) Covered services are those services that are listed as a benefit that the subscriber is entitled to receive under the contract. A health maintenance organization may not provide merely de minimis reimbursement or coverage in order to avoid the requirements of this subsection. Fees for covered services shall be set in good faith and must not be nominal.

(c) A health maintenance organization may not require as a condition of the contract that the dentist participate in a discount medical plan under part II of chapter 636.

Section 4. This act shall take effect July 1, 2013, and applies to contracts entered into or renewed on or after that date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 581 Dentists
SPONSOR(S): Renuart and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 0 N	Poche	Shaw
2) Insurance & Banking Subcommittee		Cooper	Cooper
3) Health & Human Services Committee			

SUMMARY ANALYSIS

House Bill 581 prohibits health insurance provider contracts from containing provisions requiring dentists to provide services at a fee set by the health insurer, prepaid limited health service organization or health maintenance organization unless the services are covered under the subscriber agreement. The bill defines "covered services" and requires the insurer or organization to set fees for covered services in good faith. Fees may not be nominal or de minimis in an effort to circumvent the provisions of the bill. Lastly, the bill prohibits an insurer or an organization from requiring, as a term of its contract with a dentist, that the dentist participate in a discount medical plan.

The bill also adds PLHSO provider arrangement contracts to the list of insurers which may not require a health care practitioner to accept the terms of other health care practitioner contracts with an insurer, PLHSO, or HMO as a condition of continuing or renewing a contract.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2013, and applies to contracts entered into or renewed on or after that date.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Health Insurers and Health Maintenance Organizations (HMOs)

The Office of Insurance Regulation (OIR) regulates health insurance policies and rates under Part VI of Chapter 627, F.S. OIR also regulates HMO contracts and rates under Part I of Chapter 641, F.S. The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under Part III of Chapter 641, F.S.

Health Care Practitioners

Health care practitioners, as defined in s. 456.001(4), F.S., include, but are not limited to, physicians, osteopathic physicians, chiropractors, podiatrists, nurses, pharmacists, dentists, midwives, optometrists, speech pathologists, occupational therapists, orthotic providers, massage therapists, clinical laboratory personnel, and psychologists.

Health Insurer Provider Arrangements

Health insurer provider contracts are regulated by the OIR. Current Florida law does not prohibit provider contracts between health insurers and dentists from containing provisions that require the dentist to provide services to the subscribers to a health insurance plan or policy at a fee set by the health insurer, regardless of whether or not the services are covered under the health insurance plan or policy.

Section 627.6474, F.S., provides that a health insurer cannot require a contracted health care practitioner to accept the terms of other health care practitioner contracts with the insurer, or any other insurer or HMO under common management and control with the insurer, including Medicare and Medicaid practitioner contracts, preferred provider, exclusive provider organizations, or provider contracts, except for a practitioner in a group practice who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this provision is considered void.

Prepaid Limited Health Service Organization (PLHSO) Provider Arrangements

PLHSOs are authorized in s. 636.003, F.S. This statute defines "limited health service" to include the following:

- ambulance services;
- dental care services;
- vision care services;
- mental health services;
- substance abuse services;
- chiropractic services;
- podiatric care services; and
- pharmaceutical services.

AHCA currently has two types of PLHSOs- a prepaid dental health plan (PDHP), as authorized in s. 409.912(43), F.S., and a prepaid mental health plan (PMHP), as authorized in s. 409.912(4)(b), F.S.

These prepaid limited health service organizations are administered under contract with AHCA and reimbursed on a capitated basis.

As of March 2013, approximately 1,385,862 beneficiaries are enrolled in the PDHP program and 632,150 beneficiaries are enrolled in the PMHP program.

Provider arrangements for PLHSOs are authorized in s. 636.035, F.S. Current law does not prohibit provider contracts between PLHSOs and dentists from containing provisions that require dentists to provide non-covered services to the PLHSO subscribers at a fee set by the PLHSO.

HMO Provider Contracts

Section 641.315, F.S., specifies requirements for the HMO provider contracts with "health care practitioners" as defined in s. 456.001(4), F.S. Section 641.315, F.S., does not currently prohibit provider contracts between health maintenance organizations and dentists from containing provisions that require the practitioner to provide services to the HMO subscribers at a fee set by the HMO unless the services are covered services under the applicable subscriber agreement.

Effect of Proposed Changes

The bill amends s. 627.6474, F.S., to add PLHSO provider arrangement contracts, authorized under s. 636.035, F.S., to the list of insurers which may not require a health care practitioner to accept the terms of other health care practitioner contracts with an insurer, PLHSO, or HMO.

The bill also amends ss. 627.6474, 636.035, and 641.315, F.S., to prohibit a contract between a health insurer, a PLHSO, or an HMO and a dentist from containing provisions that require the dentist to provide a service to the insured or subscriber at a fee set by the insurer, PLHSO, or HMO, unless the service is a covered service under the applicable policy or subscriber agreement. The bill defines a "covered service" as a service listed as a benefit to which the insured or subscriber is entitled under the contract with the insurer, PHLSO, or HMO. The bill requires the insurer to set reimbursement rates for covered services in good faith, prohibiting de minimis or nominal payments for covered services as a means to avoid the requirement of the bill

The bill prohibits an insurer, PHLSO, or HMO from including in its contract with a dentist a requirement that the dentist participate in a discount medical plan.

The bill defines "covered services" as those services that are reimbursable under an applicable contract, subject to contractual limitations on benefits. The bill specifically exempts from the definition of "covered services" any dental services provided by a dentist to a covered individual who has met or exceeded the periodic maximum amount of benefits allowed by the individual's health insurance plan or policy. Also, services that are not listed in an individual's health insurance plan or policy as a benefit to which the individual is entitled under the plan or policy are not considered covered services.

The bill applies to all contracts entered into or renewed on or after July 1, 2013.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6474, F.S., relating to provider contracts.
Section 2: Amends s. 636.035, F.S., relating to provider arrangements.
Section 3: Amends s. 641.315, F.S., relating to provider contracts.
Section 4: Provides an effective date of July 1, 2013, and applies to contracts entered into or renewed on or after that date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may allow dentists to charge higher fees to patients for services that are not considered "covered services" under a contract with a PLHSO, HMO, or health insurer.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The title of the bill, an act relating to dentists, is narrower than the substance of the bill. For instance, section 1 of the bill concerns provider contracts between health insurers and health care providers. Because the bill, in part, applies to health care providers other than dentists, it is recommended that the title of the bill be amended to a more general "act relating to" clause. An appropriate title is, "An act relating to health care provider contracts."

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to workers' compensation; amending s. 440.13, F.S.; revising requirements for determining the amount of a reimbursement for repackaged or relabeled prescription medication; providing limitations; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) of subsection (12) of section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(c) As to reimbursement for a prescription medication, regardless of the location from which or the provider from whom the claimant receives the prescription medication, the reimbursement amount ~~for a prescription~~ shall be the average wholesale price plus $4.18 for the dispensing fee, unless ~~except where~~ the carrier has contracted for a lower amount. If the drug has been repackaged or relabeled, the reimbursement amount shall be calculated by multiplying the number of units dispensed times the per-unit average wholesale price set by the original manufacturer of the underlying drug, which may not be the manufacturer of the repackaged or relabeled drug, plus a $4.18 dispensing fee, unless the carrier has contracted for a lower amount. The repackaged or relabeled drug price may not exceed

the amount otherwise payable had the drug not been repackaged or relabeled. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. If ~~Where~~ the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. ~~No~~ Such contract may not ~~shall~~ rely on a provider that is not reasonably accessible to the employee.

Section 2. This act shall take effect July 1, 2013.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 605 Workers' Compensation
SPONSOR(S): Hudson
TIED BILLS: **IDEN./SIM. BILLS:** SB 662

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N	Poche	O'Callaghan
2) Insurance & Banking Subcommittee		Reilly	Cooper
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida's workers' compensation law, ch. 440, F.S., provides medically necessary treatment and care for injured employees, including medications. Reimbursement for prescription drugs (generally to dispensing physicians and pharmacies) is the average wholesale price (AWP) plus a $4.18 dispensing fee, or at a contract rate, whichever is lower. AWP is not defined in the worker's compensation law and does not have a universally accepted definition.

Prescription drug repackaging companies are licensed by the Department of Business and Professional Regulation. Drug repackagers purchase pharmaceuticals in bulk from the manufacturer and repackage the drugs into individual prescription sizes. The repackaged drugs are then assigned a different AWP than the manufacturer's suggested AWP, which is often substantially higher than the manufacturer's AWP. As such, the cost for a prescription filled with repackaged drugs in the workers' compensation system is generally much higher than it would have been if the prescription had been filled with the same drug that had not been repackaged. The overwhelming majority of repackaged drugs in Florida's workers' compensation system are dispensed by physicians who are authorized to dispense drugs at their office.

It is estimated that higher reimbursements for repackaged or relabeled drugs add $27.3 million annually to workers' compensation costs, and that providing the same reimbursement for the same prescription drug, regardless of whether the dispensed drug is repackaged, relabeled, or non-repackaged, will decrease system costs by 1.1%. The Office of Insurance Regulation approved a workers' compensation rate filing that provides for an overall 6.1% increase in workers' compensation premiums effective January 1, 2013.

The bill provides the same rate of reimbursement for repackaged or relabeled drugs as for non-repackaged drugs. Specifically, reimbursement for repackaged or relabeled drugs is to be calculated by multiplying the number of units of the drug dispensed by the per-unit AWP set by the original manufacturer of the drug (which may not be the manufacturer of the repackaged or relabeled drug), plus a $4.18 dispensing fee, unless the carrier has contracted for a lower amount. The bill expressly prohibits the price of repackaged or relabeled drugs from exceeding the amount that would otherwise be payable had the drug not been repackaged or relabeled. This reimbursement formula was included in HB 5603 (2010), which was vetoed by Governor Crist.

The bill appears to have an indeterminate fiscal impact on state and local government.

The bill is effective July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Workers' Compensation Benefits[1]

Chapter 440, F.S., is Florida's workers' compensation law. For work-related injuries, workers' compensation requires employers, or employers' insurance carriers, to pay for:

- Medically necessary remedial treatment, care, and attendance, including medicines,[2] medical supplies, durable medical equipment, and prosthetics.[3]
- Compensation for disability when the injury causes an employee to miss more than 7 days of work.[4]

The Division of Workers' Compensation (Division) within the Department of Financial Services (DFS) provides regulatory oversight of Florida's workers' compensation system.

Reimbursement for Prescription Drugs in Workers' Compensation

Reimbursement to pharmacies and dispensing physicians for prescription drugs in workers' compensation is provided for in s. 440.13(12)(c), F.S. Under current law, prescription drugs are reimbursed at the average wholesale price (AWP) plus a $4.18 dispensing fee, or at a contract rate, whichever is lower.[5, 6] AWP is not defined in the workers' compensation statute and does not appear to have a universally accepted definition.[7,8,]

---

[1] Whether an employer is required to have workers' compensation insurance depends upon the employer's industry (construction, non-construction, or agricultural) and the number of employees.

[2] Many workers' compensation insurers have implemented prescription drug programs (sometimes called "first fill" programs) designed to avoid out-of-pocket pharmacy expenses to injured employees for the initial prescription filled at the pharmacy as well as subsequent prescriptions. Under such a program, an injured employee may be given a form or card to show at a pharmacy to avoid out-of-pocket expense.

[3] Section 440.13(2) (a), F.S.

[4] Section 440.12(1), F.S.

[5]Fees for pharmaceuticals and pharmaceutical services must be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier must reimburse at the scheduled, negotiated, or contract price, whichever is lower. The contract may not rely on a provider that is not reasonably accessible to the employee. Section 440.13(12)(c), F.S.

[6] In response to inquiries received by the Florida Division of Workers' Compensation (Division) as to whether employers/carriers may appropriately deny authorization or reimbursement for prescription medication that is dispensed by a physician instead of a pharmacist, the DFS issued Informational Bulletin DFS-02-2009 on August 12, 2009. The bulletin informs, in part, that the Division is unaware of any specific provisions of the workers' compensation law that addresses the issue presented; available at: http://www.myfloridacfo.com/wc/ (last viewed on March 20, 2013).

[7] *See*, for example, "Prescription Benchmarks for Florida, 2nd Edition," a 2011 study by the Workers' Compensation Research Institute (WCRI study) compared with "Impact of Physician-Dispensing of Repackaged Drugs on California Workers' Compensation, Employers Cost, and Workers' Access to Quality Care," a 2006 study conducted by Frank Neuhauser and colleagues for the California Commission on Health and Safety and Workers' Compensation (California study). The WCRI defines average wholesale price as: "Published by First DataBank and Medi-Span ®. The AWP operates as an available price index that represents the most common wholesaler price charged to customers. The AWP does not necessarily represent the actual sales price in any single transaction. The payors may negotiate for lower prices. In workers' compensation systems, however, the AWP is often used as a price benchmark for pharmacy reimbursements of prescription drugs." [Note: On September 28, 2011, First DataBank discontinued publication of the "Blue Book Average Wholesale Price." *See* http://www.firstdatabank.com/Support/drug-pricing-policy.aspx.] The California study states that: "AWP is probably the most widely quoted pricing benchmark, but the least meaningful.... unlike what the name implies, the price has no relation to a wholesale price, average or otherwise. It is simply a price point established by the manufacturer, wholesaler, or repackager....The AWP...is typically much higher than the actual amounts that are paid by pharmacies and other wholesale drug purchasers...." Details on the WCRI study are available at http://www.wcrinet.org/. The California study is available at http://www.dir.ca.gov/chswc/search/query.asp?SearchType=0 (last viewed March 20, 2013).

Physician Dispensing of Drugs

The authority for a physician to dispense medicinal drugs is found in s. 465.0276, F.S. To dispense medicinal drugs, a physician must register with the applicable professional licensing board and pay a fee of $100.[9] In addition, the physician must comply with all applicable statutes found in ch. 465, ch. 499, and ch. 893, F.S., all applicable rules, and federal laws regarding the dispensing of medicinal drugs.[10] Lastly, a physician must provide the patient with a written prescription and advise him or her, orally or in writing, that there is an option to have the prescription filled at the doctor's office or at a pharmacy.[11] Physician dispensing is regulated by the relevant licensing boards with the Department of Health. Currently, there are 7,187 registered dispensing physicians in Florida.[12]

A physician may not dispense controlled substances listed in Schedule II and Schedule III, as provided in s. 893.03, F.S.[13] However, the following physicians are exempted from the ban on dispensing:

- A physician who dispenses complimentary medications in the normal course of practice without payment or remuneration;
- A physician dispensing a controlled substance listed in Schedule II or Schedule III in connection with the performance of a surgical procedure, limited to a 14 day supply;
- A physician dispensing a controlled substance listed in Schedule II or Schedule III pursuant to an approved clinical trial;
- A physician dispensing methadone in a methadone clinic licensed under s. 397.427, F.S.; and
- A physician dispensing a controlled substance listed in Schedule II or Schedule III in a hospice care facility licensed under part IV of ch. 400, F.S.[14]

To be eligible for payment under the workers' compensation law, health care providers who treat injured employees, except for emergency treatment, must apply for and be certified by the DFS and receive authorization from the insurer before providing treatment.[15] As of March 25, 2013, there were 37,037 certified health care providers in the workers' compensation system.[16] The number of certified workers' compensation health care providers who are also authorized to dispense drugs is unknown.

Relabeled or Repackaged Drugs

The term "repackage," used in the context of distributing drugs in Florida, means to repack or otherwise change the container, wrapping, or labeling to further the distribution of a drug, device, or cosmetic.[17] A "repackager" means a person who repackages a drug, device, or cosmetic, but specifically excludes pharmacies operating in compliance with pharmacy practice standards set out in ch. 465, F.S., and

---

[8] The Florida Division of Workers' Compensation informs that in the event of a reimbursement dispute it would rely on the "Drug Topics Red Book," published by Thomson Reuters (New York) to determine the average wholesale price. The "Red Book" is listed as a reference source in the "Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2008 Edition." The Reimbursement Manual is available at http://www.myfloridacfo.com/wc/ (last viewed March 20, 2013).

[9] Section 465.0276(2)(a), F.S.; Rule 64B8-3.006, F.A.C. Registration is not required for dispensing complimentary medications in the normal course of practice without payment or remuneration.

[10] Section 465.0276(2)(b), F.S.; ch. 499, F.S., contains the Florida Drug and Cosmetic Act, administered by the DBPR; ch. 893, F.S., contains the Florida Comprehensive Drug Abuse Prevention and Control Act, which was significantly amended during the 2011 Regular Legislative session; *see also* ch. 2011-141, L.O.F.

[11] S. 465.0276(2)(c), F.S.

[12] Email correspondence from the Florida Department of Health on file with staff of the Insurance & Banking Subcommittee, dated March 15, 2013.

[13] Section 465.0276(1)(b), F.S.; *see also* s. 15, ch. 2011-141, L.O.F.

[14] Sections 465.0276(1)(b)1. through 6., F.S.

[15] Section 440.13(3)(a), F.S.; Rule 69L-29.002, F.A.C.

[16] Florida Department of Financial Services, "Division of Workers Compensation Health Care Provider Directory," available at https://apps.fldfs.com/provider/ (last viewed March 20, 2013).

[17] Section 499.03(49), F.S.

under applicable rules.[18] The term "repackaged" drugs refers to pharmaceuticals that have been purchased in bulk by a repackager from a manufacturer, relabeled, and repackaged into individual prescription sizes that can be dispensed directly by physicians to patients.

Rule 61N-1.001, F.A.C., defines "repackaging or otherwise changing the container, wrapper, or labeling to further the distribution" to mean:

- Altering a packaging component that is or may be in direct contact with the drug, device, or cosmetic. For example, repackaging from bottles of 1000 pills to bottles of 100 pills.
- Altering a manufacturer's package for sale under a label different from the manufacturer. For example, a kit that contains an injectable vaccine from manufacturer A; a syringe from manufacturer B; alcohol from manufacturer C; and sterile gauze from manufacturer D packaged together and marketed as an immunization kit under a label of manufacturer Z.
- Altering a package of multiple-units, which the manufacturer intended to be distributed as one unit, for sale or transfer to a person engaged in the further distribution of the product. This does not include:
    - Selling or transferring an individual unit which is a fully labeled self-contained package that is shipped by the manufacturer in multiple units, or
    - Selling or transferring a fully labeled individual unit, by adding the package insert, by a person authorized to distribute prescription drugs to an institutional pharmacy permit, health care practitioner or emergency medical service provider for the purpose of administration and not for dispensing or further distribution.

Repackagers may assign an AWP for a repackaged drug that differs from the AWP suggested by the original manufacturer of the drug.[19] Frequently, the AWP assigned by the drug repackager is significantly greater than the AWP suggested by the drug's manufacturer. Thus, the cost of the repackaged drug, in terms of reimbursement paid by an insurer, is often significantly greater than it would have been if the prescription had been filled with the identical non-repackaged drug.

The Florida Department of Business and Professional Regulation (DBPR), which regulates prescription drug repackagers, reports that there are 28 licensed prescription drug repackagers in the state.[20]

The Cost of Repackaged or Relabeled Prescription Drugs to Florida's Workers' Compensation System

The National Council on Compensation Insurance (NCCI) is the designated licensed rating and statistical organization for workers' compensation in Florida. Among its responsibilities, NCCI collects data from workers' compensation insurers in Florida and makes rate filings on the insurers' behalf. The workers' compensation rate filing for 2013 provides for an overall increase in workers' compensation rates of 6.1%.[21]

Using 2011 data from the Division, the NCCI has estimated that reimbursements for repackaged or relabeled prescription drugs add $27.3 million in annual costs to the workers' compensation system, and that elimination of the higher reimbursements available for these drugs, as compared to non-repackaged drugs, would decrease system costs by 1.1%.[22]

---

[18] Section 499.003(50), F.S.

[19] United States Government Accountability Office, "Brand-Name Prescription Drug Pricing: Lack of Therapeutically Equivalent Drugs and Limited Competition May Contribute to Extraordinary Price Increases" (GAO-10-201, December 2009); available at http://www.gao.gov/products/GAO-10-201 (last viewed March 20, 2013).

[20] Correspondence from the Department of Business and Professional Regulation, dated March 14, 2013 (on file with staff of the Insurance & Banking Subcommittee). The DBPR also reports that as of March 2013, there were 275 "out-of-state prescription wholesaler distributor" permits issued. Such distributors are able to repackage drugs. However, the DBPR does not collect information as to whether applicants for such permits repackage drugs, as it does not have legal authority to regulate repackaging outside of the state of Florida.

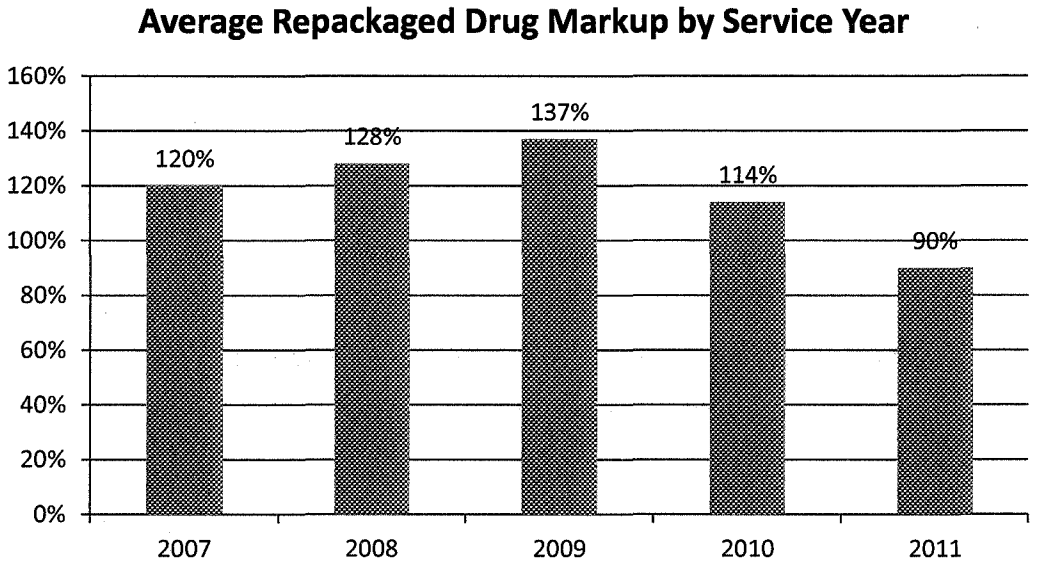
[21] Florida Office of Insurance Regulation, Office Statement, "OIR Approves Final Order for Workers' Compensation Rates" (November 5, 2012), available at http://www.floir.com/PressReleases/index.aspx (last viewed March 20, 2013).

[22] National Council on Compensation Insurance, :Pricing of Workers Compensation Proposals 2013," page 8 (on file with staff of the Insurance & Banking Subcommittee); *see also* National Council on Compensation Insurance, "Analysis of Florida Proposal to Revise

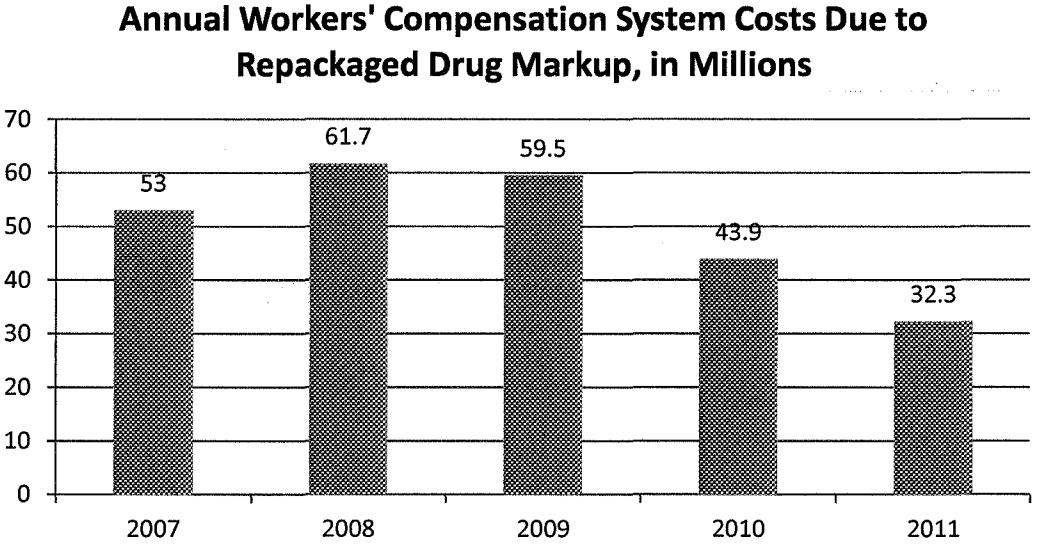
Additional findings about Florida's workers' compensation system include the following:

- The 10 most frequently dispensed repackaged drugs have an average markup of 54% to 625%.[23]
- Physician-dispensed drugs account for 62% of all prescription drug dollars; the second highest percentage of the 23 states in one study.[24]

The following chart illustrates the average markup of repackaged drugs from 2007 through 2011:[25]



Total workers' compensation system costs as a result of the markup on repackaged drugs were $250 million over the last five years.[26] The following chart shows the annual system costs attributed to the markup of repackaged drugs from 2007 to 2011:[27]



Reimbursement for Repackaged or Relabeled Prescription Drugs Effective Upon Adoption," September 25, 2012, page 1 (on file with staff of the Insurance & Banking Subcommittee).

[23] *Id.* at page 12. The 10 drugs are Meloxicam, Carisoprodol, Lidoderm®, Tramadol HCL, Omeprazole, Gabapentin, Ranitidine HCL, Cyclobenzaprine HCL, Naproxen, and Lyrica.

[24] Workers Compensation Research Institute, Wang, D., "Physician Dispensing in Workers' Compensation," July 2012, page 8, table A.

[25] *See supra*, FN 22 at page 10.

[26] *Id.* at page 14.

[27] *Id.*

The Three Member Panel (Panel) Biennial Report for 2013 makes the following observation regarding reimbursement to physicians in the workers' compensation system who are repackaging and dispensing medications:

> "...the current statutory benchmark of reimbursing prescription drugs at the Average Wholesale Price has led to a pricing environment that is not conducive to the self-execution of the workers' compensation system and does not provide reimbursement clarity and uniformity, which is a detriment to the payers and payees. The result has been a dramatic increase in the number of petitions for reimbursement dispute filed by physicians in FY 2011/2012 (up 872% over FY 2010/2011 from 1,308 to 12,718, respectively) primarily due to disputes involving physician dispensed medication."

The Panel believes that the Division will continue to see great numbers of petitions for reimbursement dispute being filed until a legislative and/or regulatory solution is achieved.[28],[29]

Findings of the Workers' Compensation Research Institute[30]

In July 2011, the Workers' Compensation Research Institute (WCRI) published "Prescription Benchmarks for Florida, 2nd Edition,"[31] a study that compares the cost, price, and use of pharmaceuticals in workers' compensation in Florida with 16 other states.[32] Among the study's findings on Florida:

- For 2007/2008, the average payment per workers' compensation claim for prescription drugs was $536, the second highest cost of the 17 states studied, and 45% higher than the median[33] of the states studied.[34]
- Between 2005/2006 and 2007/2008, the average cost per claim for prescription drugs in Florida increased by 14%, but remained relatively stable in the other study states.
- Higher and growing costs of prescription drugs in Florida were largely due to more frequent and higher-priced physician dispensing.
- Over a four-year period (from 2004/2005 and 2007/2008), the percentage of payments for physician-dispensed prescriptions increased from 17% to 46% of all prescription payments.
- In 2007/2008, for many common drugs, physicians were paid 40% to 80% more than pharmacies for the same prescription.
- 65% of physician-dispensed prescriptions were for pain medications.

Further, the WCRI study identifies and addresses two concerns that have been raised in response to proposals to eliminate higher reimbursements for repackaged drugs, and to provide the same rate of reimbursement for the same drug, whether it is repackaged or non-repackaged. The first concern is that prescription drug costs would increase. This position is based on the following assumptions: that physician dispensing would decrease and that physicians dispense generic drugs more frequently than

---

[28] *Id.* at page 6.

[29] The three-member panel is comprised of the Chief Financial Officer, or the CFO's designee, and two members appointed by the Governor, subject to confirmation by the Senate. The two appointed members represent employers and employees, respectively, The panel determines statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment under Florida's workers' compensation system. See s. 440.13(12), F.S.

[30] WCRI is an independent research organization that analyzes workers' compensation systems for states with which it contracts. WCRI provides information through studies and data collection efforts, and does not take positions on the issues it researches.

[31] WCRI study, *supra* note 7.

[32] The 17 states in the WCRI study are California, Florida, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, Pennsylvania, Tennessee, Texas, and Wisconsin.

[33] The Merriam-Webster Dictionary online defines median as "a value in an ordered set of values below and above which there is an equal number of values or which is the arithmetic mean of the two middle values if there is no one middle number...." *See* http://www.merriam-webster.com/dictionary.htm.

[34] WCRI study, *supra* note 7, informs that physician dispensing is not generally allowed in three of the states in its study - Massachusetts, New York, and Texas.

pharmacies. For the most commonly dispensed drugs, the WCRI found that physicians and pharmacies almost always dispense generic drugs, and that physicians are paid much higher prices per pill than pharmacies for the same prescription.

A second concern with providing the same reimbursement for repackaged and non-repackaged drugs is that physicians would stop dispensing drugs, and patients who do not have prescriptions filled by their doctor are less likely to take their medicine as prescribed, which would be detrimental to the patient. For California, the 2011 WCRI study reports that physician dispensing decreased from 50% to 25% of all prescriptions immediately following enactment of a reform to provide the same reimbursement for repackaged and non-repackaged drugs.[35] In a subsequent study, "Physician Dispensing in Workers' Compensation," published in July 2012, the WCRI reports that three years after the California reform nearly half of all prescriptions in that state were dispensed by physicians.[36]

Effect of Proposed Changes

The bill provides the same rate of reimbursement for repackaged or relabeled drugs as for non-repackaged drugs. Specifically, reimbursement for repackaged or relabeled drugs is to be calculated by multiplying the number of units of the drug dispensed by the per-unit AWP set by the original manufacturer of the drug (which may not be the manufacturer of the repackaged or relabeled drug), plus a $4.18 dispensing fee, unless the carrier has contracted for a lower amount. The bill expressly prohibits the price of repackaged or relabeled drugs from exceeding the amount that would otherwise be payable had the drug not been repackaged or relabeled.

B. SECTION DIRECTORY:

Section 1: Amends s. 440.13, F.S., relating to medical services and supplies; penalty for violations; limitations.
Section 2: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

To the extent that repackaged drugs are dispensed by physicians to state government employees who suffer a workplace injury, the bill will lower the costs that state government pays for prescription drugs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

[35] Data from the first quarter of 2008. Subsequent dispensing patterns are not addressed in this study.
[36] *See* http://www.wcrinet.org/.

2. Expenditures:

To the extent that repackaged drugs are dispensed by physicians to local government employees who suffer a workplace injury, the bill will lower the costs that local governments pay for prescription drugs. Also, for local governments that have procured workers' compensation insurance coverage, there may be a reduction in insurance premiums to reflect system-wide savings of 1.1%, as estimated by the NCCI.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Providing the same rate of reimbursement for repackaged or relabeled drugs as for non-repackaged drugs could save Florida employers $27.3 million annually in workers' compensation costs, a 1.1% system savings.[37]

Physicians that dispense prescription drugs under the workers' compensation system will continue to receive a $4.18 dispensing fee for each prescription they fill, but will no longer derive additional income from current higher reimbursements.

D. FISCAL COMMENTS:

The bill will result in significant savings to state and local governments and lower workers' compensation costs for Florida employers.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

[37] *See supra* at FN 22.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to general assignments; amending s. 727.103, F.S.; defining the term "negative notice"; amending s. 727.104, F.S.; requiring an assignee's bond to be in at least a specific amount or double the liquidation value of the unencumbered and liquid assets of the estate, whichever is higher; amending s. 727.108, F.S.; authorizing an assignee to conduct certain discovery to determine whether to prosecute certain claims or causes of action; extending the time period an assignee may conduct the business of the assignor; authorizing the assignee to continue conducting the business of the assignor under certain circumstances by serving negative notice; amending s. 727.109, F.S.; extending the time period for which a court may authorize an assignee to conduct the business of the assignor; amending s. 727.110, F.S.; providing procedures for an assignee's rejection of an unexpired lease of nonresidential real property or of personal property; requiring the assignee to serve a notice of rejection on certain persons and file it with the court; requiring that a notice of rejection for personal property include certain information about the affected property; specifying the effective date of the rejection; requiring the estate's rights and obligations to and liability for the affected property to terminate under certain circumstances; amending s. 727.111, F.S.; extending the minimum time

period for giving notice to the assignor and creditors; conforming language; providing a procedure for serving notice on certain persons; requiring an objection to be filed and served within a specific time period; requiring the notice to be in a specified form; providing that the assignee may take certain actions if an objection is not filed; requiring the court to hear a filed objection; authorizing the court to shorten negative notice under certain circumstances; providing that a party may raise the shortened notice period in certain objections; requiring a certificate of service for negative notice to be filed with the court under certain circumstances; requiring negative notice to be given to certain persons under certain circumstances; amending s. 727.113, F.S.; providing procedures for serving an objection to a claim; providing that the Florida Rules of Civil Procedure apply to objections to claims in all pending cases beginning on a specific date; creating s. 727.117, F.S.; requiring an assignee's deed to be in a specific form; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present subsection (13) of section 727.103, Florida Statutes, is redesignated as subsection (14), and a new subsection (13) is added to that section, to read:

727.103 Definitions.—As used in this chapter, unless the context requires a different meaning, the term:

(13) "Negative notice" means notice as set forth in s. 727.111(4) which, unless a response is filed within 21 days after the date of service thereof, allows certain actions set forth in the notice to occur.

Section 2. Subsection (2) of section 727.104, Florida Statutes, is amended to read:

727.104 Commencement of proceedings.—

(2) Within 10 days after delivery of the assignment to the assignee, the assignee shall:

(a) Record the original assignment in the public records of the county in which the assignor had its principal place of business and shall thereafter promptly record a certified copy of the assignment in each county where assets of the estate are located.~~;~~

(b) File, in the office of the clerk of the court in the county of the assignor's place of business if it has one, in the county of its chief executive office if it has more than one place of business, or in the county of the assignor's residence if the assignor is an individual not engaged in business, in accordance with the procedures for filing a complaint as set forth in the Florida Rules of Civil Procedure, a petition setting forth the name and address of the assignor and the name and address of the assignee; a copy of the assignment, together with Schedules A and B; and a request that the court fix the amount of the assignee's bond to be filed with the clerk of the court. This bond is ~~shall be~~ subject to reconsideration upon the

motion of any party in interest after notice and hearing. The bond is ~~shall be~~ payable to the clerk of the court, in an amount not less than $25,000 or double the liquidation value of the unencumbered and liquid assets of the estate as set forth in Schedule B, whichever is higher, conditioned upon the assignee's faithful discharge of her or his duties. Within 30 days after the court enters an order setting the amount of such bond, the assignee shall file the bond with the clerk of the court, who shall approve the bond.

Section 3. Subsections (1) and (4) of section 727.108, Florida Statutes, are amended to read:

727.108 Duties of assignee.—The assignee shall:

(1) Collect and reduce to money the assets of the estate, whether by suit in any court of competent jurisdiction or by public or private sale, including, but not limited to, prosecuting any tort claims or causes of action that ~~which~~ were previously held by the assignor, regardless of any generally applicable law concerning the nonassignability of tort claims or causes of action.~~, and;~~

(a) With respect to the estate's claims and causes of action, the assignee may:

1. Conduct discovery as provided under the Florida Rules of Civil Procedure to determine whether to prosecute such claims or causes of actions.

2. Prosecute such claims or causes of action as provided in this section. ~~or~~

3. Sell and assign, in whole or in part, such claims or causes of action to another person or entity on the terms that

the assignee determines are in the best interest of the estate under ~~to~~ s. 727.111(4)~~.; and~~

(b) In an action in any court by the assignee or the first immediate transferee of the assignee, other than an affiliate or insider of the assignor, against a defendant to assert a claim or chose in action of the estate, the claim is not subject to, and any remedy may not be limited by, a defense based on the assignor's acquiescence, cooperation, or participation in the wrongful act by the defendant which forms the basis of the claim or chose in action.

(4) Conduct the business of the assignor for a limited period ~~that may~~ not to exceed 45 ~~14~~ calendar days, if doing so is in the best interest of the estate, or for a longer period if~~,~~ in the best interest of the estate, upon notice and until such time as an objection, if any, is sustained by the court~~; however, the assignee may not operate the business of the assignor for longer than 45 calendar days without a court order authorizing such operation if an objection by a party in interest is interposed to the assignee's motion for authority to operate the assignor's business~~. An assignee's authorization to conduct the business of the assignor may be extended for a period longer than 45 days upon service of negative notice. If no timely objection is filed with the court, the assignee may continue to operate the assignor's business for an additional 90 days. The court may extend the 90-day period if it finds an extension to be in the best interest of the estate.

Section 4. Subsection (3) of section 727.109, Florida Statutes, is amended to read:

727.109 Power of the court.—The court shall have power to:

(3) Upon notice and a hearing, if requested, authorize the business of the assignor to be conducted by the assignee for longer than 45 ~~14~~ calendar days, if in the best interest of the estate.

Section 5. Subsection (3) is added to section 727.110, Florida Statutes, to read:

727.110 Actions by assignee and other parties in interest.—

(3) As to an assignee's rejection of an unexpired lease of nonresidential real property or of personal property, as provided under ss. 727.108(5) and 727.109(6):

(a) The assignee shall file a notice of rejection with the court and serve a copy on the owner or lessor of the affected property and, for personal property, on the landlord of the premises on which the property is located. A notice of rejection relating to personal property must identify the affected property, the address at which the affected property is located, the name and telephone number of the person in possession of the affected property, and the deadline for removal of the affected property.

(b) The effective date of the rejection is the date of entry of a court order authorizing such rejection.

(c) If the lessor of the affected property fails to take possession thereof after notice of the rejection, the estate's rights and obligations to and liability for the property terminate upon the effective date of the rejection.

Section 6. Subsections (4), (6), and (8) of section

727.111, Florida Statutes, are amended to read:

727.111 Notice.—

(4) The assignee shall give the assignor and all creditors at least ~~not less than~~ 21 ~~20~~ days' notice by mail of a proposed sale of assets of the estate other than in the ordinary course of business, the assignee's continued operation of the assignor's business for longer than 45 ~~14~~ calendar days, the compromise or settlement of a controversy, and the payment of fees and expenses to the assignee and to professional persons employed by the assignee pursuant to s. 727.108(7). The notice shall be served on all creditors and their attorneys, if any, at the address provided in the creditor's proof of claim. If a proof of claim has not been filed by a creditor that is registered to do business in this state, the notice must be served on the creditor's registered agent as listed with the Division of Corporations of the Department of State and on the creditor's attorney, if known. If a proof of claim has not been filed and the creditor does not have a registered agent within the state, the notice must be served on the creditor at the address listed in the schedules filed by the assignor. Objection ~~Any objections~~ to the proposed action must be filed and served upon the assignee and the assignee's attorney, if any, within 21 days after service of the notice ~~not less than 3 days before the date of the proposed action~~. The notice shall be in the following form: ~~must include a description of the proposed action to be taken, the date of the proposed action, and the date and place for the hearing at which any objections will be heard.~~

NOTICE OF OPPORTUNITY TO OBJECT AND REQUEST A HEARING

IN THE CIRCUIT COURT
OF THE ....
CIRCUIT, IN AND FOR
.... COUNTY,
FLORIDA

IN RE:.....,
Assignor,
TO:.....,
Assignee.

TO CREDITORS AND OTHER INTERESTED PARTIES:

PLEASE TAKE NOTICE that, pursuant to s. 727.111(4), Florida Statutes, the assignee may ...(List applicable action(s) described in s. 727.111(4))..., and the Court may consider these actions without further notice or hearing unless a party in interest files an objection within 21 days from the date this paper is served. If you object to the relief requested in this paper, you must file your objection with the Clerk of the Court at...(Clerk's address)..., and serve a copy on the assignee's attorney,...(attorney's name and address)..., and any other appropriate person.

If you file and serve an objection within the time permitted,

the Court shall schedule a hearing and notify you of the scheduled hearing. If a hearing is already scheduled, list the date, time, and location of the hearing: ...(date, time, and location)...

If you do not file an objection within the time permitted, the assignee and the Court will presume that you do not oppose the granting of the relief requested in the paper.

.....

ASSIGNEE

Attorney for assignee (if any):.....

Address:.....

If no objections are ~~not~~ timely filed and served, the assignee may take such action as described in the notice without further order of the court or may obtain an order approving the action without further notice or hearing ~~of the court granting such motion if the assignee reasonably believes that the order is necessary to proceed with the action contemplated by the motion~~. If an objection is filed, the court shall hold a hearing on the objection.

(6) For good cause shown and without notice of hearing, the court may shorten the notice or negative notice period or limit the parties to whom notice or negative notice need be given, pursuant to subsection (3) or subsection (4). This subsection does not affect the right of a party in interest to raise the shortened notice period in any objection to the relief

sought under subsection (4).

(8) Wherever notice or negative notice is required to be given under this chapter, a certificate of service of such notice or negative notice shall be filed with the court, and notice or negative notice shall be given to all consensual lienholders and counsel who have filed a notice of appearance with the court or who are identified in the assignor's schedules.

Section 7. Subsection (1) of section 727.113, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

727.113 Objections to claims.—

(1) At any time before ~~prior to~~ the entry of an order approving the assignee's final report, the assignee or any party in interest~~, including another creditor of the assignor,~~ may file with the court an objection to a claim, which objection must be in writing and set forth the nature of the objection, and shall serve a copy thereof on the creditor at the address provided in the proof of claim, and to the assignee and the assignee's attorney, if any. The objection may be served on negative notice. ~~A copy of the objection, together with notice of hearing thereon, shall be mailed to the creditor at least 20 days prior to the hearing.~~ All claims properly filed with the assignee and not disallowed by the court constitute all claims entitled to distribution from the estate.

(5) The discovery provisions of the Florida Rules of Civil Procedure apply to objections to claims in all cases pending on July 1, 2013, or filed thereafter.

Section 8. Section 727.117, Florida Statutes, is created to read:

727.117 Assignee's deed form.—If an assignee sells property of the estate, the deed shall be in substantially the following form:

ASSIGNEE'S DEED

This Assignee's Deed is made and executed this .... day of ...., ...(year)..., by ...., as Assignee for the Estate of ...., Case No. .... in the Circuit Court of .... County, Florida, whose post office address is .... (hereinafter "Grantor"), to ...., whose post office address is .... (hereinafter "Grantee").

Wherever used herein, the terms "Grantor" and "Grantee" include all the parties to this instrument, singular and plural, and the heirs, legal representatives, and assigns of these individuals, and the successors and assigns of corporations, wherever the context so admits or requires.

WITNESSETH:

That Grantor, for and in consideration of the sum of Ten Dollars ($10.00) and other good and valuable consideration in hand paid to said Grantor by Grantee, the receipt of which is hereby acknowledged, hereby grants, bargains, sells, aliens, remises, releases, conveys, and confirms unto Grantee, all of that certain real property lying and being in the County of ...., State of Florida, more particularly described as follows:

SEE ATTACHED "EXHIBIT A," which is incorporated herein by the term "Property."

This conveyance is subject to taxes accruing for the year of conveyance and subsequent years, and all encumbrances, covenants, conditions, and restrictions of record, except nothing herein operates to reimpose same.

TOGETHER with all the tenements, hereditaments, and appurtenances thereto belonging or in anywise appertaining.

TO HAVE AND TO HOLD the same in fee simple forever.

AND the Grantor hereby covenants with said Grantee that Grantor has good right and lawful authority to sell and convey said Property.

Grantor executed this instrument only in Grantor's capacity as Assignee of the above referenced Assignment estate and no personal judgment shall ever be sought or obtained against Grantor individually by reason of this instrument.

IN WITNESS WHEREOF, said Grantor has caused these presents to be executed the day and year first written above.

GRANTOR:

...(Grantor's Signature)...
Print Name:.....
As Assignee for the Estate of ...(Assignor's Name)...
Case No. ....
Circuit Court of .... County, Florida

Signed, sealed and delivered
in the presence of:

...(Witness's Signature)...
Witness
...(Witness's Name Printed)...
Print Name

...Witness's Signature...
Witness
...(Witness's Name Printed)...
Print Name

STATE OF FLORIDA
COUNTY OF ....

Sworn to and subscribed before me this .... day of ....,
...(year)..., by ...(Assignee's Name)..., as Assignee for the
Estate of ...(Assignor's Name)..., Case No. ...., Circuit Court
of .... County, Florida, on behalf of said estate.

...(Signature of Notary Public - State of Florida)...

...(Print, Type, or Stamp Commissioned Name of Notary Public)...

Personally Known .... OR Produced Identification ....

Type of Identification Produced:....

Section 9. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 833 General Assignments
SPONSOR(S): Civil Justice Subcommittee; Passidomo
TIED BILLS: None **IDEN./SIM. BILLS:** SB 1098

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee	13 Y, 0 N, As CS	Ward	Bond
2) Insurance & Banking Subcommittee		Bauer	Cooper
3) Judiciary Committee			

SUMMARY ANALYSIS

An assignment for the benefit of creditors (ABC) is a state law procedure under Chapter 727, Florida Statutes, for the administration of an insolvent estate. It is somewhat analogous to federal bankruptcy, in that there is a liquidation of the debtor's property through a third person, but the debtor is not discharged from debt, and there is no automatic stay of collection efforts. The debtor is called the assignor. The debtor makes a general assignment of the estate assets to an assignee. This document is recorded in the public records, and then claims of creditors can be filed. Claims are paid by priorities set out in the statute, and the entire process is supervised by the circuit court. Hearings are held as necessary to process payment of claims.

Practitioners have reported a need to amend the general assignment statute based upon experience and a lack of consistency in the way the law of general assignments for the benefit of creditors is interpreted throughout the state.

The bill standardizes and streamlines certain procedures applicable to an assignment for the benefit of creditors ("ABC") pursuant to Chapter 727, Florida Statutes. The bill provides:

- "Negative notice" as a procedure to allow an assignee to give notice to interested parties of an action to be taken. In the absence of objection, the assignee may proceed without a hearing.
- The assignee's bond must not be less than $25,000 or double the liquidation value of the unencumbered and liquid assets of the estate, whichever is higher.
- An assignee may conduct discovery as provided for in the Florida Rules of Civil Procedure.
- An assignee may conduct the business of the assignor for 45 days without an extension, instead of the current 14 days.
- Identification of the parties entitled to notice and the contents of the notice, when an assignee rejects a current lease of the assignor.
- Procedural amendments to clarify which parties are entitled to service of objections to claims, and the service address of the claimant.
- A form for deeds to be used by assignees in the sale of real property.
- A form for providing notice of certain acts to be taken by the assignor.

The bill does not appear to have a fiscal impact on the state or local governments.

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Summary

The bill standardizes and streamlines certain procedures applicable to an assignment for the benefit of creditors ("ABC") pursuant to Chapter 727, Florida Statutes.

Statutory Background

An assignment for the benefit of creditors (ABC) is a state law procedure for the administration of an insolvent estate.[1] An ABC allows a debtor to voluntarily assign its assets to a third party of the debtor's choosing. That third party (the "assignee") is charged with the duty of liquidating the debtor's assets for the purpose of satisfying creditors' claims against the debtor. Many ABC cases are filed with the consent of some or all of the debtor's creditors. It is commenced with an assignment recorded in the public records[2], and the proceedings are conducted under the court's supervision.[3]

An ABC is similar to federal bankruptcy liquidation proceedings in that it requires full reporting to creditors and an equal distribution of a debtor's assets according to the priorities established in the statute.[4]

An ABC is primarily distinguishable from the federal bankruptcy process in that:

- It does not impose an automatic stay in favor of the debtor;[5]
- It does not grant an assignee special authority to recover pre-filing transfers as a result of the ABC;[6] and
- It does not provide a discharge of any debt.[7]

Practitioners report that in recent years, confusion has arisen in ABC cases over some of the statute's inconsistent procedural requirements, and the applicability of other state procedural rules to ABC proceedings. There is also a need for consistency on a statewide basis at the trial court level. Accordingly, both practitioners and judges alike report the need for additional statutory guidance and clarification regarding the appropriate procedures for an ABC proceeding. The bill addresses eight areas of concern reported by practitioners.

---

[1] "Estate" in this sense is a body of property, not to be confused with procedures for handling a decedent's estate upon death of the owner.
[2] Section 727.104, F.S.
[3] Section 727.102, F.S.
[4] Section 727.114, F.S.
[5] Although there is no automatic stay in favor of the debtor, the statute does preclude creditors from commencing proceedings against the assignee, except as provided therein, and from levying, executing, attaching, or similarly pursuing assets of the estate in the possession, custody, or control of the assignee, unless the creditor is a consensual lienholder. *See* s. 727.105(13), F.S.
[6] Certain other state laws allow such recovery under some circumstances, such as Florida's Fraudulent Transfer Act (ch. 726, F. S.), but those laws are independent of the ABC process.
[7] *Moecker v. Antoine*, 845 So.2d 904 (Fla. 2003).

Effect of Proposed Changes

Negative Notice

Section 1 of the bill introduces a "negative notice" procedure for ABC cases.[8] A negative notice provides that unless an objection is filed within 21 days of receiving the notice, the requested action will be taken. Such a procedure reduces both the administrative burden on the court and the cost to the estate necessitated by a hearing for relief which is neither contested nor opposed.

Negative notice is a common procedural tool in federal bankruptcy court. Attorneys and creditors are generally familiar with the requirements for utilizing such notice.[9] Under the bill, notice may be served by negative notice by including a specific form "warning" in the document (as set forth in s. 727.111(4), F.S.) that:

- The assignee proposes to take the actions described therein without further notice or a hearing unless a party in interest files an objection within 21 days of service of the notice;
- Any such objection must be filed with the clerk of court and served on the assignee's attorney and any other appropriate person(s);
- If an objection is filed and served, the court may schedule a hearing; and
- If no objection is filed, the assignee and the court will consider the proposed relief unopposed.

If no objection is filed within the time prescribed, the assignee may take the action described in the notice. The negative notice procedure will be available for a continuation of the assignor's business for an extended period, a proposed sale of assets of the estate other than in the ordinary course of business, the compromise or settlement of a controversy, the payment of fees, and the payment of expenses.

Assignee Bond

Much like receivers, assignees are required to post a bond with the clerk of court to ensure the faithful discharge of their duties. The purpose of the bond is to protect the assignor's creditors from potential loss in the event of the assignee's improper and irreparable disposition of the assignor's assets.[10] Section 727.104(2)(b), F.S., currently requires the court to set the bond "in an amount not less than double the liquidation value of the assets of the estate." "Liquidation value" is defined in s. 727.103(12), F.S., as "the value in cash obtainable upon a forced sale of assets after payment of valid liens encumbering said assets." The reason for deducting the value of liens encumbering the assets when calculating "liquidation value" is that a debt secured by a lien against the debtor's asset does not need the protection of a bond. It is already protected by the lien, which attaches to the asset and may be enforced despite disposition by the assignee.

In addition to assets secured by liens, unliquidated assets are also less susceptible to immediate and irreparable disposition by an assignee. The difficulty of valuing the asset consequently increases the difficulty of selling the asset. As a result, in cases where a significant portion of the debt is secured or unliquidated, practitioners report that some courts have been requiring a bond that seems too high. An unnecessarily high bond requirement causes an estate to incur additional cost and may discourage otherwise qualified assignee candidates from serving as assignees.

Section 2 of the bill amends s. 727.104(2)(b), F.S. to provide that the assignee's bond must not be less than $25,000 or double the liquidation value of the unencumbered and liquid assets of the estate,

---

[8] The bill defines "negative notice" as the notice procedure set forth in s. 727.111(4), F.S.
[9] It is also used in the Florida Probate Code and the Florida Trust Code in a similar manner. *See*, ss. 731.201 and. 736.0206, F.S., where this analogous provision is called "formal notice."
[10] *See Williamson v. Leith*, 36 F.2d 643, 644 (Fla. 5th DCA 1929).

whichever is higher. The amendment to the statute guarantees a minimum bond amount, yet provides that the bond amount is not substantially and artificially inflated by a large amount of secured or unliquidated debt.

Discovery

An area of obscurity in the present statute revolves around the applicability of the discovery provisions in the Florida Rules of Civil Procedure to ABC cases. Assignees are statutorily charged with the duty to:

- Determine whether or not prosecution of the estate's claims and causes of actions is in the best interest of the estate; [11]
- Examine the validity and priority of claims against the estate;[12] and
- Conduct due investigation of the estate's assets' value and benefit to the estate.[13]

Discovery is necessary for the assignee to fulfill its duties. An assignee must be able to conduct discovery related to claims and potential causes of action in order to properly discharge its obligations to an estate.

Sections 3 and 7 of the bill amends s. 727.108(1)(a), F.S., and s. 727.113, F.S., respectively, to confirm an assignee's right to conduct discovery as provided in the Florida Rules of Civil Procedure in the following circumstances:

- In order to determine whether to prosecute claims and causes of action on behalf of the estate; and
- Concerning objections to claims.

Conducting the Business of the Assignor

There currently exists a subtle conflict between s. 727.108(4), F.S., which allows an assignee to conduct the business of the assignor for up to 14 days (or longer upon notice), and s. 727.111(4), F.S., which requires not less than 20 days' notice of an assignee's continued operation of the assignor's business for longer than 14 calendar days. Thus, an assignee's compliance with both provisions is impossible unless the notice required by s. 727.111(4), F.S., is sent before the assignment has occurred.

To remedy the conflict, Sections 3 and 4 of the bill provides an extension of the time within which an assignee may conduct the business of the assignor under s. 727.108(4), F.S., from 14 days to 45 days.[14] The additional time is a larger window within which an assignee can assess the business, determine a strategy for liquidation, and, if necessary, give notice of intent to operate the business for an additional period of time. The assignee may continue to operate the business for up to 90 days if there is no objection to a negative notice given to interested parties. This period may also be extended. The bill leaves intact the condition that such operation of the business must be in the best interest of the estate.

Rejection of Unexpired Leases

The statute currently allows an assignee to reject an unexpired lease of non-residential real property or personal property.[15] However, it provides little guidance regarding the proper procedure for such

[11] *See* s. 727.108(1)(a), F.S.
[12] *Id.* at (10).
[13] *Id.* at (11).
[14] This extended timeframe also requires amendment of s. 727.109(3), F.S.
[15] *See* ss. 727.108(5) and 727.109(6), F.S.

rejection. In the interest of establishing consistent practices, the bill changes s. 727.110, F.S., to codify the procedure for such rejection.

Section 5 of the bill provides:

- Identification of the parties entitled to notice of the rejection;
- The information that should be included in the notice of such rejection; and
- The effective date of the rejection.

The bill also confirms the termination of an estate's rights, obligations, and liability concerning the leased property in the event a lessor fails to take possession upon rejection and the assignor may use the negative notice procedure for the notice of rejection.

Notice to Creditors

Currently, s. 727.111, F.S. provides for notice to be mailed not less than 20 days prior to a proposed sale of assets, a payment of fees, or settlement of a case which might be an asset of the estate.

To streamline the deadlines set forth in the statute into multiples of 7 days, Section 6 of the bill extends the minimum amount of time for notice under the statute from 20 days to 21 days.[16] The bill adds that the address on the claim is the address for service, and that service will also be made upon the designated registered agent listed with the Division of Corporations. The bill creates a notice form.

Objections to Claims

In current ABC proceedings, creditors of an assignor file claims with the assignee who is charged with determining the validity and priority of such claims before distributing the assignor's assets in accordance with statutory requirements. The assignee or any other party in interest may object to a creditor's claim.

Section 7 of the bill adds procedural amendments to s. 727.113(1), F.S., to specify which parties are entitled to service of any such objection, and the service address of the claimant. This provision is also subject to the negative notice procedure.

Assignee's Deed

Section 8 of the bill creates s. 727.117, F.S., adding a form deed to the ABC statute. The deed is in substantially the same form as the warranty deed set forth in s. 689.02, F.S., without the warranties of title. Instead, the assignee states that the grantor executes the instrument in its capacity as assignee of the estate, and is not personally liable under the instrument.

B. SECTION DIRECTORY:

Section 1 amends s. 727.103, F.S., relating to definitions.

Section 2 amends s. 727.104, F.S., relating to commencement of proceedings.

Section 3 amends s. 727.108, F.S., relating to duties of an assignee.

Section 4 amends s. 727.109, F.S., relating to power of the court.

Section 5 amends s. 727.110, F.S., relating to actions by assignee and other parties in interest.

[16] *See* ss. 727.103(13), 727.111(4), F.S.

Section 6 amends s. 727.111, F.S., relating to notice.

Section 7 amends s. 727.113, F.S., relating to objections to claims.

Section 8 creates s. 727.117, F.S., relating to the assignee's deed form.

Section 9 provides the bill is effective upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill does not appear to have any impact on state revenues.

2. Expenditures:

   The bill does not appear to have any impact on state expenditures.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The bill does not appear to have any impact on local government revenues.

2. Expenditures:

   The bill does not appear to have any impact on local government expenditures.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill does not appear to have any direct economic impact on the private sector.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rulemaking or rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The deed form created in section 8 does not include a space for the parcel identification number, which would make the form more analogous to the usual form of deed. Line 282 also does not refer to 'real property,' but only 'property.' The addition of the word 'real' would clarify the meaning of the change.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Florida Hurricane Catastrophe Fund; amending s. 215.555, F.S.; revising the definitions of the terms "covered policy," "retention," and "corporation"; providing for calculation of an insurer's reimbursement premium and retention under the reimbursement contract; revising coverage levels available under the reimbursement contract; revising aggregate coverage limits; providing for the phase-in of changes to coverage levels and limits; deleting the scheduled repeal of an exemption of medical malpractice insurance premiums from emergency assessments if certain revenues are determined to be insufficient to fund the obligations, costs, and expenses of the Florida Hurricane Catastrophe Fund and the Florida Hurricane Catastrophe Fund Finance Corporation; changing the name of the Florida Hurricane Catastrophe Fund Finance Corporation; amending s. 215.555, F.S.; deleting provisions relating to temporary emergency options for additional coverage; amending s. 627.062, F.S.; providing for recoupment of certain costs of reinsurance; amending s. 627.0629, F.S.; conforming a cross-reference; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Effective June 1, 2013, paragraphs (c), (e),

and (n) of subsection (2), paragraphs (b) and (c) of subsection (4), and paragraphs (b) and (d) of subsection (6) of section 215.555, Florida Statutes, are amended to read:

215.555 Florida Hurricane Catastrophe Fund.—

(2) DEFINITIONS.—As used in this section:

(c) "Covered policy" means any insurance policy covering residential property in this state, including, but not limited to, any homeowner's, mobile home owner's, farm owner's, condominium association, condominium unit owner's, tenant's, or apartment building policy, or any other policy covering a residential structure or its contents issued by any authorized insurer, including ~~a commercial self-insurance fund holding a certificate of authority issued by the Office of Insurance Regulation under s. 624.462~~, the Citizens Property Insurance Corporation~~,~~ and any joint underwriting association or similar entity created under law. The term "covered policy" includes any collateral protection insurance policy covering personal residences which protects both the borrower's and the lender's financial interests, in an amount at least equal to the coverage for the dwelling in place under the lapsed homeowner's policy, if such policy can be accurately reported as required in subsection (5). Additionally, covered policies include policies covering the peril of wind removed from the Florida Residential Property and Casualty Joint Underwriting Association or from the Citizens Property Insurance Corporation, created under s. 627.351(6), or from the Florida Windstorm Underwriting Association, created under s. 627.351(2), by an authorized insurer under the terms and conditions of an executed assumption

agreement between the authorized insurer and such association or Citizens Property Insurance Corporation. Each assumption agreement between the association and such authorized insurer or Citizens Property Insurance Corporation must be approved by the Office of Insurance Regulation before the effective date of the assumption, and the Office of Insurance Regulation must provide written notification to the board within 15 working days after such approval. "Covered policy" does not include any policy that excludes wind coverage or hurricane coverage or any reinsurance agreement and does not include any policy otherwise meeting this definition which is issued by a surplus lines insurer or a reinsurer. All commercial residential excess policies and all deductible buy-back policies that, based on sound actuarial principles, require individual ratemaking shall be excluded by rule if the actuarial soundness of the fund is not jeopardized. For this purpose, the term "excess policy" means a policy that provides insurance protection for large commercial property risks and that provides a layer of coverage above a primary layer insured by another insurer.

(e) "Retention" means the amount of losses below which an insurer is not entitled to reimbursement from the fund. An insurer's retention shall be calculated as follows:

1.a. The board shall calculate and report to each insurer the retention multiples for that year. For the contract year beginning June 1, 2005, the retention multiple shall be equal to $4.5 billion divided by the total estimated reimbursement premium for the contract year; for subsequent years, the retention multiple shall be equal to $4.5 billion, adjusted

based upon the reported exposure for the contract year occurring 2 years before the particular contract year to reflect the percentage growth in exposure to the fund for covered policies since 2004, divided by the total estimated reimbursement premium for the contract year. Total reimbursement premium for purposes of the calculation under this subparagraph shall be estimated using the assumption that all insurers have selected the 90-percent coverage level.

b. In order to implement the phase-in of reduced coverage levels as provided in paragraph (4)(b), total reimbursement premium for purposes of the calculation under this subparagraph shall be estimated using the following assumptions:

(I) For the 2013-2014 contract year, the assumption is that all insurers have selected the 90 percent coverage level.

(II) For the 2014-2015 contract year, the assumption is that all insurers have selected the 85 percent coverage level.

(III) For the 2015-2016 contract year, the assumption is that all insurers have selected the 80 percent coverage level.

(IV) For the 2016-2017 contract year and subsequent contract years, the assumption is that all insurers have selected the 75 percent coverage level.

2. The retention multiple as determined under subparagraph 1. shall be adjusted to reflect the coverage level elected by the insurer.

a. For an insurer electing the maximum coverage level available under paragraph (4)(b) for a particular contract year ~~For insurers electing the 90-percent coverage level~~, the adjusted retention multiple is 100 percent of the amount

determined under subparagraph 1.

b. In order to implement the phase-in of reduced coverage levels as provided in paragraph (4)(b), for an insurer electing a coverage level other than the maximum coverage level, the adjusted retention multiple is as follows:

(I) With respect to the 2013-2014 contract year, for an insurer ~~For insurers~~ electing the 75-percent coverage level, the retention multiple is 90/75ths ~~120 percent~~ of the amount determined under subparagraph 1., and for an insurer ~~For insurers~~ electing the 45-percent coverage level, the adjusted retention multiple is 90/45ths ~~200 percent~~ of the amount determined under subparagraph 1.

(II) With respect to the 2014-2015 contract year, for an insurer electing the 75-percent coverage level, the retention multiple is 85/75ths of the amount determined under subparagraph 1., and for an insurer electing the 45-percent coverage level, the retention multiple is 85/45ths of the amount determined under subparagraph 1.

(III) With respect to the 2015-2016 contract year, for an insurer electing the 75-percent coverage level, the retention multiple is 80/75ths of the amount determined under subparagraph 1., and for an insurer electing the 45-percent coverage level, the retention multiple is 80/45ths of the amount determined under subparagraph 1.

(IV) With respect to the 2016-2017 contract year and subsequent contract years, for an insurer electing the 45-percent coverage level, the retention multiple is 75/45ths of the amount determined under subparagraph 1.

3. An insurer shall determine its provisional retention by multiplying its provisional reimbursement premium by the applicable adjusted retention multiple and shall determine its actual retention by multiplying its actual reimbursement premium by the applicable adjusted retention multiple.

4. For insurers who experience multiple covered events causing loss during the contract year, beginning June 1, 2005, each insurer's full retention shall be applied to each of the covered events causing the two largest losses for that insurer. For each other covered event resulting in losses, the insurer's retention shall be reduced to one-third of the full retention. The reimbursement contract shall provide for the reimbursement of losses for each covered event based on the full retention with adjustments made to reflect the reduced retentions on or after January 1 of the contract year provided the insurer reports its losses as specified in the reimbursement contract.

(n) "Corporation" means the State Board of Administration ~~Florida Hurricane Catastrophe Fund~~ Finance Corporation created in paragraph (6)(d).

(4) REIMBURSEMENT CONTRACTS.—

(b)1.a. The contract shall contain a promise by the board to reimburse the insurer for a specified percentage ~~45 percent, 75 percent, or 90 percent~~ of its losses from each covered event in excess of the insurer's retention, plus 10 ~~5~~ percent of the reimbursed losses to cover loss adjustment expenses.

b. The available coverage levels are as follows:

(I) For the 2013-2014 contract year, 90 percent, 75 percent, and 45 percent.

(II) For the 2014-2015 contract year, 85 percent, 75 percent, and 45 percent.

(III) For the 2015-2016 contract year, 80 percent, 75 percent, and 45 percent.

(IV) For the 2016-2017 contract year and subsequent contract years, 75 percent and 45 percent.

2.a. The insurer must elect one of the percentage coverage levels specified in this paragraph and may, upon renewal of a reimbursement contract, elect a lower percentage coverage level if no revenue bonds issued under subsection (6) after a covered event are outstanding, or elect a higher percentage coverage level, regardless of whether or not revenue bonds are outstanding. All members of an insurer group must elect the same percentage coverage level. Any joint underwriting association, risk apportionment plan, or other entity created under s. 627.351 must elect the maximum ~~90-percent~~ coverage level available under subparagraph 1.

b. In order to implement the phase-in of reduced coverage levels as provided in subparagraph 1., and notwithstanding any provisions of sub-subparagraph a. to the contrary, if revenue bonds issued under subsection (6) after a covered event are outstanding and the insurer has elected the maximum coverage level available under subparagraph 1., the insurer must, upon renewal of the reimbursement contract, elect the maximum coverage level available under subparagraph 1. for the renewal contract year.

3. The contract shall provide that reimbursement amounts shall not be reduced by reinsurance paid or payable to the

insurer from other sources.

~~4. Notwithstanding any other provision contained in this section, the board shall make available to insurers that purchased coverage provided by this subparagraph in 2008, insurers qualifying as limited apportionment companies under s. 627.351(6)(c), and insurers that have been approved to participate in the Insurance Capital Build-Up Incentive Program pursuant to s. 215.5595 a contract or contract addendum that provides an additional amount of reimbursement coverage of up to $10 million. The premium to be charged for this additional reimbursement coverage shall be 50 percent of the additional reimbursement coverage provided, which shall include one prepaid reinstatement. The minimum retention level that an eligible participating insurer must retain associated with this additional coverage layer is 30 percent of the insurer's surplus as of December 31, 2008, for the 2009-2010 contract year; as of December 31, 2009, for the 2010-2011 contract year; and as of December 31, 2010, for the 2011-2012 contract year. This coverage shall be in addition to all other coverage that may be provided under this section. The coverage provided by the fund under this subparagraph shall be in addition to the claims-paying capacity as defined in subparagraph (c)1., but only with respect to those insurers that select the additional coverage option and meet the requirements of this subparagraph. The claims-paying capacity with respect to all other participating insurers and limited apportionment companies that do not select the additional coverage option shall be limited to their reimbursement premium's proportionate share of the actual~~

~~claims-paying capacity otherwise defined in subparagraph (c)1. and as provided for under the terms of the reimbursement contract. The optional coverage retention as specified shall be accessed before the mandatory coverage under the reimbursement contract, but once the limit of coverage selected under this option is exhausted, the insurer's retention under the mandatory coverage will apply. This coverage will apply and be paid concurrently with mandatory coverage. This subparagraph expires on May 31, 2012.~~

(c)1. The contract shall also provide that the obligation of the board with respect to all contracts covering a particular contract year shall not exceed the actual claims-paying capacity of the fund up to the limit specified in this subparagraph.

a. For the 2013-2014 contract year, the limit is $17 billion.

b. For the 2014-2015 contract year, the limit is $16 billion.

c. For the 2015-2016 contract year, the limit is $15 billion.

d. For the 2016-2017 contract year and subsequent contract years, the limit is $14 billion.

e. For contract years after the 2016-2017 contract year, if ~~a limit of $17 billion for that contract year, unless~~ the board determines that there is sufficient estimated claims-paying capacity to provide $14 ~~$17~~ billion of capacity for the current contract year and an additional $14 ~~$17~~ billion of capacity for subsequent contract years~~. If the board makes such a determination~~, the estimated claims-paying capacity for the

particular contract year shall be determined by adding to the $14 ~~$17~~ billion limit one-half of the fund's estimated claims-paying capacity in excess of $28 ~~$34~~ billion. However, the dollar growth in the limit may not increase in any year by an amount greater than the dollar growth of the balance of the fund as of December 31~~, less any premiums or interest attributable to optional coverage~~, as defined by rule which occurred over the prior calendar year.

2. In May and October of the contract year, the board shall publish in the Florida Administrative Weekly a statement of the fund's estimated borrowing capacity, the fund's estimated claims-paying capacity, and the projected balance of the fund as of December 31. After the end of each calendar year, the board shall notify insurers of the estimated borrowing capacity, estimated claims-paying capacity, and the balance of the fund as of December 31 to provide insurers with data necessary to assist them in determining their retention and projected payout from the fund for loss reimbursement purposes. In conjunction with the development of the premium formula, as provided for in subsection (5), the board shall publish factors or multiples that assist insurers in determining their retention and projected payout for the next contract year. For all regulatory and reinsurance purposes, an insurer may calculate its projected payout from the fund as its share of the total fund premium for the current contract year multiplied by the sum of the projected balance of the fund as of December 31 and the estimated borrowing capacity for that contract year as reported under this subparagraph.

(6) REVENUE BONDS.—

(b) Emergency assessments—

1. If the board determines that the amount of revenue produced under subsection (5) is insufficient to fund the obligations, costs, and expenses of the fund and the corporation, including repayment of revenue bonds and that portion of the debt service coverage not met by reimbursement premiums, the board shall direct the Office of Insurance Regulation to levy, by order, an emergency assessment on direct premiums for all property and casualty lines of business in this state, including property and casualty business of surplus lines insurers regulated under part VIII of chapter 626, but not including any workers' compensation premiums or medical malpractice premiums. As used in this subsection, the term "property and casualty business" includes all lines of business identified on Form 2, Exhibit of Premiums and Losses, in the annual statement required of authorized insurers by s. 624.424 and any rule adopted under this section, except for those lines identified as accident and health insurance and except for policies written under the National Flood Insurance Program. The assessment shall be specified as a percentage of direct written premium and is subject to annual adjustments by the board in order to meet debt obligations. The same percentage shall apply to all policies in lines of business subject to the assessment issued or renewed during the 12-month period beginning on the effective date of the assessment.

2. A premium is not subject to an annual assessment under this paragraph in excess of 6 percent of premium with respect to

obligations arising out of losses attributable to any one contract year, and a premium is not subject to an aggregate annual assessment under this paragraph in excess of 10 percent of premium. An annual assessment under this paragraph shall continue as long as the revenue bonds issued with respect to which the assessment was imposed are outstanding, including any bonds the proceeds of which were used to refund the revenue bonds, unless adequate provision has been made for the payment of the bonds under the documents authorizing issuance of the bonds.

3. Emergency assessments shall be collected from policyholders. Emergency assessments shall be remitted by insurers as a percentage of direct written premium for the preceding calendar quarter as specified in the order from the Office of Insurance Regulation. The office shall verify the accurate and timely collection and remittance of emergency assessments and shall report the information to the board in a form and at a time specified by the board. Each insurer collecting assessments shall provide the information with respect to premiums and collections as may be required by the office to enable the office to monitor and verify compliance with this paragraph.

4. With respect to assessments of surplus lines premiums, each surplus lines agent shall collect the assessment at the same time as the agent collects the surplus lines tax required by s. 626.932, and the surplus lines agent shall remit the assessment to the Florida Surplus Lines Service Office created by s. 626.921 at the same time as the agent remits the surplus

lines tax to the Florida Surplus Lines Service Office. The emergency assessment on each insured procuring coverage and filing under s. 626.938 shall be remitted by the insured to the Florida Surplus Lines Service Office at the time the insured pays the surplus lines tax to the Florida Surplus Lines Service Office. The Florida Surplus Lines Service Office shall remit the collected assessments to the fund or corporation as provided in the order levied by the Office of Insurance Regulation. The Florida Surplus Lines Service Office shall verify the proper application of such emergency assessments and shall assist the board in ensuring the accurate and timely collection and remittance of assessments as required by the board. The Florida Surplus Lines Service Office shall annually calculate the aggregate written premium on property and casualty business, other than workers' compensation and medical malpractice, procured through surplus lines agents and insureds procuring coverage and filing under s. 626.938 and shall report the information to the board in a form and at a time specified by the board.

5. Any assessment authority not used for a particular contract year may be used for a subsequent contract year. If, for a subsequent contract year, the board determines that the amount of revenue produced under subsection (5) is insufficient to fund the obligations, costs, and expenses of the fund and the corporation, including repayment of revenue bonds and that portion of the debt service coverage not met by reimbursement premiums, the board shall direct the Office of Insurance Regulation to levy an emergency assessment up to an amount not

exceeding the amount of unused assessment authority from a previous contract year or years, plus an additional 4 percent provided that the assessments in the aggregate do not exceed the limits specified in subparagraph 2.

6. The assessments otherwise payable to the corporation under this paragraph shall be paid to the fund unless and until the Office of Insurance Regulation and the Florida Surplus Lines Service Office have received from the corporation and the fund a notice, which shall be conclusive and upon which they may rely without further inquiry, that the corporation has issued bonds and the fund has no agreements in effect with local governments under paragraph (c). On or after the date of the notice and until the date the corporation has no bonds outstanding, the fund shall have no right, title, or interest in or to the assessments, except as provided in the fund's agreement with the corporation.

7. Emergency assessments are not premium and are not subject to the premium tax, to the surplus lines tax, to any fees, or to any commissions. An insurer is liable for all assessments that it collects and must treat the failure of an insured to pay an assessment as a failure to pay the premium. An insurer is not liable for uncollectible assessments.

8. When an insurer is required to return an unearned premium, it shall also return any collected assessment attributable to the unearned premium. A credit adjustment to the collected assessment may be made by the insurer with regard to future remittances that are payable to the fund or corporation, but the insurer is not entitled to a refund.

9. When a surplus lines insured or an insured who has procured coverage and filed under s. 626.938 is entitled to the return of an unearned premium, the Florida Surplus Lines Service Office shall provide a credit or refund to the agent or such insured for the collected assessment attributable to the unearned premium prior to remitting the emergency assessment collected to the fund or corporation.

~~10. The exemption of medical malpractice insurance premiums from emergency assessments under this paragraph is repealed May 31, 2013, and medical malpractice insurance premiums shall be subject to emergency assessments attributable to loss events occurring in the contract years commencing on June 1, 2013.~~

(d) State Board of Administration ~~Florida Hurricane Catastrophe Fund~~ Finance Corporation.—

1. In addition to the findings and declarations in subsection (1), the Legislature also finds and declares that:

a. The public benefits corporation created under this paragraph will provide a mechanism necessary for the cost-effective and efficient issuance of bonds. This mechanism will eliminate unnecessary costs in the bond issuance process, thereby increasing the amounts available to pay reimbursement for losses to property sustained as a result of hurricane damage.

b. The purpose of such bonds is to fund reimbursements through the Florida Hurricane Catastrophe Fund to pay for the costs of construction, reconstruction, repair, restoration, and other costs associated with damage to properties of

policyholders of covered policies due to the occurrence of a hurricane.

c. The efficacy of the financing mechanism will be enhanced by the corporation's ownership of the assessments, by the insulation of the assessments from possible bankruptcy proceedings, and by covenants of the state with the corporation's bondholders.

2.a. There is created a public benefits corporation, which is an instrumentality of the state, to be known as the State Board of Administration ~~Florida Hurricane Catastrophe Fund~~ Finance Corporation.

b. The corporation shall operate under a five-member board of directors consisting of the Governor or a designee, the Chief Financial Officer or a designee, the Attorney General or a designee, the director of the Division of Bond Finance of the State Board of Administration, and the Chief Operating Officer ~~senior employee of the State Board of Administration responsible for operations~~ of the Florida Hurricane Catastrophe Fund.

c. The corporation has all of the powers of corporations under chapter 607 and under chapter 617, subject only to the provisions of this subsection.

d. The corporation may issue bonds and engage in such other financial transactions as are necessary to provide sufficient funds to achieve the purposes of this section.

e. The corporation may invest in any of the investments authorized under s. 215.47.

f. There shall be no liability on the part of, and no cause of action shall arise against, any board members or

employees of the corporation for any actions taken by them in the performance of their duties under this paragraph.

3.a. In actions under chapter 75 to validate any bonds issued by the corporation, the notice required by s. 75.06 shall be published in two newspapers of general circulation in the state, and the complaint and order of the court shall be served only on the State Attorney of the Second Judicial Circuit.

b. The state hereby covenants with holders of bonds of the corporation that the state will not repeal or abrogate the power of the board to direct the Office of Insurance Regulation to levy the assessments and to collect the proceeds of the revenues pledged to the payment of such bonds as long as any such bonds remain outstanding unless adequate provision has been made for the payment of such bonds pursuant to the documents authorizing the issuance of such bonds.

4. The bonds of the corporation are not a debt of the state or of any political subdivision, and neither the state nor any political subdivision is liable on such bonds. The corporation does not have the power to pledge the credit, the revenues, or the taxing power of the state or of any political subdivision. The credit, revenues, or taxing power of the state or of any political subdivision shall not be deemed to be pledged to the payment of any bonds of the corporation.

5.a. The property, revenues, and other assets of the corporation; the transactions and operations of the corporation and the income from such transactions and operations; and all bonds issued under this paragraph and interest on such bonds are exempt from taxation by the state and any political subdivision,

including the intangibles tax under chapter 199 and the income tax under chapter 220. This exemption does not apply to any tax imposed by chapter 220 on interest, income, or profits on debt obligations owned by corporations other than the State Board of Administration ~~Florida Hurricane Catastrophe Fund~~ Finance Corporation.

b. All bonds of the corporation shall be and constitute legal investments without limitation for all public bodies of this state; for all banks, trust companies, savings banks, savings associations, savings and loan associations, and investment companies; for all administrators, executors, trustees, and other fiduciaries; for all insurance companies and associations and other persons carrying on an insurance business; and for all other persons who are now or may hereafter be authorized to invest in bonds or other obligations of the state and shall be and constitute eligible securities to be deposited as collateral for the security of any state, county, municipal, or other public funds. This sub-subparagraph shall be considered as additional and supplemental authority and shall not be limited without specific reference to this sub-subparagraph.

6. The corporation and its corporate existence shall continue until terminated by law; however, no such law shall take effect as long as the corporation has bonds outstanding unless adequate provision has been made for the payment of such bonds pursuant to the documents authorizing the issuance of such bonds. Upon termination of the existence of the corporation, all of its rights and properties in excess of its obligations shall

pass to and be vested in the state.

7. The State Board of Administration Finance Corporation is for all purposes the successor to the Florida Hurricane Catastrophe Fund Finance Corporation.

Section 2. Effective June 1, 2013, subsections (17) and (18) of section 215.555, Florida Statutes, are renumbered as subsections (16) and (17), respectively, and present subsection (16) of that section is amended to read:

215.555 Florida Hurricane Catastrophe Fund.—

~~(16) TEMPORARY EMERGENCY OPTIONS FOR ADDITIONAL COVERAGE.—~~

~~(a) Findings and intent.—~~

~~1. The Legislature finds that:~~

~~a. Because of temporary disruptions in the market for catastrophic reinsurance, many property insurers were unable to procure reinsurance for the 2006 hurricane season with an attachment point below the insurers' respective Florida Hurricane Catastrophe Fund attachment points, were unable to procure sufficient amounts of such reinsurance, or were able to procure such reinsurance only by incurring substantially higher costs than in prior years.~~

~~b. The reinsurance market problems were responsible, at least in part, for substantial premium increases to many consumers and increases in the number of policies issued by the Citizens Property Insurance Corporation.~~

~~c. It is likely that the reinsurance market disruptions will not significantly abate prior to the 2007 hurricane season.~~

~~2. It is the intent of the Legislature to create a temporary emergency program, applicable to the 2007, 2008, and~~

~~2009 hurricane seasons, to address these market disruptions and enable insurers, at their option, to procure additional coverage from the Florida Hurricane Catastrophe Fund.~~

~~(b) Applicability of other provisions of this section.—All provisions of this section and the rules adopted under this section apply to the program created by this subsection unless specifically superseded by this subsection.~~

~~(c) Optional coverage.—For the contract year commencing June 1, 2007, and ending May 31, 2008, the contract year commencing June 1, 2008, and ending May 31, 2009, and the contract year commencing June 1, 2009, and ending May 31, 2010, the board shall offer for each of such years the optional coverage as provided in this subsection.~~

~~(d) Additional definitions.—As used in this subsection, the term:~~

~~1. "TEACO options" means the temporary emergency additional coverage options created under this subsection.~~

~~2. "TEACO insurer" means an insurer that has opted to obtain coverage under the TEACO options in addition to the coverage provided to the insurer under its reimbursement contract.~~

~~3. "TEACO reimbursement premium" means the premium charged by the fund for coverage provided under the TEACO options.~~

~~4. "TEACO retention" means the amount of losses below which a TEACO insurer is not entitled to reimbursement from the fund under the TEACO option selected. A TEACO insurer's retention options shall be calculated as follows:~~

~~a. The board shall calculate and report to each TEACO~~

~~insurer the TEACO retention multiples. There shall be three TEACO retention multiples for defining coverage. Each multiple shall be calculated by dividing $3 billion, $4 billion, or $5 billion by the total estimated mandatory FHCF reimbursement premium assuming all insurers selected the 90-percent coverage level.~~

~~b. The TEACO retention multiples as determined under sub-subparagraph a. shall be adjusted to reflect the coverage level elected by the insurer. For insurers electing the 90-percent coverage level, the adjusted retention multiple is 100 percent of the amount determined under sub-subparagraph a. For insurers electing the 75-percent coverage level, the retention multiple is 120 percent of the amount determined under sub-subparagraph a. For insurers electing the 45-percent coverage level, the adjusted retention multiple is 200 percent of the amount determined under sub-subparagraph a.~~

~~c. An insurer shall determine its provisional TEACO retention by multiplying its estimated mandatory FHCF reimbursement premium by the applicable adjusted TEACO retention multiple and shall determine its actual TEACO retention by multiplying its actual mandatory FHCF reimbursement premium by the applicable adjusted TEACO retention multiple.~~

~~d. For TEACO insurers who experience multiple covered events causing loss during the contract year, the insurer's full TEACO retention shall be applied to each of the covered events causing the two largest losses for that insurer. For other covered events resulting in losses, the TEACO option does not apply and the insurer's retention shall be one-third of the full~~

~~retention as calculated under paragraph (2)(c).~~

~~5. "TEACO addendum" means an addendum to the reimbursement contract reflecting the obligations of the fund and TEACO insurers under the program created by this subsection.~~

~~6. "FHCF" means the Florida Hurricane Catastrophe Fund.~~

~~(e) TEACO addendum.~~

~~1. The TEACO addendum shall provide for reimbursement of TEACO insurers for covered events occurring during the contract year, in exchange for the TEACO reimbursement premium paid into the fund under paragraph (f). Any insurer writing covered policies has the option of choosing to accept the TEACO addendum for any of the 3 contract years that the coverage is offered.~~

~~2. The TEACO addendum shall contain a promise by the board to reimburse the TEACO insurer for 45 percent, 75 percent, or 90 percent of its losses from each covered event in excess of the insurer's TEACO retention, plus 5 percent of the reimbursed losses to cover loss adjustment expenses. The percentage shall be the same as the coverage level selected by the insurer under paragraph (4)(b).~~

~~3. The TEACO addendum shall provide that reimbursement amounts shall not be reduced by reinsurance paid or payable to the insurer from other sources.~~

~~4. The TEACO addendum shall also provide that the obligation of the board with respect to all TEACO addenda shall not exceed an amount equal to two times the difference between the industry retention level calculated under paragraph (2)(c) and the $3 billion, $4 billion, or $5 billion industry TEACO retention level options actually selected, but in no event may~~

~~the board's obligation exceed the actual claims-paying capacity of the fund plus the additional capacity created in paragraph (g). If the actual claims-paying capacity and the additional capacity created under paragraph (g) fall short of the board's obligations under the reimbursement contract, each insurer's share of the fund's capacity shall be prorated based on the premium an insurer pays for its mandatory reimbursement coverage and the premium paid for its optional TEACO coverage as each such premium bears to the total premiums paid to the fund times the available capacity.~~

~~5. The priorities, schedule, and method of reimbursements under the TEACO addendum shall be the same as provided under subsection (4).~~

~~6. A TEACO insurer's maximum reimbursement for a single event shall be equal to the product of multiplying its mandatory FHCF premium by the difference between its FHCF retention multiple and its TEACO retention multiple under the TEACO option selected and by the coverage selected under paragraph (4)(b), plus an additional 5 percent for loss adjustment expenses. A TEACO insurer's maximum reimbursement under the TEACO option selected for a TEACO insurer's two largest events shall be twice its maximum reimbursement for a single event.~~

~~(f) TEACO reimbursement premiums.~~

~~1. Each TEACO insurer shall pay to the fund, in the manner and at the time provided in the reimbursement contract for payment of reimbursement premiums, a TEACO reimbursement premium calculated as specified in this paragraph.~~

~~2. The insurer's TEACO reimbursement premium associated~~

~~with the $3 billion retention option shall be equal to 85 percent of a TEACO insurer's maximum reimbursement for a single event as calculated under subparagraph (c)6. The TEACO reimbursement premium associated with the $4 billion retention option shall be equal to 80 percent of a TEACO insurer's maximum reimbursement for a single event as calculated under subparagraph (c)6. The TEACO premium associated with the $5 billion retention option shall be equal to 75 percent of a TEACO insurer's maximum reimbursement for a single event as calculated under subparagraph (c)6.~~

~~(g) Effect on claims-paying capacity of the fund.—For the contract term commencing June 1, 2007, the contract year commencing June 1, 2008, and the contract term beginning June 1, 2009, the program created by this subsection shall increase the claims-paying capacity of the fund as provided in subparagraph (4)(c)1. by an amount equal to two times the difference between the industry retention level calculated under paragraph (2)(e) and the $3 billion industry TEACO retention level specified in sub-subparagraph (d)4.a. The additional capacity shall apply only to the additional coverage provided by the TEACO option and shall not otherwise affect any insurer's reimbursement from the fund.~~

Section 3. Subsection (5) of section 627.062, Florida Statutes, is amended to read:

627.062 Rate standards.—

(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund,

the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the fund, together with reasonable costs of other reinsurance~~; however, except as otherwise provided in this section, the insurer may not recoup reinsurance costs that duplicate coverage provided by the fund~~. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium, and any over-recoupment must be subtracted from the following year's reimbursement premium.

Section 4. Subsection (5) of section 627.0629, Florida Statutes, is amended to read:

627.0629 Residential property insurance; rate filings.—

(5) In order to provide an appropriate transition period, an insurer may implement an approved rate filing for residential property insurance over a period of years. Such insurer must provide an informational notice to the office setting out its schedule for implementation of the phased-in rate filing. The insurer may include in its rate the actual cost of private market reinsurance that corresponds to available coverage of the Temporary Increase in Coverage Limits, TICL, from the Florida Hurricane Catastrophe Fund. The insurer may also include the cost of reinsurance to replace the TICL reduction implemented pursuant to s. 215.555(16)(d)9. ~~215.555(17)(d)9.~~ However, this cost for reinsurance may not include any expense or profit load or result in a total annual base rate increase in excess of 10 percent.

Section 5. Except as otherwise expressly provided in this

act, this act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1107 Florida Hurricane Catastrophe Fund
SPONSOR(S): Hager
TIED BILLS: **IDEN./SIM. BILLS:** HB 1055

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Callaway	Cooper
2) Government Operations Appropriations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

The Florida Hurricane Catastrophe Fund (FHCF or Fund) is a tax-exempt trust fund created as a form of reinsurance for residential property insurers. The Fund reimburses (reinsures) insurers for a portion of their hurricane losses to residential property. Each insurance company writing insurance policies covering residential property or any policy covering a residential structure or its contents must participate in the FHCF. The deductible amount insurers must pay for reinsurance in the FHCF is set by statute and the maximum amount of coverage from the FHCF insurers can buy is also set by statute.

The overarching goal of the bill is to restructure the FHCF to reduce the size and exposure of the FHCF so that the Fund relies less on bonding and more on cash resources to pay its obligations to insurers. This will also result in a reduced likelihood and reduced amount of assessments against property and casualty policyholders. The bill implements most of the FHCF coverage changes over three years, from 2014 to 2016. Specifically, the FHCF restructuring proposed by the bill:

- reduces the size of the mandatory coverage,
- increases the participating insurer co-pay,
- increases loss adjustment expenses reimbursed by the FHCF,
- permanently exempts medical malpractice premiums from the FHCF assessment, and
- changes the name of the finance corporation used for bonding by the FHCF.

The bill repeals current law that allows commercial self-insurance funds to buy reinsurance in the FHCF and repeals outdated provisions in the FHCF law.

Currently, some insurers purchase private reinsurance duplicating FHCF coverage to insure against any shortfalls of the Fund. If purchased, current law prohibits these reinsurance costs from being recouped in rates. The bill repeals the prohibition in current law and allows these costs to be recouped in rates, meaning the costs would ultimately be passed on to the insurer's policyholders.

In 2014, property insurance rates should increase due to the bill's restructuring of the FHCF as insurers replace reinsurance sold by the FHCF with more expensive reinsurance sold by private reinsurers. Rates are likely to increase until the bill is fully implemented, in 2016. Estimates vary as to the amount of rate increase, as discussed in the fiscal analysis. If private reinsurance costs decrease during the implementation period, then the rate increases associated with the changes to the FHCF made by the bill could be offset by the decrease in these costs. Rates will increase for insurers who buy reinsurance duplicating FHCF reinsurance because the bill allows these reinsurance costs to be included in rates and thus passed on to policyholders. This rate increase will occur in the year the insurer purchases the private reinsurance, which could be 2013. Citizens Property Insurance Corporation, insurer solvency, and timely payment of homeowner's insurance claims may also be impacted by the bill. These impacts are discussed further in the fiscal analysis. The bill has no fiscal impact on state or local governments. The bill is effective upon becoming a law, unless expressly provided otherwise.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The Florida Hurricane Catastrophe Fund (FHCF or Fund) is a tax-exempt trust fund created in 1993 as a form of reinsurance for residential property insurers.[1] The purpose of the FHCF is to protect and advance the state's interest in maintaining insurance capacity in Florida by providing reimbursements to insurers for a portion of their catastrophic hurricane losses.

The FHCF sells reinsurance to property insurance companies significantly cheaper than reinsurance sold by private reinsurance companies. It is estimated that coverage purchased through the FHCF costs insurers one-fourth to one-third what it would cost in the private reinsurance market.[2] There are several reasons for these cost savings:[3]

1. The FHCF operating cost is less than 1% of the annual premium collected, whereas, the operating costs for private reinsurance can range from 10% to 15% of the premium collected.
2. The FHCF does not pay reinsurance brokerage commissions.
3. The FHCF has no underwriting costs.
4. The FHCF is a tax-exempt entity that does not pay federal income taxes or state taxes.
5. The FHCF has the ability to issue tax-exempt debt which results in lower financing costs should it become necessary to finance losses with revenue bonds.
6. The FHCF does not include a factor for profit for reinsurance sold by the FHCF.
7. The FHCF does not include a risk load for reinsurance sold by the FHCF.

Each insurance company writing insurance policies covering residential property or any policy covering a residential structure or its contents must participate in the FHCF. (s. 215.555(4)(a), F.S. and s. 215.555(2)(c), F.S.). Residential property is defined in s. 627.4025(1), F.S. to include personal lines and commercial lines residential coverage. This coverage includes the following insurance policies: homeowner's, mobile homeowner's, dwelling, tenant's, condominium unit owner's, condominium association, cooperative association, and apartment building.

The FHCF is administered by the State Board of Administration and reimburses property insurers for a selected percentage (45, 75, or 90%) of hurricane losses to residential property above the insurer's retention (deductible).[4] The amount of hurricane losses the FHCF will not reimburse (45, 25, or 10%) is the insurer's co-pay for FHCF reinsurance. Insurers finance the co-pay with funds from insurance premiums paid by homeowners or with private reinsurance. Most property insurers select the 90% coverage level, meaning the FHCF will reimburse the insurer 90% of the insurer's specified hurricane losses with the insurer paying the remaining co-pay of 10% from other sources.

A reimbursement contract between the FHCF and the property insurer governs an insurer's participation in the FHCF and the percentage of the insurer's reimbursement. Reimbursement contracts run from June 1st–May 30th. The current contract year (2012-2013 contract year) runs from June 1, 2012–May 30, 2013.

The FHCF must offer two options for reinsurance coverage for all residential property insurers. One of the two options is mandatory and thus must be purchased by all insurers on their residential property exposure. The voluntary coverage option, Temporary Increase In Coverage Limit Options (TICL), offers reinsurance to insurers above the mandatory coverage.

---

[1] s. 215.555, F.S. The FHCF was created after Hurricane Andrew in 1992.
[2] Annual Report of the Florida Hurricane Catastrophe Fund Fiscal Year 2010-2011, p. 19.
[3] Annual Report of the Florida Hurricane Catastrophe Fund Fiscal Year 2010-2011, p. 19.
[4] Retention is defined to mean the amount of losses below which an insurer is not entitled to reimbursement from the Fund. A retention is calculated for each insurer based on its proportionate share of Fund premiums.

For the mandatory coverage, the FHCF charges insurers the "actuarially indicated" premium for the coverage provided by the FHCF, based on hurricane loss projection models found acceptable by the Florida Commission on Hurricane Loss Projection Methodology. Each insurer's premium amount for mandatory coverage is different because the premium is based on the insured value of the residential property the insurer insures, the location of the property insured, the construction type of the property insured, the deductible amounts for the property insured, and other factors. The premium for mandatory coverage also includes a cash build-up factor which is charged on top of the actuarially indicated premium. For the 2012-2013 contract year, the cash build-up factor is 20%, meaning an insurer's premium is 20% greater than the actuarially indicated premium. The cash build-up factor increases by 5% each year until it is 25% (2013-2014 contract year).

Florida law sets the maximum amount the FHCF reimburses insurers each year for the mandatory coverage.[5] This is the FHCF's capacity. Under current law, the FHCF's capacity is $17 billion for each contract year. The capacity does not increase until the FHCF's cash and bonding ability exceeds $34 billion. This allows the FHCF to accumulate funds to pay the maximum mandatory coverage FHCF obligations ($17 billion a year) for claims resulting from hurricanes in back-to-back seasons.[6] Once a $34 billion funding level is reached by the FHCF, the FHCF's capacity will increase. The method for calculating the Fund's capacity under current law allows the FCHF's cash balance to grow in years where there are no hurricanes while keeping the FHCF's exposure (capacity) frozen so that the FHCF is less reliant on bonding to meet its mandatory coverage obligations. For the current contract year, the insurance industry as a whole is covered for losses up to $17 billion by the mandatory coverage.

Before FHCF monies are available to pay claims each insurer must meet a retention/deductible. The retention amount for each insurer is different because the amount is based on the amount of premium the insurer pays to the FHCF. For the 2012-2013 contract year, the insurance industry as a whole has an aggregate retention of $7.389 billion for mandatory coverage, meaning the total of all individual insurer retentions/deductibles will total $7.389 billion per hurricane event if all participating insurers reached their retention. Although the insurance industry's aggregate deductible/retention totals $7.389 billion, insurers can obtain reimbursement from the FHCF before the insurance industry losses total $7.389 billion because loss recovery from the FHCF is based on an individual insurer meeting its own retention for mandatory coverage prior to losses being reimbursed.

The TICL options were added to the FHCF in 2007.[7] The purchase of these options is voluntary and if purchased provides the insurer a share of additional coverage above the mandatory FHCF coverage in $1 billion increments. When the TICL options were created in 2007, $12 billion of additional FHCF coverage was available for purchase. However, due to the statutory reductions in TICL options available, for the 2012-2013 Fund contract year, only $4 billion is available for purchase.[8] Of the $4 billion available in TICL coverage this contract year, $0.023 billion was purchased by insurance companies, representing less than 1% of the available coverage. By law, the 2013-2014 contract year is the last contract year TICL options can be purchased by insurers.

For the 2012-13 contract year (June 1, 2012–May 31, 2013), the maximum amount the FHCF would have to reimburse insurers is $17.023 billion, allocated as follows:

- $17 billion for the mandatory coverage.
- $.023 billion for the TICL coverage option.[9]

To fund its obligations of $17.023 billion the FHCF has $8.503 billion in cash.

---

[5] s. 215.555(4)(c)1., F.S.
[6] The funds may be accumulated from premiums and bonding.
[7] Ch. 2007-1, L.O.F.
[8] Under current law, the maximum amount of TICL coverage offered for purchase by the FHCF decreases by $2 billion each contract year.
[9] Report of Claims-Paying Capacity Estimates dated October 9, 2012, available at http://www.sbafla.com/fhcf/AdvisoryCouncil/2012MeetingMaterials/tabid/1311/Default.aspx (last accessed March 8, 2013).

Because the obligations of the FHCF exceed the cash of the FHCF by approximately $8.5 billion, if the FHCF had to pay its maximum actual obligations of $17.023 billion in the 2012-2013 contract year, the FHCF would have to bond for additional funds of $8.5 billion to pay claims. In October 2012, the Fund estimated it could borrow $7 billion through bonding.[10] Thus, the FHCF would be short $1.5 billion to pay claims. However, it is noteworthy that the projected shortfall of $1.5 billion is for the contract year ending on May 31, 2013. Absent a major hurricane before the current contract year expires, the projected shortfall for the hurricane season beginning on June 1, 2013, should be lower. This is because the FHCF will receive additional revenue from the collection of premium for the 2013-2014 contract year. The current estimated additional premium is approximately $1.1 billion.[11]

Revenue bonds issued by the FHCF to pay claims when the FHCF's funds are inadequate are funded by emergency assessments on property and casualty policyholders.[12] The FHCF is authorized to levy emergency assessments against all property and casualty insurance premiums paid by policyholders (other than workers' compensation, accident and health, federal flood and, until May 31, 2013, medical malpractice), including surplus lines policyholders, when reimbursement premiums and other FHCF resources are insufficient to cover the FHCF's obligations.[13] Annual assessments are capped at 6% of premium with respect to losses from any one year and a maximum of 10% of premium to fund hurricane losses from multiple years.[14] Revenue bonds issued by the FHCF may be amortized over a term up to 30 years. Thus, the FHCF may levy assessments for as long as 30 years.

Currently, the FHCF is levying an assessment of 1.3% of premium against all property and casualty insurance policyholders subject to the assessment.[15] Typically, insurers pass this assessment directly to policyholders. The current FHCF assessment is due to a deficit in the Fund associated with the 2005 hurricanes. This is the first assessment the FHCF has had to levy to cover a deficit since its creation in 1993. The current assessment of 1.3% will be levied until December 31, 2016.

Effect of Proposed Changes

The overarching goal of the bill is to restructure the FHCF to reduce the size and exposure of the FHCF so that the Fund relies less on bonding and more on cash resources to pay its obligations to insurers. This will also result in a reduced likelihood and reduced amount of assessments against property and casualty policyholders.

The bill implements most of the FHCF coverage changes over three years, from 2014 to 2016.

Specifically, the FHCF restructuring proposed by the bill:

- reduces the size of the mandatory coverage,
- increases the participating insurer co-pay,
- increases loss adjustment expenses reimbursed by the FHCF,
- permanently exempts medical malpractice premiums from the FHCF assessment, and
- changes the name of the finance corporation used for bonding by the FHCF.

The bill also allows private reinsurance costs for FHCF duplicate coverage in property insurance rate filings. It repeals current law relating to FHCF coverage below the retention which has expired by operation of law and repeals current law that allows commercial self-insurance funds to buy reinsurance in the FHCF.

---

[10] https://www.flrules.org/gateway/readFile.asp?sid=12&tid=12136269&type=1&File=19.htm (last accessed March 8, 3013).

[11] The additional $1.1 billion is not all collected at the beginning of the contract year. Instead, it is collected quarterly. Thus, the entire $1.1 billion will not be available to pay claims starting June 1, 2013.

[12] s. 215.555(6)(a)1., F.S.; s. 215.555(6)(b)1., F.S.

[13] s. 215.555(6)(b)1., F.S.; s. 215.555(6)(b)(10), F.S.

[14] s. 215.555(6)(b)2., F.S.

[15] A 1% assessment was levied and paid by insurers from January 1, 2007–December 31, 2010. The 1% assessment was increased to 1.3% on January 1, 2011 due to increasing losses from the 2005 hurricanes.

Reduces the Size of the Mandatory Coverage

Over a three year period starting in 2014, the bill reduces the limits of the FHCF mandatory coverage from the current $17 billion. For the 2014-2015 contract year, the limit is reduced to $16 billion; for the 2015-2016 contract year, the limit is reduced to $15 billion; and for the 2016-2017 and subsequent contract years, the limit is reduced to $14 billion. After the 2016-2017 contract year, the limit will be more than $14 billion only if the FHCF has enough funding to fully fund a $14 billion single season and a $14 billion second season capacity (a total of $28 billion in funding). The current $17 billion mandatory coverage maximum stays in effect for the 2013-2014 contract year.

The change to the mandatory coverage will reduce the FHCF's reliance on large bonding transactions to raise funds to pay claims. Currently, if the FHCF had to pay its obligations in full, the FHCF is $8.5 billion short in funding and is relying on bonding to raise the needed funds. In fact, the Fund's financial advisors estimate the Fund could only borrow $7 billion through bonding in the current financial market. Thus, the Fund has a potential shortfall of over $1.5 billion.

Because of the current fluctuating financial markets, there is a great deal of risk and uncertainty associated with large bond transactions, making large bond transactions impossible or extremely expensive. Under current law, the FHCF is only obligated to use cash on hand and funds raised through bonding to reimburse insurers for claims.[16] Thus, if the FHCF cannot raise enough funds through bonding to pay its obligations, then the FHCF is not required to pay all its obligations to insurers. This could be problematic for insurers as they rely on the Fund being able to reimburse them for claims when constructing their business model for catastrophes. Insurers do not typically purchase private reinsurance to duplicate reinsurance bought from the FHCF as duplicative reinsurance costs cannot be passed through to policyholders in a rate filing and thus is an added expense for the insurer that cannot be recouped. Furthermore, keeping bonding costs as low as possible is important because bonding costs are included in the calculation of assessments levied by the FHCF and passed through to most property and casualty policyholders.

Reducing the mandatory coverage of the FHCF will likely result in increased property insurance rates for homeowners, if all other costs to the insurer factored into rates are static. Reinsurance purchased from the FHCF is considerably cheaper than reinsurance purchased from private reinsurance companies. It is estimated that coverage purchased through the FHCF costs insurers between one-fourth to one-third what it would cost in the private reinsurance market.[17] For solvency reasons, property insurers are required by the Office of Insurance Regulation (OIR) to purchase reinsurance.[18] Reducing the mandatory coverage layer of the FHCF will require most property insurers to replace FHCF reinsurance with more expensive reinsurance from private reinsurers. The increased reinsurance costs will be passed through to homeowners.[19]

Increases the Participating Insurer Co-Pay

The bill increases the participating insurer co-pay by reducing the maximum available coverage percentage from the current 90% (a co-pay of 10%) over a three-year period. For the 2014-2015 contract year, the maximum available percentage is 85% (a co-pay of 15%); for the 2015-2016 contract year, the maximum available percentage is 80% (a co-pay of 20%); and for the 2016-2017 and subsequent contract years, maximum available percentage is 75% (a co-pay of 25%). The current lower coverage percentages of 45% (a co-pay of 55%) and 75% (a co-pay of 25%) are still available each year.

An increased insurer co-pay reduces the amount the FHCF pays in claims which decreases the likelihood of assessments levied by the FHCF. Increasing the insurer co-pay will also encourage

---

[16] s. 215.555(2)(m), F.S.; s. 215.555(4)(c)1., F.S.

[17] Annual Report of the Florida Hurricane Catastrophe Fund Fiscal Year 2009-2010 , p. 18.

[18] The amount of reinsurance required to be purchased varies from insurer to insurer and is based, in part, on the insurer's exposure and funds on hand to pay claims.

[19] Section 627.062(2)(b), F.S. requires the OIR to consider reinsurance costs when reviewing a rate filing for approval. Section 627.062(2)(k), F.S. allows insurers to make an expedited rate filing in order to change rates based solely on reinsurance costs.

insurers to exercise diligence in claim settlement practice with homeowners because insurers will obtain less reimbursement from the FHCF for settled claims.

Increasing the insurer co-pay, however, could increase property insurance rates from 2014-2016. Increasing the insurer co-pay for claims covered by FHCF reinsurance means insurers will either purchase private reinsurance to replace the increased co-pay or use funds on hand to pay the increased co-pay. If the insurer purchases private reinsurance to replace the increased co-pay, then the cost for this reinsurance can be included in a rate filing as justification for a rate increase, and thus passed on to homeowners. After 2016, the insurer co-pay amount does not change so rates should not increase due to the insurer co-pay.

To implement the phase-in of increased insurer co-pays and resulting reduced Fund coverage percentage, the bill requires insurers that choose the maximum coverage percentage (which means the smallest co-pay) in one year to choose the same coverage percentage the following year if the Fund has revenue bonds outstanding.

Increases Loss Adjustment Expenses Reimbursed by the FHCF
Under current law, the FHCF reimburses an insurer for the percentage of losses selected by the insurer (currently, 90%, 75%, or 45%) plus an additional five percent. The additional five percent reimburses the insurer for loss adjustment expenses. Loss adjustment expenses are expenses associated with an insurer investigating and settling insurance claims, including the cost of defending a lawsuit in court.[20] The expense amount can vary from claim to claim depending on the complexity of the claim. The bill increases the percentage for loss adjustment expenses reimbursed by the Fund to insurers from 5 percent to 10 percent of reimbursed losses.

Permanently Exempts Medical Malpractice Premiums from the FHCF Assessment:
Revenue bonds are issued by the FHCF to pay claims when the FHCF's funds are inadequate. These bonds are funded by emergency assessments levied by the FHCF against property and casualty insurance premiums paid by policyholders (other than workers' compensation, accident and health, federal flood and, until May 31, 2013, medical malpractice), including surplus lines policyholders.[21] The FHCF assessment base is over $34.6 billion.[22] Annual assessments are capped at 6% of premium with respect to losses from any one year and a maximum of 10% of premium to fund hurricane losses from multiple years.[23]

The bill allows medical malpractice insurance policyholders to be exempt from FHCF assessments permanently. Although these policyholders are currently exempt from the assessment base, they will be added to the base starting June 1, 2013 because their exemption expires on May 31, 2013.

Changes the Name of the Finance Corporation Used For Bonding By the FHCF The bill changes the name of the Florida Hurricane Catastrophe Fund Finance Corporation to the "State Board of Administration Finance Corporation." The Florida Hurricane Catastrophe Fund Finance Corporation is the corporation that issues revenue bonds for the Florida Hurricane Catastrophe Fund. The Florida Hurricane Catastrophe Fund Corporation had long-term ratings of Aa3/AA-/AA from Moody's, Standard and Poor's, and Fitch, respectively.[24]

---

[20] http://www2.iii.org/glossary/l/ (last accessed March 8, 2013).
[21] s. 215.555(6)(b)1., F.S.; s. 215.555(6)(b)(10), F.S.
[22] Assessment base total is as of the end of 2011. See Report Prepared for the Florida Hurricane Catastrophe Fund on Claims-Paying Capacity Estimates by Raymond James Public Finance Department, dated October 9, 2012, available at http://www.sbafla.com/fhcf/AdvisoryCouncil/2012MeetingMaterials/tabid/1311/Default.aspx (last accessed February 27, 2013).
[23] s. 215.555(6)(b)2., F.S.
[24] Report Prepared for the Florida Hurricane Catastrophe Fund Claims-Paying Capacity Estimates, dated October 9, 2012, available at http://www.sbafla.com/fhcf/AdvisoryCouncil/2012MeetingMaterials/tabid/1311/Default.aspx (last accessed March 5, 2013).

This change should not impact property insurance rates. However, the change may prevent confusion among bond purchasers with other types of catastrophe bonding and may make bonds issued by the FHCF easier to sell at a lower price.

Allows Costs for FHCF Duplicate Coverage in Property Insurance Rate Filings

The Rating Law for property, casualty, and surety insurance is located in Part I of ch. 627, F.S., (ss. 627.011 – 627.311, F.S.). The primary purpose of the Rating Law is to ensure insurance rates are not excessive, inadequate, or unfairly discriminatory. This standard applies to every property insurance rate.

Section 627.0645, F.S, requires every property insurance company to make a rate filing with the OIR each year. The rate filing contains the insurance company's proposed rates. The OIR reviews the rate filing and either approves or disapproves the proposed rates. If an insurance company does not want to change its rates one year, instead of a rate filing, the insurer can file a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate.

In determining whether a rate is excessive, inadequate, or unfairly discriminatory, the OIR uses the following statutory factors.[25]

- Past and prospective loss experience in Florida and in other jurisdictions.
- Past and prospective expenses.
- Degree of competition to insure the risk.
- Investment income reasonably expected by the insurer.
- Reasonableness of the judgment reflected in the filing.
- Dividends, savings, or unabsorbed premium deposits returned to Florida insureds.
- Adequacy of loss reserves.
- Cost of reinsurance.
- Trend factors, including those for actual losses per insured unit.
- Catastrophe and conflagration hazards, when applicable.
- Projected hurricane losses, when applicable.
- A reasonable margin for underwriting profit and contingencies.
- Cost of medical services, when applicable.
- Other relevant factors impacting frequency and severity of claims or expenses.

The Rating Law specifically allows insurers to fully recoup the premiums paid to the FHCF for coverage and private reinsurance costs in rate filings. This means the costs are ultimately passed on to the insurer's policyholders.

Currently, some insurers purchase private reinsurance within the covered layers of the FHCF to insure against any shortfalls of the Fund. If purchased, the costs cannot be recouped in a rate filing because current law specifically prohibits insurers from recouping private reinsurance costs that duplicate coverage provided by the FHCF. The bill would allow such a recoupment and the costs would ultimately be passed on to the insurer's policyholders.

Repeals Provisions Relating to FHCF Coverage

The bill repeals several provisions in the FHCF governing statute that are obsolete because they sunset. For example, current law allowing certain insurers to buy $10 million of FHCF coverage below their FHCF retention is repealed because current law allowing this purchase expired on May 31, 2012. Also, current law allowing insurers to buy additional reinsurance from the FHCF below their retention (TEACO coverage) is repealed because current law allowed this purchase only through May 31, 2010.

[25] s. 627.062(2), F.S.

One type of insurance policy for which the Fund reimburses losses is repealed by the bill. Currently, the Fund reimburses insurers for losses on covered policies. Covered policies include those insuring residential property and include homeowner's, mobile homeowner's, condominium association, condominium unit owner's, tenant's, apartment building, and similar policies, issued by authorized insurers, Citizens Property Insurance Corporation, or other joint underwriting associations. Covered policies issued by a commercial self-insurance fund[26] are also covered by the FHCF if the self-insurance fund has a certificate of authority to transact insurance from the OIR. The bill repeals this law, so these self-insurance funds will no longer be able to buy reinsurance from the FHCF. According to the OIR, there are currently no commercial self-insurance funds with a certificate of authority from the OIR.[27] Thus, no self-insurance funds are currently able to purchase reinsurance from the FHCF.

B. SECTION DIRECTORY:

Section 1: Amends s. 215.555, F.S., relating to the Florida Hurricane Catastrophe Fund, effective June 1, 2013 and is effective June 1, 2013.

Section 2: Amends s. 215.555, F.S., relating to the Florida Hurricane Catastrophe Fund, effective June 1, 2013.

Section 3: Amends s. 627.062, F.S., relating to rate standards.

Section 4: Amends s. 627.0629, F.S., relating to residential property insurance; rate filings.

Section 5: Provides an effective date of upon becoming law unless expressly provided otherwise.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[26] Commercial self-insurance funds are formed under and governed by s. 624.462, F.S. They can be formed to pool commercial property or casualty risk or surety insurance among the members of the fund. Who is eligible to be a member of the fund is set out in s. 624.462(2), F.S. Under s. 624.462(5), F.S., a commercial self-insurance fund created by a nonprofit group of at least 50 residential parcels or units operating as condominiums, cooperatives, homeowner's associations, vacation and timeshare plans, or mobile home park lot tenancies is an insurer for FHCF assessment purposes, meaning the fund must pay FHCF assessments on the property self-insured.

[27] Information obtained from the OIR on March 8, 2013, on file with the Insurance & Banking Subcommittee.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Provision Relating to Commercial Self-Insurance Funds
Even though there are currently no commercial self-insurance funds (SIFs) with a certificate of authority, so there are none buying reinsurance from the FHCF on property insured by the SIFs, repealing the authority for these SIFs to buy reinsurance from the FHCF will preclude any future SIFs from buying FHCF coverage.

Provision Relating to Recoupment of Duplicative Private Reinsurance
Allowing insurers to fully recoup costs for private reinsurance that duplicates FHCF coverage will increase property insurance rates and the resulting premiums paid by policyholders. However, because the FHCF has a bonding shortfall, insurers who replace FHCF coverage with private insurance for their amount of FHCF coverage in the shortfall will be able to collect reinsurance proceeds for this amount. This ensures the insurer has sufficient funds to pay claims and remain solvent.

Provision Relating to Medical Malpractice Exemption from Assessments
Removing medical malpractice insurance from the FHCF assessment base permanently will cause policyholders of the other types of property and casualty insurance included in the assessment base to pay higher assessments. Although medical malpractice is not currently in the FHCF assessment base, it was to be added as of June 1, 2013. Adding additional types of insurance to the assessment base grows the base and lowers the assessment for all types of insurance in the base. As of December 31, 2011, medical malpractice premiums totaled almost $555 million.[28] Thus, the bill precludes the FHCF assessment base of $34.6 billion[29] to increase by $555 million.

If the FHCF has to issue revenue bonds to pay claims, it is likely to obtain more favorable bonding terms with a larger the assessment base. Thus, preventing medical malpractice from being added to the assessment base may result in the FHCF receiving less favorable bonding terms than it would receive had medical malpractice been added to the base on June 1, 2013.

Policyholders of medical malpractice insurance will never have to pay FHCF assessments on their medical malpractice insurance under the bill. Under current law, these policyholders would have had to start paying FHCF assessments levied due to hurricanes occurring on or after June 1, 2013.

Provisions Relating to Restructuring the FHCF
Because the restructuring of the FHCF proposed by the bill reduces the amount of reinsurance sold by the FHCF, property insurers will likely replace the reinsurance coverage currently sold by the FHCF with more expensive reinsurance sold by private reinsurers. Thus, it is anticipated property insurance rates and resulting premiums will increase due to the changes to the FHCF made by the bill. Estimates of the bill's impact on property insurance rates have been calculated by various entities with differing results. All estimates, however, conclude rates will increase due to the changes to the FHCF made by the bill, even though the amount of increase varies. The estimates are as follows:

The proposed changes will result in no increase in residential property insurance rates for the 2013-2014 contract year (June 1, 2013–May 31, 2014) because the changes reduce coverage offered by the FHCF starting in the 2014–2015 contract year.

Estimate by the Insurance Consumer Advocate (ICA)[30]
The ICA estimates the following rate impact from the bill, however, the analysis is for an implementation period of 2013-2016, whereas the bill's implementation period is 2014-2017. According to the ICA,

[28] This total includes premiums from surplus lines insurance and risk retention groups. Information obtained from the OIR on February 27, 2013, on file with the Insurance & Banking Subcommittee.
[29] Assessment base total is as of the end of 2011. See Report Prepared for the Florida Hurricane Catastrophe Fund on Claims-Paying Capacity Estimates by Raymond James Public Finance Department, dated October 9, 2012, available at http://www.sbafla.com/fhcf/AdvisoryCouncil/2012MeetingMaterials/tabid/1311/Default.aspx (last viewed February 27, 2013).
[30] Email from the FHCF dated March 11, 2013, on file with the Insurance & Banking Subcommittee.

moving the implementation period out one year results in the same rate impact, although the impact becomes more uncertain over a longer time period:[31]

2013-2014 Contract Year
- 1.2% increase associated with increasing the insurer co-pay to 15%
- 1% increase associated with reducing the mandatory coverage to $16 billion

2014-2015 Contract Year
- 1.2% increase associated with increasing the insurer co-pay to 20%
- 1% increase associated with reducing the mandatory coverage to $15 billion

2015-2016 Contract Year
- 1.2% increase associated with increasing the insurer co-pay to 25%
- 1.1% increase associated with reducing the mandatory coverage to $14 billion

Total Estimated Cumulative Premium Increase 2013-2016 – 6.7%
- 3.7% of which is associated with increasing the insurer co-pay
- 3.0% of which is associated with reducing the mandatory coverage

Estimate by the Office of Insurance Regulation[32]
The OIR estimates a rate increase of a minimum of 3.6% over the three year implementation period for the mandatory coverage reductions only. The OIR did not provide an estimate for the increasing the insurer co-pay over three years.

The OIR also notes rates will increase if any private reinsurance cost that duplicates FHCF coverage is included in an insurer's rates as is allowed under the bill. However, the amount of rate increase is indeterminable because the private reinsurance costs would be specific and different to each insurer.

Impact of Decreasing Private Reinsurance Costs on Rate Increases Resulting from the Bill
Some proponents of the bill assert costs for private reinsurance will decrease for reinsurance sold effective June 1, 2013 because there is more than adequate supply of private reinsurance in the market.[33] Accordingly, the proponents conclude the reduction in private reinsurance costs, which are fully passed through to policyholders in property insurance rates, will more than offset the rate increase associated with restructuring the FHCF. The ICA estimated private insurance rates would have to decrease 3.9% per year for three years to completely offset the rate increase associated with the increasing the FHCF co-pays.[34] Similarly, the ICA estimates private reinsurance would have to decrease by 3.2% per year for three years to offset the rate increase associated with reducing the mandatory layer of the FHCF.

However, the information provided to document the anticipated decrease in private reinsurance costs are for costs effective June 1, 2013. No information has been provided to document there will also be a decrease in private reinsurance costs effective June 1, 2014 when the changes made to the FHCF insurer co-pay and mandatory layer take effect. Because private reinsurance rates depend, in part, on the capacity of the market which depends, in part, on the amount of losses private reinsurers sustained the previous year, it is very speculative to extrapolate reinsurance cost decreases in 2013 to 2014.

[31] Presentation by the ICA to the Insurance & Banking Subcommittee on March 13, 2013 and email to staff of the Insurance & Banking Subcommittee dated March 14, 2013.
[32] OIR Bill Analysis dated March 12, 2013, on file with the Insurance & Banking Subcommittee.
[33] Testimony presented at the Insurance & Banking Subcommittee meeting on March 13, 2013.
[34] Testimony presented and materials distributed by the ICA at the Insurance & Banking Subcommittee meeting on March 13, 2013.

Impact on Policy Count of Citizens Property Insurance Corporation

The bill may have a collateral fiscal impact of the bill for Citizens Property Insurance Corporation (Citizens).[35] According to the OIR, as property insurance rates in the private market increase due to changes made by the bill while Citizens rate increases are capped,[36] an unintended consequence could develop where consumers decided to enter or remain in Citizens where lower rates may be available.[37] In addition, Citizens' reinsurance costs could increase if reinsurance currently sold by the FHCF is eliminated by the bill and Citizens replaces that reinsurance with more expensive private reinsurance. In this case, Citizens may be unable to fully recoup their reinsurance costs in rates due to the Citizens' rate cap of 10%.[38]

Moreover, further disparity between Citizens' rates and those of private sector insurers may be created if private insurers raise rates more than 10% due to the increased cost of replacing FHCF reinsurance with private reinsurance and Citizens also needs to raise rates more than 10% to recoup reinsurance costs, but cannot due to the 10% rate cap. Additionally, even if Citizens does not replace FHCF reinsurance with private reinsurance, then the rate disparity between Citizens' rates and those of private sector insurers could increase as private insurer's rates go up to account for the purchase of more private reinsurance to replace FHCF reinsurance and Citizens' rates do not increase because the corporation chooses not to purchase private reinsurance to replace FHCF insurance.[39] Thus, depending on Citizens' response to the changes to the FHCF provided by the bill, the bill could result in Citizens offering lower rates than private sector insurers which may increase the number of policies in Citizens, assuming homeowners purchase property insurance solely on rates.

Impact on Solvency of Insurers

The bill could present solvency concerns for some private insurers. As FHCF reimbursements are reduced by the bill, insurers may not be able to obtain or maintain sufficient reinsurance amounts to cover potential losses arising from a hurricane. Insufficient reinsurance impairs the solvency of the insurers.[40]

Based on input from its financial advisors, the Fund estimates it cannot issue bonds to obtain over $1.5 billion needed to pay claims if the Fund had to pay its maximum obligations of over $17 billion in the 2012-2013 contract year. Thus, insurers who have purchased reinsurance from the FHCF may not be fully reimbursed by the Fund. Some insurers rely on Fund reimbursement to meet solvency requirements, so not receiving full reimbursement could impair solvency of these insurers. However, because the bill allows insurers that buy duplicate FHCF coverage to recoup the costs of such in a rate filing, the insurers who buy private reinsurance to cover the projected FHCF shortfall should continue to meet solvency requirements.

Reducing the structure and size of the Fund will provide more assurance to property insurers in the private sector that the Fund will be able to fully reimburse insurers.

---

[35] Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market. It is not a private insurance company. As of January 31, 2013, Citizens is the largest property insurer in Florida with almost 1.3 million policies extending approximately $418 billion of property coverage to Floridians.

[36] Citizens' rate increases are capped under current law from increasing more than 10% per policy per year until the rates are actuarially sound. (s. 627.351(6)(n), F.S.)

[37] This impact was initially noted in the OIR Bill Analysis for HB 833 filed in 2012, but the OIR indicated in an email to staff of the Insurance & Banking Subcommittee on March 12, 2013, the impact would apply to HB 1107 too.

[38] By law, Citizens cannot increase rates more than 10% per policy per year (s. 627.351(6)((n)6., F.S.).

[39] Private insurance companies must maintain a certain amount of reinsurance for solvency purposes, however, Citizens does not have to comply with the solvency requirements required of private insurers so does not have to maintain a certain amount of reinsurance.

[40] This impact was initially noted in the OIR Bill Analysis for HB 833 filed in 2012, but the OIR indicated in an email to staff of the Insurance & Banking Subcommittee on March 12, 2013, the impact would apply to HB 1107 too.

Impact on Homeowners' Ability to Have Their Claims Timely Paid

Reducing the size of the FHCF could increase the likelihood homeowners will have their property insurance claims paid in a timely manner following a hurricane. If the FHCF has a bonding shortfall after a hurricane, then the FHCF may have to reimburse insurers at a slower pace while the Fund seeks additional funds to reimburse insurers through bonding. If this happens, property insurers may take longer to pay policyholders' claims as some of the funds they likely rely on to pay these claims of are derived from their receipt of reimbursements from the FHCF.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Because certain SIFs are no longer able to receive FHCF coverage on their insured property, as a conforming change, the governing statute for SIFs (s. 624.462(5), F.S.) should be amended to repeal current law providing certain commercial SIFs are insurers for FHCF.

Some assert the FHCF current bonding shortfall estimate is theoretical because the FHCF would not have to pay its full obligations in one year as the estimate assumes. Rather, the FHCF would pay the obligations as they are requested by insurers, likely over two or three years. Thus, if the FHCF could not bond for funds to pay its full obligations soon after a hurricane, the FHCF would still have ample time to bond for the remaining funds needed before the full obligations were requested by insurers.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health flex plans; amending s. 408.909, F.S.; revising the expiration date to extend the availability of health flex plans to low-income uninsured state residents; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

(1) INTENT.—The Legislature finds that a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for low-income uninsured state residents by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services. To the maximum extent possible, these options should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives and requirements of such programs.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(c) "Enrollee" means an individual who has been determined to be eligible for and is receiving health care coverage under a health flex plan approved under this section.

(d) "Health care coverage" or "health flex plan coverage" means health care services that are covered as benefits under an approved health flex plan or that are otherwise provided, either directly or through arrangements with other persons, via a health flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(e) "Health flex plan" means a health plan approved under subsection (3) which guarantees payment for specified health care coverage provided to the enrollee who purchases coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government.

(f) "Health flex plan entity" means a health insurer, health maintenance organization, health-care-provider-sponsored organization, local government, health care district, other public or private community-based organization, or public-private partnership that develops and implements an approved health flex plan and is responsible for administering the health flex plan and paying all claims for health flex plan coverage by enrollees of the health flex plan.

(3) PROGRAM.—The agency and the office shall each approve or disapprove health flex plans that provide health care

coverage for eligible participants. A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions. A health flex plan offering may include the option of a catastrophic plan supplementing the health flex plan.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care. The agency shall ensure that the health flex plans follow standardized grievance procedures similar to those required of health maintenance organizations.

(b) The office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices;

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided; or

4. Cannot demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3).

(c) The agency and the Financial Services Commission may adopt rules as needed to administer this section.

(4) LICENSE NOT REQUIRED.—Neither the licensing requirements of the Florida Insurance Code nor chapter 641, relating to health maintenance organizations, is applicable to a health flex plan approved under this section, unless expressly made applicable. However, for the purpose of prohibiting unfair trade practices, health flex plans are considered to be insurance subject to the applicable provisions of part IX of chapter 626, except as otherwise provided in this section.

(5) ELIGIBILITY.—Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

(a)1. Have a family income equal to or less than 300 percent of the federal poverty level;

2. Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, or another public health care program, such as Kidcare, and have not been covered at any time during the past 6 months, except that:

a. A person who was covered under an individual health maintenance contract issued by a health maintenance organization licensed under part I of chapter 641 which was also an approved

health flex plan on October 1, 2008, may apply for coverage in the same health maintenance organization's health flex plan without a lapse in coverage if all other eligibility requirements are met; or

b. A person who was covered under Medicaid or Kidcare and lost eligibility for the Medicaid or Kidcare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved health flex plan may apply for coverage in a health flex plan without a lapse in coverage if all other eligibility requirements are met; and

3. Have applied for health care coverage as an individual through an approved health flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or

(b) Are part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization licensed under Florida law, only 50 percent of the employees must meet the income requirements for the purpose of this paragraph.

(6) RECORDS.—Each health flex plan shall maintain enrollment data and reasonable records of its losses, expenses, and claims experience and shall make those records reasonably available to enable the office to monitor and determine the

financial viability of the health flex plan, as necessary. Provider networks and total enrollment by area shall be reported to the agency biannually to enable the agency to monitor access to care.

(7) NOTICE.—The denial of coverage by a health flex plan, or the nonrenewal or cancellation of coverage, must be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation must be provided at least 45 days in advance of the nonrenewal or cancellation, except that 10 days' written notice must be given for cancellation due to nonpayment of premiums. If the health flex plan fails to give the required notice, the health flex plan coverage must remain in effect until notice is appropriately given.

(8) NONENTITLEMENT.—Coverage under an approved health flex plan is not an entitlement, and a cause of action does not arise against the state, a local government entity, or any other political subdivision of this state, or against the agency, for failure to make coverage available to eligible persons under this section.

(9) PROGRAM EVALUATION.—The agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by

January 1, 2005, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(10) EXPIRATION.—This section expires July 1, 2018 ~~July 1, 2013~~.

Section 2. This act shall take effect June 30, 2013.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1157 Health Flex Plans
SPONSOR(S): Powell
TIED BILLS: **IDEN./SIM. BILLS:** SB 1278

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	13 Y, 0 N	Poche	Shaw
2) Insurance & Banking Subcommittee		Cooper	Cooper
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Health flex plans were established in 2002 as a pilot program in Indian River County to offer basic affordable health care services to low-income uninsured state residents. Health insurers, health maintenance organizations, and other entities were encouraged to develop low cost, basic benefit health coverage plans that would provide uninsured individuals with access to primary care treatment, prescription drugs, screenings, and diagnostic and radiology procedures. Subsequent legislation has expanded availability of the program to other counties.

There are currently more than 12,000 individuals enrolled in three health flex plans in six counties. Under current law, the pilot program will end on July 1, 2013, unless it is extended by legislative action.

House Bill 1157 extends the health flex plan program to July 1, 2018.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of June 30, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The health flex plan program was established in 2002 as a pilot program to offer basic affordable health care services to low-income uninsured state residents "by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services."[1] Health flex plans are not insurance products. Plan providers are not subject to the Florida Insurance Code. The plans are also not required to offer the mandated health benefits found in chapter 627, F.S., or chapter 641, F.S., as applicable. Health flex plans provide coverage for basic health care services, such as preventive health screenings, office visits for primary care treatment, basic prescription drug coverage, blood chemistry screenings, and certain diagnostic and radiology procedures.

Eligibility to enroll in a health flex plan is limited to persons who:

- Are residents of the state;
- Are 64 years old or younger;
- Have a family income equal to or less than 300 percent of the federal poverty level;[2]
- Are not covered by private insurance and are not eligible for coverage through a public health insurance program or have not been covered for the past six months, with exceptions.[3]

The program was initially available in Indian River County from July 2002 until July 2004. Subsequent legislation in 2003 extended the program to July 2008, and later legislation expanded the counties of availability. In 2008, the Legislature passed and the Governor signed HB 461, which extended the program from July 2008 to July 2013.[4] Current law provides for expiration of the program on July 1, 2013.[5]

There are three health flex plans in the state, American Care, Inc., Preferred Medical Plan, Inc., and Vita Health Plan, operating in Broward, Hillsborough, Miami-Dade, Palm Beach, Polk, and St. Lucie counties. The following chart shows the total enrollment in each of the plans[6]:

---

[1] S. 408.909(1), F.S.; *see also* Florida Agency for Health Care Administration and Office of Insurance Regulation, *Health Flex Plan Program Annual Report-January 2012*, page 2, available at http://ahca.myflorida.com/mchq/managed_health_care/Health_Flex/ANNUAL_REPORT-FINAL_2013[1].pdf (on file with Health Innovation Subcommittee staff).

[2] The federal poverty level for a family of four, based on 2013 federal guidelines, is $23,550. 300 percent of the federal poverty level for a family of four is $70,650. *See* U.S. Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation, *2013 Poverty Guidelines*, available at http://aspe.hhs.gov/poverty/13poverty.cfm (last viewed March 14, 2013); *see also* 78 Fed. Reg. 5,182, 5,183 (January 24, 2013).

[3] S. 408.909(5)(a)2.a. and b., and (b), F.S., contain specific criteria to be eligible for health flex plan coverage under the exceptions.

[4] S. 1, Ch. 2008-118, L.O.F.

[5] S. 408.909(10), F.S.

[6] Florida Agency for Health Care Administration and the Office of Insurance Regulation, *Health Flex Plan Program Annual Report-January 2013*, page 6, available at http://ahca.myflorida.com/mchq/managed_health_care/Health_Flex/ANNUAL_REPORT-FINAL_2013[1].pdf (on file with Health Innovation Subcommittee staff).

COMPANY	ENROLLEES
American Care, Inc.	347
Preferred Medical Plan, Inc.	1,630
Vita Health Plan	10,150
TOTAL	**12,127**

Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA")[7], as amended by the Health Care and Education Reconciliation Act of 2010[8]. The law contains comprehensive changes to the entire health care system in the United States. Most of the PPACA provisions take effect in 2014; however, many changes are phased in, starting from the day the bill was signed on March 23, 2010 and continuing through 2019.

Specifically, PPACA:

- Requires most U.S. citizens and legal residents to obtain health insurance coverage or pay a penalty;
- Substantially expands Medicaid;
- Establishes new requirements on employers and health plans;
- Restructures the private health insurance market;
- Creates health insurance exchanges for individuals and employers to obtain coverage;
- Sets minimum standards for health coverage offered in the health insurance exchange; and
- Provides premium tax credits and cost-sharing subsidies for eligible individuals that obtain coverage through the health insurance exchange.

Health Insurance Exchanges under PPACA

PPACA requires that a health insurance exchange be established in each state. Individuals and small businesses will be able to purchase health insurance coverage that meets the minimum essential coverage provisions of PPACA. The exchanges must begin open enrollment on October 1, 2013, for coverage effective January 1, 2014. The exchange is not an insurer; instead, it will provide eligible individuals and businesses with access to qualified health plans. Each plan must be one of following "metal levels":

- Bronze: 60% actuarial value[9]
- Silver: 70% actuarial value
- Gold: 80% actuarial value
- Platinum: 90% actuarial value

In addition to enrolling individuals in qualified health plans, the exchange will also determine eligibility for Medicaid and the Child Health Insurance Plan (CHIP). The exchange will also determine if an individual is eligible for advance premium tax credits and cost-sharing reductions.

Individuals with household income between 100% and 400% of poverty are eligible to receive an advance premium tax credit if "affordable coverage"[10] is not available through an employer. The amount of the tax credit that an individual can receive is based on the premium for the second lowest cost silver plan in the exchange and area where the person is eligible to purchase coverage. The

[7] P.L. 111-148, 124 Stat. 119 (2010)
[8] P.L. 111-152, 124 Stat. 1029 (2010)
[9] Actuarial value is calculated by computing the ratio of total expected payments by the plan for essential health benefits and cost-sharing rules with the total costs of the essential health benefits the standard population is expected to incur. For example, a health plan with an actuarial value of 80 percent would be expected to pay an average of 80 percent of a standard population's expected medical expenses for the EHB. Individuals covered by the plan would then be expected to pay the remaining 20 percent, on average, through cost sharing such as deductibles, co-pays, and co-insurance.
[10] See discussion of "affordable coverage" under Employer Responsibility supra.

amount of the tax credit varies with income so the premium that a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income as follows:

Income Level	Premium as a Percent of Income
Up to 133% FPL	2% of income
133-150% FPL	3 – 4% of income
150-200% FPL	4 – 6.3% of income
200-250% FPL	6.3 – 8.05% of income
250-300% FPL	8.05 – 9.5% of income
300-400% FPL	9.5% of income

Effect of Proposed Changes

The bill extends the health flex plan program for 5 years, from July 1, 2013 to July 1, 2018.

Because eligibility for health flex plans is limited to individuals at or below 300 percent of the federal poverty level, it is likely that many people currently enrolled in a health flex plan would qualify for subsidized health insurance coverage in the federal health insurance exchange. However, since advance premium tax credits are not available to individuals having incomes below 100 percent of the federal poverty level, these individuals are likely to choose to remain in the health flex plan program.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.909, F.S., relating to health flex plans.
Section 2: Provides an effective date of June 30, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Failure to extend the pilot program could leave 12,127 residents of Florida with no coverage for health care services until January 1, 2014.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to hurricane mitigation; transferring responsibility for the public model for hurricane loss projection from the Office of Insurance Regulation to the Division of Emergency Management; amending s. 215.559, F.S.; revising provisions relating to the Hurricane Loss Mitigation Program; deleting provisions specifying how program funds are to be spent, including the Manufactured Housing and Mobile Home Mitigation and Enhancement Program, and the Florida International University International Hurricane Research Center; deleting reports prepared by Tallahassee Community College and a report prepared by the division; specifying program components, including responsibility for the public model for hurricane loss projections, which includes the charging of an access fee, the development of a mitigation database, mitigation credits and inspections, mitigation grants, mitigation outreach, and mitigation research; authorizing the division to leverage program funding; repealing s. 627.06281, F.S., relating to the public hurricane loss projection model; transferring provisions of that section to ss. 212.559 and 627.06292, F.S.; amending s. 627.0629, F.S.; revising factors that must be considered or included in the rate filings for residential property insurance; reordering and amending s. 627.06292, F.S.; revising provisions relating to the public model for hurricane

loss projections; conforming a cross-reference; amending s. 627.351, F.S.; conforming a cross-reference; deleting obsolete provisions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Responsibility for the public hurricane loss projection model currently located in the Office of Insurance Regulation of the Department of Financial Services is transferred to the Division of Emergency Management in the Executive Office of the Governor by a type two transfer, as provided in s. 20.06(2), Florida Statutes.

Section 2. Section 215.559, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 215.559, F.S., for present text.)

215.559 Hurricane Loss Mitigation Program.—A Hurricane Loss Mitigation Program is established in the Division of Emergency Management.

(1) ANNUAL APPROPRIATION.—The $10 million annual appropriation authorized under s. 215.555(7) from the Florida Hurricane Catastrophe Fund shall be used for the purposes specified in that subsection and to coordinate and centralize mitigation efforts in this state in accordance with the program established in this section. Of that amount:

(a) Seven million dollars shall be used for mitigation programs to improve the hazard resistance of residential

property in this state, including loans, subsidies, grants, demonstration projects, and direct assistance; educating state residents concerning hazard risk and risk reduction or mitigation; hurricane mitigation research; and other efforts to prevent or reduce losses or reduce the cost of rebuilding after a disaster.

(b) Three million dollars shall be used to retrofit existing facilities used as public hurricane shelters. The division shall annually prioritize the use of these funds for projects included in the annual report of the Shelter Retrofit Report prepared in accordance with s. 252.385(3). The division shall give funding priority to projects in regional planning council regions that have shelter deficits and to projects that maximize the use of state funds.

(2) ADVISORY COUNCIL.—An advisory council is created to provide advice and assistance to the division regarding administration of the public hurricane model, the mitigation database, and the development of appropriate standards for mitigation credits.

(a) The advisory council is composed of:

1. The director of the Division of Emergency Management, or his or her designee.

2. A representative from the Office of Insurance Regulation.

3. The chief executive officer of Citizens Property Insurance Corporation, or his or her designee.

4. The Insurance Consumer Advocate, or his or her designee.

5. The lead scientist from the team that runs the public hurricane loss projection model, or his or her designee.

6. Three representatives from educational institutions with programs dedicated to mitigation research or testing, selected by the director of the Division of Emergency Management.

7. A representative of property insurers recommended by the Chief Financial Officer.

8. A representative of reinsurers recommended by the Chief Financial Officer.

9. A representative designated by the Florida Building Commission.

10. A representative designated by the Building Officials Association of Florida.

11. The chief executive officer of the Institute for Business and Home Safety, or his or her designee.

12. The chief executive officer of the Federal Alliance for Safe Homes, Inc., or his or her designee.

13. A real estate professional recommended by Florida Realtors.

(b) Beginning the first fiscal year after July 1, 2013, members of the advisory council serve 2-year terms. Members serve without compensation, but are entitled to reimbursement as provided in s. 112.061 for per diem and travel expenses incurred in the performance of their official duties. All members of the advisory council shall sign the same code of ethics form used by the Executive Office of the Governor.

(3) PROGRAM COMPONENTS.—The division shall develop and

administer a comprehensive and coordinated program for hurricane damage mitigation which includes:

(a) *Hurricane loss projection model.*—The division is responsible for the supervision and administration of the public model for hurricane loss projections developed, maintained, and updated by the Florida International University center established pursuant to s. 627.06292.

1. A property insurer may have access to and use the public model, including all assumptions and factors and all detailed loss results, for the purpose of calculating rate indications in a rate filing and for analytical purposes, including any analysis or evaluation of the model required under actuarial standards of practice.

2. The division may charge a fee for private sector access to and use of the public model, which may not exceed the reasonable costs associated with the operation and maintenance of the model by the division. Such fees do not apply to access and use of the model by the Office of Insurance Regulation.

(b) *Mitigation database.*—The division shall develop a centralized public database that contains information regarding the inspection and mitigation of residential property throughout the state. The purpose of this database is to accurately collect all information regarding the construction and mitigation features for each property. The mitigation database may contain, but is not limited to, the elements of the loss and exposure data reported for the hurricane loss projection model under s. 627.06292, with the exception of proprietary information submitted by insurers relating to reserves for future payments.

(c) *Mitigation credits and inspections.*—The division, in consultation with the council, shall establish mitigation features eligible for mitigation credit to be published yearly and used for hurricane mitigation inspection forms adopted pursuant to s. 627.711. Using the hurricane loss projection model, methodology shall be developed to incorporate appropriate standards for mitigation credits into any model approved by the Florida Commission on Hurricane Loss Projection Methodology under s. 627.0628. The methodology established shall be applied in the commission's review of the public model.

(d) *Mitigation grants.*—Financial grants shall be used to encourage property owners to retrofit their properties to make them less vulnerable to hurricane damage. The division shall establish objective, reasonable criteria for prioritizing grant applications in accordance with the division's standard operating procedures as set forth in state and federal law.

(e) *Mitigation outreach.*—The division shall conduct outreach to stakeholders interested in mitigation in order to promote a better understanding of risk and the reduction of risk in the form of mitigation practices and policies.

(f) *Mitigation research.*—The division shall research mitigation practices and products in order to better inform the public and the division's mitigation initiatives.

(4) FUNDING.—Moneys provided to the division under this section are intended to supplement, not supplant, the division's other funding sources. The division may seek out and leverage local, state, federal, or private funds to enhance financial resources for mitigation initiatives.

Section 3. Section 627.06281, Florida Statutes, is repealed.

Section 4. Subsection (1) of section 627.0629, Florida Statutes, is amended to read:

627.0629 Residential property insurance; rate filings.—

(1) It is the intent of the Legislature that insurers provide savings to consumers who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. Therefore, a rate filing for residential property insurance must include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. ~~The fixtures or construction techniques must include, but are not limited to, fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code must be included in the rate filing.~~ The hurricane loss projection model established pursuant to s. 627.06292 shall be used to establish the appropriate methodology for determining such ~~office shall determine the~~ discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such

revaluation, which may be used by insurers in rate filings.

Section 5. Section 627.06292, Florida Statutes, is reordered and amended to read:

627.06292 Public model for hurricane loss projections; annual report ~~Reports of hurricane loss data and associated exposure data~~; public records exemption.—The Florida International University center is established to conduct hurricane research and study hurricane mitigation for the purposes of developing, maintaining, and updating a public model for hurricane loss projections.

(1) Within 30 days after receipt of a written request for loss data and associated exposure data from the Division of Emergency Management, property insurers and licensed rating and advisory organizations that compile property insurance loss data shall provide loss data and associated exposure data, including data related to property insurance policies, to the center. The loss data and associated exposure data provided may be provided electronically.

(2) The public model shall be submitted to the Florida Commission on Hurricane Loss Projection Methodology for review under s. 627.0628. The Office of Insurance Regulation may continue to use the model for its review of rate filings pursuant to ss. 627.062 and 627.351 until such time as the Florida Commission on Hurricane Loss Projection Methodology determines that the public model is not accurate or reliable pursuant to the same process and standards as the commission uses for the review of other hurricane loss projection models.

(5) ~~(1)~~ Reports of hurricane loss data and associated

exposure data that are specific to a particular insurance company, as reported by an insurer or a licensed rating organization to the ~~office or to a~~ center pursuant to this section ~~at a state university pursuant to s. 627.06281~~, are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(4) ~~(2)~~ For the purposes of this section, the term "loss data and associated exposure data" means the type, age, wind mitigation features, and location of each property insured; the amount and type of coverage written on each of those properties; the amount, date, and type of damage paid for by the insurer on each property; and the amount of any reserves held by an insurer for future payments or expenses on damages associated with the date or dates of occurrence of hurricanes.

(3) Annually by ~~On October 1, 2011, and on each~~ October 1 ~~thereafter~~, the Florida International University center ~~that develops, maintains, and updates the public model for hurricane loss projections~~ shall publish a report summarizing loss data and associated exposure data collected from residential property insurers and licensed rating and advisory organizations. The ~~Florida International University~~ center shall submit the report ~~annually,~~ on or before October 1~~,~~ to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(a) Such report must include a summary of the data supplied by residential property insurers and licensed rating and advisory organizations from September 1 of the prior year to August 31 of the current year, and ~~must include~~ the following information:

1. The total amount of insurance written by county.

2. The number of property insurance policies by county.

3. The number of property insurance policies by county and by construction type.

4. The number of property insurance policies by county and by decade of construction.

5. The number of property insurance policies by county and by deductible amount.

6. The number of property insurance policies by county and by wind mitigation features if ~~when~~ the information is supplied by the residential property insurer or licensed rating and advisory organization.

7. The total amount of hurricane losses by county and by decade of construction.

8. The total amount of hurricane losses by county and by deductible amount.

9. The total amount of hurricane losses by county and by wind mitigation features if ~~when~~ the information is supplied by the residential property insurer or licensed rating and advisory organization.

(b) Separate compilations of the data obtained shall be presented in order to use the public model for calculating rate indications and to update, validate, or calibrate the public model. Additional detail and a description of the operation and maintenance of the public model may be included in the report.

(c) The report may not contain any information that identifies a specific insurer or policyholder.

Section 6. Paragraph (n) of subsection (6) of section

627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(n)~~1.~~ Rates for coverage provided by the corporation must be actuarially sound and subject to s. 627.062, except as otherwise provided in this paragraph.

1. The corporation shall file its recommended rates with the office at least annually. The corporation shall provide any additional information regarding the rates which the office requires. The office shall consider the recommendations of the board and issue a final order establishing the rates for the corporation within 45 days after the recommended rates are filed. The corporation may not pursue an administrative challenge or judicial review of the final order of the office.

2. ~~In addition to the rates otherwise determined pursuant to this paragraph,~~ The corporation shall also impose and collect an amount equal to the premium tax provided in s. 624.509 to augment the financial resources of the corporation.

3. After the public hurricane loss-projection model under s. 627.06292 ~~s. 627.06281~~ has been found to be accurate and reliable by the Florida Commission on Hurricane Loss Projection Methodology, the model must ~~shall~~ serve as the minimum benchmark for determining the windstorm portion of the corporation's rates. This subparagraph does not require or allow the corporation to adopt rates lower than the rates otherwise required or allowed by this paragraph.

4. The rate filings for the corporation which were approved by the office and took effect January 1, 2007, are

rescinded, except for those rates that were lowered. As soon as possible, the corporation shall begin using the lower rates that were in effect on December 31, 2006, and provide refunds to policyholders who paid higher rates as a result of that rate filing. The rates in effect on December 31, 2006, remain in effect for the 2007 and 2008 calendar years except for any rate change that results in a lower rate. The next rate change that may increase rates shall take effect pursuant to a new rate filing recommended by the corporation and established by the office, subject to this paragraph.

5. Beginning on July 15, 2009, and annually thereafter, the corporation shall ~~must~~ make a recommended actuarially sound rate filing for each personal and commercial line of business it writes~~, to be effective no earlier than January 1, 2010~~.

6. ~~Beginning on or after January 1, 2010, and~~ Notwithstanding the board's recommended rates and the office's final order regarding the corporation's filed rates under subparagraph 1., the corporation shall annually implement a rate increase that ~~which~~, except for sinkhole coverage, does not exceed 10 percent for any single policy issued by the corporation, excluding coverage changes and surcharges.

7. The corporation may also implement an increase to reflect the effect on the corporation of the cash buildup factor pursuant to s. 215.555(5)(b).

8. The corporation's implementation of rates as prescribed in subparagraph 6. shall cease for any line of business written by the corporation upon the corporation's implementation of actuarially sound rates. Thereafter, the corporation shall

annually make a recommended actuarially sound rate filing for each commercial and personal line of business the corporation writes.

Section 7. This act shall take effect July 1, 2013.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1247 Hurricane Mitigation
SPONSOR(S): Nuñez
TIED BILLS: **IDEN./SIM. BILLS:** SB 1248

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Callaway	Cooper
2) Government Operations Appropriations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

The Florida Hurricane Catastrophe Fund (FHCF) is a tax-exempt trust fund that was created by the Legislature in 1993 in response to the numerous problems that developed in the residential property insurance market as a result of Hurricane Andrew in August 1992. The FHCF operates as a state administered insurer reimbursement program (similar to reinsurance). All residential property insurers writing covered policies in Florida must participate in the FHCF. In order for the FHCF to maintain its tax-exempt status, the Internal Revenue Service mandates that:

> Each fiscal year, the Florida Legislature shall appropriate from the investment income of the FHCF an amount no less than $10 million...for the purpose of providing funding for local governments, state agencies, public and private educational institutions, and nonprofit organizations to support programs intended to improve hurricane preparedness, reduce potential losses in the event of a hurricane, provide research into means to reduce such losses, educate or inform the public as to means to reduce hurricane losses, assist the public in determining appropriateness of particular upgrades to structures or in the financing of such upgrades, or to protect local infrastructure from potential damage from a hurricane.

To satisfy this condition, the FHCF annually appropriates $10 million for the Hurricane Loss Mitigation Program (Mitigation Program) administered by the Florida Division of Emergency Management (DEM).

The 2000 Legislature authorized the creation of a public hurricane loss projection model (public model). The Office of Insurance Regulation (OIR) contracted with the Florida International University (FIU) to develop the model. The public model, which is operational, assesses hurricane risk for property insurers and predicts annual expected insured residential losses. The bill transfers the public model from the OIR to the DEM.

The bill substantially expands the Mitigation Program. Changes made to the Mitigation Program include:

- Removing the specific appropriation of funds from the Mitigation Program to the Mobile Home Tie-Down Enhancement Program and to the FIU for hurricane research.
- Requiring the DEM, through the Mitigation Program, to use the public hurricane model to set the methodology for determining mitigation credits for property insurance premiums, instead of the OIR.
- Requiring Mitigation Program moneys to be used for mitigation grants, mitigation outreach, research on mitigation practices and products, and the establishment of a mitigation database.

The bill has no fiscal impact on local government and an insignificant fiscal impact on state government. The bill has a fiscal impact on the private sector relating to mitigation credits and funding currently allocated to mitigation projects and specific programs under the Mitigation Program.

The bill is effective on July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background on the Florida Hurricane Catastrophe Fund

The Florida Hurricane Catastrophe Fund (FHCF)[1] is a tax-exempt trust fund that was created by the Legislature in 1993 in response to the numerous problems that developed in the residential property insurance market as a result of Hurricane Andrew in August 1992. The FHCF operates as a state administered insurer reimbursement program (similar to reinsurance) and is mandatory for residential property insurers writing property insurance policies in the Florida. In order for the FHCF to maintain its tax-exempt status, the Internal Revenue Service mandates that:

> Each fiscal year, the Florida Legislature shall appropriate from the investment income of the FHCF an amount no less than $10 million…for the purpose of providing funding for local governments, state agencies, public and private educational institutions, and nonprofit organizations to support programs intended to improve hurricane preparedness, reduce potential losses in the event of a hurricane, provide research into means to reduce such losses, educate or inform the public as to means to reduce hurricane losses, assist the public in determining appropriateness of particular upgrades to structures or in the financing of such upgrades, or to protect local infrastructure from potential damage from a hurricane.[2]

To satisfy this condition, the FHCF annually appropriates funds to the Hurricane Loss Mitigation Program (Mitigation Program) administered by the Florida Division of Emergency Management (DEM).

Background on the Hurricane Loss Mitigation Program

The Legislature passed the Bill Williams Residential Safety and Preparedness Act, creating the Mitigation Program in 1999.[3] Located in s. 215.559, F.S., the Mitigation Program receives an annual appropriation of $10 million from the FHCF which is submitted to the Division of Emergency Management (DEM) within the Executive Office of the Governor for administration in accordance with the Mitigation Program governing statute.

Seven million dollars of the $10 million must be used to improve the wind resistance of residences and mobile homes, through loans, subsidies, grants, demonstration projects and direct assistance; educate individuals on Florida Building Code cooperative programs; and provide other efforts to prevent or reduce losses or the cost of rebuilding after a disaster (referred to as the Residential Construction Mitigation Program).[4] The remaining $3 million must be used to retrofit existing facilities used as public hurricane shelters (referred to as the Shelter Retrofit Program).[5]

Section 215.559(4), F.S., establishes an advisory council to provide project recommendations, selection criteria and guiding principles to administer the Mitigation Program. Membership of the advisory council consists of the following:

- A representative designated by the Chief Financial Officer;
- A representative designated by the Florida Home Builders Association;
- A representative designated by the Florida Insurance Council;

[1] s. 215.555, F.S.
[2] s. 215.555(7)(c), F.S.
[3] Ch. 99-305, L.O.F.
[4] s. 215.559(1)(a), F.S.
[5] s. 215.559(1)(b), F.S.

- A representative designated by the Federation of Manufactured Home Owners;
- A representative designated by the Florida Association of Counties;
- A representative designated by the Florida Manufactured Housing Association; and
- A representative designated by the Florida Building Commission.

Under the requirements of the Mitigation Program, the DEM must provide a full report, along with an accounting and evaluation of activities conducted under the Mitigation Program, to the Speaker of the House of Representatives, the President of the Senate, and the Majority and Minority Leaders of the House of Representatives and the Senate on January 1 of each year.

The Mitigation Program is set to be repealed on June 30, 2021.[6]

Residential Construction Mitigation Program

The $7 million comprising the Residential Construction Mitigation Program (RCMP) is currently allocated as follows:[7]

- 40 percent ($2.8 million) is used to inspect and improve tie-downs for mobile homes, through grants under the Manufactured Housing and Mobile Home Mitigation Enhancement Program at Tallahassee Community College;[8]
- 10 percent ($700,000) is directed to the Florida International University (FIU) center that is dedicated to hurricane research;[9]
- 13 percent ($925,000) is used to fund the Building Code Compliance and Mitigation Program which provides training and continuing education classes for Florida contractors,[10] and
- 36 percent ($2.575 million) is directed to programs developed by the DEM, with the advice from the advisory council, to fund residential wind mitigation retrofit projects and public outreach programs to Florida homeowners and local governments.[11]

Mobile Home Tie-Down Enhancement Program

Section 215.559(2), F.S., sets forth the provisions for the Manufactured Housing and Mobile Home Mitigation and Enhancement Program, known as the Mobile Home Tie-Down Enhancement Program (Tie-Down Program). Tallahassee Community College is the entity statutorily authorized to administer the Tie-Down Program. This program is designed to demonstrate, test and raise awareness of new techniques to enhance manufactured home wind resistance.

The Tie-Down Program provides free tie-down retrofit services to eligible owners of manufactured homes.[12] The Tie-Down Program does not bring existing manufactured homes up to code, but instead makes a mobile home as wind resistant as funding, physical characteristics and condition of the premises permit.[13] To qualify for participation in the Tie-Down Program, a manufactured home must:

- Be located within the boundaries of a mobile home community, in which 60% of the homes in the community have committed to participate in program;
- Have been built and installed prior to September 1999; and
- Be at least 15 inches from the ground to the sidewall of the home.[14]

During the 2011-12 fiscal year, the Tie-Down Program provided tie-downs and retrofitted over 1,770 manufactured homes in 13 mobile home communities within 8 Florida counties.[15]

---

[6] s. 215.559(7), F.S.
[7] Percentages have been rounded. Thus, the total percentage does not equal 100 percent.
[8] s. 215.559(2), F.S.
[9] s. 215.559(3), F.S.
[10] This appropriation is contained in the GAA for Fiscal Year 2012-2013.
[11] Florida Division of Emergency Management. Hurricane Loss Mitigation Program. 2012 Annual Report, p. 5.
[12] A tie-down system is designed to secure a manufactured home to the ground.
[13] Florida Division of Emergency Management. Hurricane Loss Mitigation Program. 2012 Annual Report, p. 22 .
[14] Id.
[15] Id. at p. 20.

Florida International University Hurricane Research Program
Of the moneys allocated to the DEM for administration of the RCMP, 10 percent, or $700,000, is annually allocated to FIU to conduct research on the following issues:

- Elimination of state and local barriers to upgrading existing mobile homes and communities;
- Recycling of existing older mobile homes; and
- Hurricane loss reduction devices and techniques for site-built residences.[16]

RCMP Competitive Funding Projects
Currently, 36 percent of the RCMP funds, $2.575 million, is used to fund residential wind mitigation retrofit projects and public outreach programs to Florida homeowners and local governments. In this regard, the DEM, with the assistance from the advisory council, annually develops a framework of grant projects which are awarded for a one-year performance period. During the 2011-12 fiscal year, 21 RCMP projects relating to residential mitigation retrofit and public outreach were recommended for funding.

Shelter Retrofit Program[17]
Section 215.559(1)(b), F.S., requires $3 million of the $10 million appropriated to the Mitigation Program to be used to retrofit existing facilities used as public hurricane shelters, known as the Shelter Retrofit Program. The DEM must annually prepare a Shelter Retrofit Report for the Governor and Legislature which prioritizes facilities recommended to be retrofitted using local, state, and federal funds with the goal of improving the relative safety of shelters and reducing the shelter space deficit of the state. The shelter retrofit projects are identified through a survey program implemented by the DEM, and are only recommended when the retrofit can create spaces that meet American Red Cross' *Standards for Hurricane Evacuation Shelter Selection* (ARC 4496, January 2002).

Background on the Florida Public Hurricane Loss Projection Model[18]

After Hurricane Andrew in 1992, insurance companies began using privately developed catastrophe loss models to estimate expected losses. Catastrophe models are complex computer simulations that property insurers worldwide use to project potential losses from natural catastrophes, such as hurricanes, earthquakes, and tornados.[19]

The 2000 Legislature authorized the creation of a public hurricane loss projection model (public model) and the Office of Insurance Regulation (OIR) contracted with FIU to develop the model in 2001. In March 2006 the public model was activated and in August 2007 it was first found acceptable by the Florida Commission on Hurricane Loss Projection Methodology (Commission).[20] Any hurricane model must be found acceptable by the Commission in order for a property insurer to use the model to develop property insurance rates.[21] The public model was last found acceptable in 2011.[22]

The public model was built to assess hurricane risk and predict annual expected insured residential losses in Florida for an insurance company, zip code, county, or for the entire state. The OIR uses the public model as an independent tool to facilitate its review of the reasonableness of property insurance

[16] Division of Emergency Management. *Residential Construction Mitigation Program website.* Available at: http://www.floridadisaster.org/mitigation/rcmp/index.htm. (last viewed March 8, 2013).
[17] Information on the Shelter Retrofit Program was obtained from the 2012 Shelter Retrofit Report available at http://www.floridadisaster.org/Response/engineers/library.htm (last viewed March 8, 2013).
[18] Summary information on the Florida Public Hurricane Loss Projection Model obtained from Office of Program Policy Analysis and Government Accountability. Report No. 11-25: *Steps Could Be Taken to Reduce the Public Hurricane Loss Projection Model's Reliance on State Funding* (December 2011). Available at: http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1125rpt.pdf.
[19] There are 4 private companies in Florida that have been approved to offer hurricane loss projection models. These include: AIR Worldwide, Applied Research Associates, EQECAT, and Risk Management Solutions.
[20] The Florida Commission on Hurricane Loss Projection Methodology is an independent body of experts created by the Legislature in 1995 for the purpose of developing standards and reviewing hurricane loss models used in the development of residential property insurance rates and the calculation of probable maximum loss levels.
[21] s. 627.0628(3), F.S.
[22] This acceptance expires on September 1, 2013.

rates proposed by insurers. Without the public model, the OIR's basis for rate determinations would be each insurer's own selected private model and corresponding loss data and the OIR would not have a way to corroborate the accuracy of this data.

The OIR holds the copyright for the public model, which means that it has exclusive rights to the model but can authorize others to use it. In addition to the OIR, users of the public model include Citizens Property Insurance Corporation, the FHCF, and some private insurers.[23] The OIR does not pay a fee for use of the public model, but private insurers do.[24] The amount of the fee is provided in current law and is the actual reasonable costs of the public model operation and maintenance.

The FIU is the lead institution for developing and operating the public model, but it collaborates with several other public and private Florida universities (including Florida State University, the Florida Institute of Technology, the University of Florida, and the University of Miami) and the U.S. National Oceanic and Atmospheric Administration. The OIR provides annual funding of almost $600,000 for the public model which is primarily used to maintain and update the model, so that it can maintain its acceptability for use in property insurance rate setting.

Background on Windstorm Mitigation Discounts

Section 627.0629, F.S., requires rate filings for residential property insurance to include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles to consumers who implement windstorm damage mitigation techniques to their properties. The windstorm mitigation measures that must be evaluated for purposes of mitigation discounts include fixtures or construction techniques that enhance roof strength; roof covering performance; roof-to-wall strength; wall-to-floor foundation strength; opening protections; and window, door, and skylight strength.

Section 627.711, F.S., requires insurers to clearly notify an applicant or policyholder of a personal lines residential property insurance policy of the availability and range of each premium discount, credit, other rate differential, or reduction in deductibles, for wind mitigation. The notice must be provided when the policy is issued and upon each renewal. The notification must be done on a form developed by the OIR, known as the Notice of Premium Discounts for Hurricane Loss Mitigation.

To qualify for a hurricane premium discount, consumers must submit a completed Uniform Mitigation Verification Inspection Form developed by rule by the Financial Services Commission (FSC). All insurers are required to use this form when factoring discounts for property insurance.

Effect of Proposed Changes Relating To the Hurricane Loss Mitigation Program

The bill substantially expands the Hurricane Loss Mitigation Program at DEM created in s. 215. 559, F.S. The annual report required of the Mitigation Program is repealed.

Consistent with current law, under the bill, the Mitigation Program receives funding of $10 million from the FHCF, $7 million of which is used for residential mitigation programs, mitigation education, and rebuilding costs and $3 million for hurricane shelter retrofits. However, the bill does not require any of the $7 million to be used for the Mobile Home Tie-Down Enhancement Program. Under current law, $2.8 million is allocated each year from the RCMP within the Mitigation Program to the Tie-Down Program. Likewise, the yearly allocation in current law of $700,000 from the RCMP to FIU for hurricane mitigation research is repealed by the bill.

The expanded Mitigation Program created by the bill receives guidance from an advisory council, as under current law. The advisory council created by the bill, however, has 15 members, rather than 7. Also, the interest groups or state agencies represented by the advisory council members under the bill

[23] See note 18.
[24] s. 627.06281(3)(b), F.S.

are different than the ones represented by the advisory council in current law. The bill also provides additional responsibilities of the advisory council. Further, the bill establishes 2-year terms for the advisory council members. No term is provided in current law. Furthermore, the bill requires advisory council members to sign a code of ethics form, which is not required in current law.

The DEM's responsibilities relating to the Mitigation Program are expanded by the bill. Under the bill, the Mitigation Program developed by the DEM must include:

- The hurricane loss projection model,
- A mitigation database,
- Mitigation credits and inspections,
- Mitigation grants,
- Mitigation outreach, and
- Mitigation research.

Hurricane Loss Projection Model

The bill makes the DEM responsible for the public hurricane model at FIU and transfers responsibility for the public model from the OIR to the DEM by a type two transfer. Private insurers are still allowed access to the model for use, but the fee charged for use is different than in current law. The bill allows the DEM to charge insurers using the public model a fee for use of the model that may not exceed the reasonable costs of the model's operation and maintenance. Current law requires the fee to be the actual reasonable costs. Thus, the cost for use of the model could be lower under the bill than under current law.

Mitigation Database

As part of the Mitigation Program, DEM must develop a public database containing information about mitigation of residential property statewide. The purpose of the database is to collect information about the construction and mitigation features of all residential property in Florida.

Mitigation Credits and Inspections

Through the Mitigation Program, the DEM, with input from the advisory council, must establish the mitigation features that are eligible for property insurance mitigation credits. Currently, the minimum types of features that are eligible for mitigation discounts or credits are provided in s. 627.0629(1), F.S. The bill repeals this provision. Instead of describing mitigation features in the law, the bill requires the public model to develop methodology to incorporate standards for mitigation credits into hurricane models. Currently, the OIR determines the value of mitigation discounts or credits.

The mitigation features developed must be used in the mitigation inspection form submitted by homeowners to insurers to document the existence of mitigation features.

Other Mitigation Program Requirements

The Mitigation Program developed by DEM must include mitigation grants to encourage retrofitting of property. Prioritization of grant applications is to be in accordance with the DEM's standard operating procedure under state and federal law. The DEM is also required to conduct outreach on mitigation and to research mitigation practices and products.

Effect of Proposed Changes Relating to the Public Hurricane Model

The bill establishes the FIU center which is to conduct research and study hurricane mitigation in order to develop, maintain, and update the public model. The public model is currently housed at FIU. The bill requires insurers to provide loss and exposure data to the center. A similar provision is in current law, however, under current law, the data provided must be in writing. The bill repeals this requirement and instead allows the data to be provided electronically.

B. SECTION DIRECTORY:

Section 1: Creates an unnumbered section of law providing for a type two transfer of responsibility for the public hurricane loss projection model from the OIR to the DEM.

Section 2: Amends s. 215.559, F.S. relating to the Hurricane Loss Mitigation Program.

Section 3: Repeals s. 627.06281, F.S., relating to public hurricane loss projection model; reporting of data by insurers.

Section 4: Amends s. 627.0629, F.S., relating to residential property insurance; rate filings.

Section 5: Amends s. 627.06292, F.S., relating to public model for hurricane loss projections; annual report.

Section 6: Amends. s. 627.351, F.S., relating to insurance risk apportionment plans.

Section 7: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill shifts the responsibility for the public hurricane model from the OIR to the DEM by a type two transfer, however, the transfer should not have a fiscal impact on state expenditures.

   The bill allows members of the Mitigation Program advisory council to be reimbursed for per diem and travel incurred while performing their duties on the council. Current law does not address reimbursement for per diem and travel for members of the advisory council. Furthermore, because the number of members on the advisory council is increased by the bill, if members of the council are currently reimbursed per diem and travel, then these expenses will increase due to the increased membership of the council. The amount of reimbursement for per diem and travel expenses for advisory council members is likely to be insignificant.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Mobile and manufactured homeowners will no longer be guaranteed funding for the Tie-Down Program. Tallahassee Community College, which administers the Tie-Down Program, will no longer be guaranteed funding for the Tie-Down Program.

FIU will no longer be guaranteed funding for hurricane research.

The funds currently allocated to mitigation projects and programs may be reduced by the bill because the bill expands the types of mitigation activities funded by the Mitigation Program. The total amount of funding for mitigation is not decreased by the bill, but the same amount of funding is spread over more types of activities. However, because the bill spread the funds over more types of activities, more Floridians may have access to funds from the Mitigation Program for mitigation.

Because the bill requires the public model to develop a methodology for mitigation credits, the same mitigation features that currently receive mitigation discounts may no longer receive them or may receive them in a lesser amount. Conversely, the methodology for mitigation credits developed could increase mitigation features qualifying for credits or increase the amount of credits for the feature.

In addition, because mitigation credits will be incorporated into hurricane models, the mitigation credit amount could be different from insurer to insurer for the same mitigation features. For example, the mitigation credit for installation of hurricane shutters could be different for homeowners with different property insurers.

Mitigation credits may also differ for the same type of mitigation products, but which are manufactured by different companies. Thus, for example, hurricane shutters manufactured by different companies may have different mitigation credits associated with them, especially if the shutters' ability to harden the home is different.

Also, the credits for the same mitigation features for the same insurer may differ by geographic area. Thus, homeowners having the same mitigation features installed and insured by the same insurer may receive different mitigation credits just because they live in different parts of the state.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Because the annual report for the Mitigation Program required by current law is repealed, an accounting and reporting to policymakers for the funds spent by the Mitigation Program is no longer required.

Because the terms of members of the advisory council are not staggered by the bill, all terms could expire simultaneously.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Citizens Property Insurance Corporation; amending s. 627.351, F.S.; deleting a provision that limits the amount that a public adjuster may charge, agree to, or accept as compensation with respect to a claim filed under a policy of the corporation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (6) of section 627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(a) The public purpose of this subsection is to ensure that there is an orderly market for property insurance for residents and businesses of this state.

1. The Legislature finds that private insurers are unwilling or unable to provide affordable property insurance coverage in this state to the extent sought and needed. The absence of affordable property insurance threatens the public health, safety, and welfare and likewise threatens the economic health of the state. The state therefore has a compelling public interest and a public purpose to assist in assuring that property in the state is insured and that it is insured at affordable rates so as to facilitate the remediation, reconstruction, and replacement of damaged or destroyed property

in order to reduce or avoid the negative effects otherwise resulting to the public health, safety, and welfare, to the economy of the state, and to the revenues of the state and local governments which are needed to provide for the public welfare. It is necessary, therefore, to provide affordable property insurance to applicants who are in good faith entitled to procure insurance through the voluntary market but are unable to do so. The Legislature intends, therefore, that affordable property insurance be provided and that it continue to be provided, as long as necessary, through Citizens Property Insurance Corporation, a government entity that is an integral part of the state, and that is not a private insurance company. To that end, the corporation shall strive to increase the availability of affordable property insurance in this state, while achieving efficiencies and economies, and while providing service to policyholders, applicants, and agents which is no less than the quality generally provided in the voluntary market, for the achievement of the foregoing public purposes. Because it is essential for this government entity to have the maximum financial resources to pay claims following a catastrophic hurricane, it is the intent of the Legislature that the corporation continue to be an integral part of the state and that the income of the corporation be exempt from federal income taxation and that interest on the debt obligations issued by the corporation be exempt from federal income taxation.

2. The Residential Property and Casualty Joint Underwriting Association originally created by this statute shall be known as the Citizens Property Insurance Corporation.

The corporation shall provide insurance for residential and commercial property, for applicants who are entitled, but, in good faith, are unable to procure insurance through the voluntary market. The corporation shall operate pursuant to a plan of operation approved by order of the Financial Services Commission. The plan is subject to continuous review by the commission. The commission may, by order, withdraw approval of all or part of a plan if the commission determines that conditions have changed since approval was granted and that the purposes of the plan require changes in the plan. For the purposes of this subsection, residential coverage includes both personal lines residential coverage, which consists of the type of coverage provided by homeowner's, mobile home owner's, dwelling, tenant's, condominium unit owner's, and similar policies; and commercial lines residential coverage, which consists of the type of coverage provided by condominium association, apartment building, and similar policies.

3. Effective January 1, 2009, a personal lines residential structure that has a dwelling replacement cost of $2 million or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $2 million or more is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2008, may continue to be covered by the corporation until the end of the policy term. However, such dwellings may reapply and obtain coverage if the property owner provides the corporation with a sworn affidavit from one or more insurance agents, on a form provided by the corporation, stating that the agents have made their best

efforts to obtain coverage and that the property has been rejected for coverage by at least one authorized insurer and at least three surplus lines insurers. If such conditions are met, the dwelling may be insured by the corporation for up to 3 years, after which time the dwelling is ineligible for coverage. The office shall approve the method used by the corporation for valuing the dwelling replacement cost for the purposes of this subparagraph. If a policyholder is insured by the corporation prior to being determined to be ineligible pursuant to this subparagraph and such policyholder files a lawsuit challenging the determination, the policyholder may remain insured by the corporation until the conclusion of the litigation.

4. It is the intent of the Legislature that policyholders, applicants, and agents of the corporation receive service and treatment of the highest possible level but never less than that generally provided in the voluntary market. It is also intended that the corporation be held to service standards no less than those applied to insurers in the voluntary market by the office with respect to responsiveness, timeliness, customer courtesy, and overall dealings with policyholders, applicants, or agents of the corporation.

5. Effective January 1, 2009, a personal lines residential structure that is located in the "wind-borne debris region," as defined in s. 1609.2, International Building Code (2006), and that has an insured value on the structure of $750,000 or more is not eligible for coverage by the corporation unless the structure has opening protections as required under the Florida Building Code for a newly constructed residential structure in

that area. A residential structure shall be deemed to comply with this subparagraph if it has shutters or opening protections on all openings and if such opening protections complied with the Florida Building Code at the time they were installed.

~~6. For any claim filed under any policy of the corporation, a public adjuster may not charge, agree to, or accept any compensation, payment, commission, fee, or other thing of value greater than 10 percent of the additional amount actually paid over the amount that was originally offered by the corporation for any one claim.~~

Section 2. This act shall take effect July 1, 2013.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1329 Citizens Property Insurance Corporation
SPONSOR(S): Oliva and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1612

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Callaway	Cooper
2) Regulatory Affairs Committee			

SUMMARY ANALYSIS

Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market. As of January 31, 2013, Citizens is the largest property insurer in Florida with almost 1.3 million policies extending approximately $418 billion of property coverage to Floridians.

There are various types of adjusters: public adjusters, independent adjusters, company employee adjusters, and catastrophe or emergency adjusters. A public adjuster is hired and paid by the policyholder to act on his or her behalf in a claim filed against an insurer. Public adjusters can represent a policyholder in any type of insurance claim, not just property insurance claims. Public adjusters operate independently and are not affiliated with any insurer, however, independent and company employee adjusters work for insurers. Public adjusters are typically paid a percentage of the claim payment or settlement, meaning the policyholder's claim payment or settlement amount is reduced by the public adjuster's fee. Independent and company employee adjusters do not charge policyholders a fee for adjusting the claim. The public adjuster fee percentage is usually negotiated between the public adjuster and the policyholder. However, in residential property and condominium unit owner property claims, the maximum public adjuster fee is set by law as follows:

Initial Claims: For initial residential and condominium unit owner property insurance claims, public adjusters are paid a maximum of 10% of the claim payment for claims resulting from a declaration of a state of emergency (i.e., claims from a hurricane) if the initial claim is made in the year after the declaration. For claims made after this time, public adjusters are paid a maximum of 20% of the claim payment. Public adjusters are paid a maximum of 20% of a claim payment for initial residential and condominium unit owner property insurance claims not resulting from hurricanes.
Reopened or Supplemental Claims: The public adjuster fee for reopened or supplemental claims on residential and condominium unit owner property insurance policies cannot exceed 20% of the claim payment obtained on the reopened or supplemental claim. Unlike initial claims, there is no difference in the fee restriction for reopened or supplemental claims based on whether or not the claim resulting from a hurricane.
Claims Filed Against Citizens: For all claims against Citizens, a public adjuster representing a Citizens' policyholder is paid a maximum fee of 10% of the additional claim amount paid over the amount originally offered by Citizens. This fee restriction applies to initial claims resulting from hurricanes, initial claims not resulting from hurricanes, and reopened or supplemental claims.

The bill repeals current law limiting the public adjuster fee for claims filed against Citizens. Thus, public adjusters representing Citizens' policyholders will be paid the same fee on initial and reopened or supplemental claims as those representing non-Citizens' policyholders.

The bill has no fiscal impact on state or local governments. Public adjusters representing Citizens' policyholders will receive higher fees than under current law, but not higher than those given public adjusters currently representing non-Citizens' policyholders. Citizens' policyholders could receive a smaller claim payment or settlement than under current law because the public adjuster fee is typically taken out of the claim payment or settlement and the fee allowed by the bill is higher than the fee allowed under current law. The bill is effective July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background of Citizens Property Insurance Corporation

Citizens is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market. It is not a private insurance company.

As of January 31, 2013, Citizens is the largest property insurer in Florida with almost 1.3 million policies extending approximately $418 billion of property coverage to Floridians.[1] Citizens insures over 444,000 residential and commercial policies in Florida's coastal areas and over 835,000 residential policies in Florida's non-coastal areas. The remaining policies are commercial policies insured in Florida's non-coastal areas. As of June 30, 2012, Citizens represented approximately 23 percent of the residential property admitted market based on number of policies.[2]

Citizens was created by the Legislature in 2002 by the merger of two existing property insurance associations: The Florida Residential Property and Casualty Joint Underwriting Association (FRPCJUA) and the Florida Windstorm Underwriting Association (FWUA). The FRPCJUA provided full-coverage personal and commercial residential property policies in all counties of Florida while the FWUA provided personal and commercial residential property wind-only coverage in designated territories.

Citizens writes various types of property insurance coverage for its policyholders. The types of coverage are divided into three separate accounts within the corporation:

1. Personal Lines Account (PLA) – Multiperil Policies[3]
   Consists of homeowners, mobile homeowners, dwelling fire, tenants, condominium unit owners and similar policies;
2. Commercial Lines Account (CLA) – Multiperil Policies
   Consists of condominium association, apartment building, homeowner's association policies, and commercial non-residential multiperil policies on property located outside the Coastal Account area; and
3. Coastal Account – Wind-only[4] and Multiperil Policies
   Consists of wind-only and multiperil policies for personal residential, commercial residential, and commercial non-residential issued in limited eligible coastal areas.

A major eligibility requirement for insurance in Citizens provided in current law is a 15 percent premium restriction. This restriction prevents a homeowner from buying insurance in Citizens if an insurer in the private market offers the homeowner insurance for a premium 15 percent or less than the Citizens' premium.[5] In addition, the coverage offered by the private insurer must be comparable to Citizens' coverage. Thus, a homeowner can buy insurance from Citizens only if the private insurer's premium is more than 15 percent than the Citizens' premium.

---

[1] https://www.citizensfla.com/ (last viewed February 22, 2013).

[2] "Florida Property Insurance Market Analysis and Recommendations," presentation to the Senate Committee on Banking and Insurance by Locke Burt, Chairman and President, Security First Insurance Company, dated February 6, 2013. Data based on the OIR QUASR Report. Citizens represents over 21% of the market based on total insured value and 20% of the homeowner's residential market based on 2011 written premium. (See "Principle-Based Reforms for Florida's Property Insurance Market," presentation to the Senate Committee on Banking and Insurance by Kevin M. McCarty, Insurance Commissioner, Florida Office of Insurance Regulation, dated January 16, 2013.).

[3] A multi-peril policy is defined as a package policy, such as a homeowners or business insurance policy that provides coverage against several different perils. It also refers to the combination of property and liability coverage in one policy. (http://www2.iii.org/glossary/) Multi-peril property insurance policies include coverage for damage from windstorm and from other perils, such as fire, theft, and liability.

[4] A wind-only policy is a property insurance policy that provides coverage against windstorm damage only. Coverage against non-windstorm events such as fire, theft, and liability are available in a separate policy.

[5] s. 627.351(6)(c)5.a., F.S. Commercial non-residential property is not subject to this eligibility restriction.

Citizens' Financial Resources to Pay Claims[6]

Citizens' financial resources include both resources typically available to private insurance companies and resources uniquely available to Citizens as a governmental entity with the statutory authority to levy assessments in the event of a deficit in Citizens' financial resources. Like typical private insurance companies, Citizens' financial resources include:

- insurance premiums;
- investment income;
- accumulated surplus;
- reimbursements from the Florida Hurricane Catastrophe Fund due to Citizens' purchase of reinsurance from the Florida Hurricane Catastrophe Fund; and
- reimbursements from private reinsurance companies if Citizens purchases private reinsurance.

Financial resources unique to Citizens include: Citizens Policyholder Surcharges, regular assessments, and emergency assessments.

Citizens projects the corporation will have $6.2 billion in surplus to pay claims during the 2012 hurricane season. In addition, Citizens could be reimbursed $6.9 billion for claims it pays by the Florida Hurricane Catastrophe Fund and $1.5 billion from private reinsurers claims paid in the Coastal Account. Thus, the maximum amount Citizens has to pay claims without levying assessments for the 2012 hurricane season is approximately $14.6 billion.[7]

As of January 31, 2013, Citizens' total exposure is over $418 billion. Citizens estimates the 1-in-100 year hurricane would cost almost $24 billion.[8] The $9.4 billion difference between Citizens' resources to pay claims ($14.6 billion) and its 1-in-100 year exposure ($24 billion) would be covered by assessments levied by Citizens on its own policyholders and on policyholders of most property and casualty insurance.

Assessments Levied by Citizens

In the event Citizens incurs a deficit (i.e. its obligations to pay claims exceeds its capital plus reinsurance recoveries), it may levy assessments on most of Florida's property and casualty insurance policyholders in a specific sequence set by statute.[9] The three Citizens' accounts calculate deficits and resulting assessment needs independently. The three types of assessments Citizens can levy are:

1. Citizens Policyholder Assessments,
2. Regular Assessments, and
3. Emergency Assessments.

Citizens Policyholder Assessments

If Citizens incurs a deficit, Citizens will first levy surcharges on its policyholders of up to 15 percent of premium per account in deficit, for a maximum total of 45 percent.

---

[6] All Citizens' projections about claims paying capacity for the 2012 hurricane season are found in meeting materials from Citizens presented at the Insurance & Banking Subcommittee meeting held on January 15, 2013. Citizens has not finalized its plan of finance for risk transfer and liquidity for 2013, although it has approval from their governing board to seek risk transfer of $1.75 billion for 2013 for the Coastal Account with the risk transfer methods of continuation of 2012 capital market transactions and private reinsurance, replacement of 2012 traditional reinsurance, and new capital market transactions. The board also approved a $600 million pre-event liquidity financing program for the Coastal Account. No risk transfer methods were requested or approved for the PLA and CLA due to the significant amount of surplus in these accounts. (See meeting materials from the Citizens' Board of Governors meeting on February 14, 2013, available at https://www.citizensfla.com/about/mDetails_boardmtgs.cfm?event=504&when=Past (last viewed February 22, 2013)).

[7] Citizens has also issued $5.1 billion in pre-event bonds to create additional liquidity to pay claims during the 2012 hurricane season. If these funds are used to pay claims during the 2012 hurricane season, then monies drawn must be repaid and assessments will likely be levied by Citizens to provide funds for repayment. Thus, pre-event bonding is not included in this calculation of the amount of funds Citizens has to pay claims because this calculation is the amount available to pay claims without assessing policyholders.

[8] A 1-in-100 year hurricane has a 1 percent probability of occurring. Information on probable maximum loss is contained in the meeting packet from the Insurance & Banking Subcommittee meeting on January 15, 2013.

[9] s. 627.351(6)(b)3.a.,d., and i., F.S.

Regular Assessments

If the Coastal Account incurs a deficit that the levy of a Citizens Policyholder Assessment does not cure, then Citizens may levy another assessment, a regular assessment, of up to 2 percent of premium or 2 percent of the remaining deficit in the Coastal Account.[10] The regular assessment is levied on virtually all property and casualty policies in the state, but not on Citizens' policies. The assessment is also not levied on workers' compensation, medical malpractice, accident and health, crop or federal flood insurance policies.

Regular assessments cannot be levied for deficits in the PLA or CLA. Only Citizens Policyholder Assessments and emergency assessments can be levied to cure deficits in these accounts.

Emergency Assessments

If the PLA or CLA incurs a deficit that a Citizens Policyholder Assessment levy does not cure, then Citizens may levy another assessment, an emergency assessment, to cure the deficit. An emergency assessment may also be levied for deficits in the Coastal Account that a Citizens Policyholder Assessment and regular assessment do not cure. Emergency assessments are limited to 10 percent of premium or 10 percent of the deficit per account, for a maximum total of 30 percent.[11] This assessment can be collected for as many years as is necessary to cure a deficit. Emergency assessments are levied on virtually all property and casualty policies in the state, including Citizens' own policies. However, this assessment is not levied on workers' compensation, medical malpractice, accident and health, crop or federal flood insurance policies.

Background on Public Adjusters

Chapter 626, F.S., regulates insurance field representatives and operations. Part VI of the chapter governs insurance adjusters. The law recognizes various types of adjusters, including public adjusters, independent adjusters, company employee adjusters, and catastrophe or emergency adjusters. Adjusters can be further classified as resident or nonresident. Resident adjusters are those who reside in Florida and are licensed in Florida, whereas, nonresident adjusters reside outside of Florida and are licensed by their home state.

The Department of Financial Services (DFS) regulates all types of adjusters. The DFS reports Florida currently licenses almost 33,000 resident adjusters and approximately 51,500 non-resident adjusters.[12] Of these, 1,095 are resident public adjusters and 336 are non-resident public adjusters. The rest are resident and nonresident independent adjusters and company employee adjusters.[13]

A public adjuster is hired and paid by the policyholder to act on his or her behalf in a claim the policyholder files against an insurance company. Public adjusters can represent a policyholder in any type of insurance claim, not just property insurance claims. Public adjusters, unlike company employee adjusters, operate independently and are not affiliated with any insurance company. Independent and company employee adjusters work for insurance companies.

Current law provides numerous restrictions and parameters on activities of public adjusters.[14] Administrative rules also address public adjuster activities.[15] Public adjuster activities addressed by current law include: advertisement and solicitation, referrals, referral fees, loans to clients or prospective clients, notice of property loss claims, and allowing access to damaged property by other parties involved in the claim.

---

[10] s. 627.351(6)(b)3.a., F.S.

[11] s. 627.352(6)(b)3.d., F.S.

[12] Information obtained from the DFS dated March 20, 2013, on file with staff of the Insurance & Banking Subcommittee.

[13] According to DFS, there are 15,035 licensed resident independent adjusters (16,214 non-resident independent adjusters); 16,015 licensed resident company employee adjusters (35,014) non-resident company employee adjusters).

[14] Laws enacted in 2008 (Ch. 2008-220, L.O.F.), in 2009 (Ch. 2009-87, L.O.F.), and 2011 (Ch. 2011-39, L.O.F.) provided significant changes relating to public adjusters.

[15] Rule 69B-220.201(4) and (5), F.A.C.

Public adjusters are licensed by the DFS if they meet the statutory qualifications for licensure found in s. 626.865, F.S. Qualifications include age, residency, testing, experience, and trustworthiness.[16] Public adjusters must also present a $50,000 bond to DFS in order to be licensed.[17] No bond is required of company employee or independent adjusters.

Report by the Office of Program Policy Analysis and Government Accountability (OPPAGA) on Public Adjusters

In January 2010, the OPPAGA, at the request of the Legislature,[18] issued Report Number 10-06 on public adjuster representation in Citizens' claims.[19] The report examined data related to public adjuster representation in general and data related to public adjuster representation in Citizens' claims. The report found Citizens' claims filed in 2008 and 2009 with public adjuster involvement took longer to reach a settlement and had higher claims payments than those without public adjuster involvement.[20]

Public Adjuster Fees[21]

Generally, public adjusters are typically paid a percentage of the claim payment, meaning the policyholder's claim payment amount is reduced by the public adjuster's fee. Independent and company employee adjusters do not charge policyholders a fee for adjusting the claim. The public adjuster fee percentage is usually negotiated between the public adjuster and the policyholder, except in residential property and condominium unit owner property claims. For these claims, public adjuster fees are limited by law to a specified percentage of the claim amount which varies depending on whether the claim is hurricane or non-hurricane related and if the claim is hurricane-related, depending on how soon after the hurricane the claims is filed. In addition with supplemental or reopened claims for residential property or condominium unit owners, the public adjuster fee cannot be based on the amount paid to the policyholder on the previous claim. Claims filed against Citizens apply a different public adjuster fee.

The Legislature first restricted fees charged by public adjusters in property insurance claims in 2008. The Legislature made further changes in 2011. Currently, the maximum fee for a public adjuster is different depending on if the claim is an initial claim, a reopened or supplemental claim, or a claim against Citizens. The fees are as follows:

Initial Claims: For initial residential and condominium unit owner property insurance claims, public adjusters are paid a maximum of ten percent of the insurance claim payment for claims resulting from a declaration of a state of emergency (i.e., claims from a hurricane) if the initial claim is made in the year after the declaration. For claims made after this time, public adjusters are paid a maximum of 20 percent of the claim payment.

Public adjusters are paid a maximum of 20 percent of a claim payment for initial residential and condominium unit owner property insurance claims not resulting from hurricanes.

Reopened or Supplemental Claims: The public adjuster fee for reopened or supplemental claims on residential and condominium unit owner property insurance policies cannot exceed 20 percent of the

[16] Similar qualifications apply to independent and company adjusters.

[17] s. 626.865(2), F.S.

[18] Ch. 2009-87, L.O.F. The legislation directed the OPPAGA report to address specific questions about public adjuster regulation in Florida, public adjuster regulation in Florida compared to other states, and the frequency and outcome on claims processing and payments resulting from public adjuster representation of Citizens' policyholders.

[19] Report available at http://www.oppaga.state.fl.us/Summary.aspx?reportNum=10-06 (last viewed March 20, 2013).

[20] The OPPAGA report found claims processing took between 132 and 296 days longer than claims without public adjuster representation and found the typical claim payment for a claim related to the 2004 hurricanes against Citizens involving a public adjuster was $22,266 for claims filed in 2008 and 2009 whereas the typical claim payment for a claim related to the 2004 hurricanes against Citizens not involving a public adjuster during the same time period was $18,659. For claims related to the 2005 hurricanes, the difference in claim payment was larger, with claims involving public adjusters resulting in claim payments that were 747% higher.

[21] Public adjuster fee restrictions are found in s. 626.854(11), F.S.

claim payment obtained on the reopened or supplemental claim. Unlike initial claims, there is no difference in the fee restriction for reopened or supplemental claims based on whether or not the claim resulting from a hurricane.

Claims Filed Against Citizens Property Insurance Corporation: For all claims against Citizens, a public adjuster representing a Citizens' policyholder is paid a maximum fee of 10 percent of the additional claim amount paid over the amount originally offered by Citizens. This fee restriction applies to initial claims resulting from hurricanes, initial claims not resulting from hurricanes, and reopened or supplemental claims.

Effect of Proposed Changes

The bill repeals the law restricting fees paid to public adjusters representing a Citizens' policyholder to 10 percent of the additional claim amount paid over the amount originally offered by Citizens. Thus, public adjusters representing Citizens' policyholders will be paid the same fees for representing Citizens' policyholders as when they represent non-Citizens' policyholders. The fee amounts differ based on whether the claim is an initial claim or reopened or supplemental claim and are set forth above.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.351, F.S., relating to insurance risk apportionment plans.

Section 2: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Public adjusters representing Citizens' policyholders will receive higher fees than they receive under current law. However, the fees will not be greater than those accorded public adjusters representing non-Citizens' policyholders. Because a public adjuster fee is taken out of a claim payment or settlement, a higher public adjuster fee for a Citizens' claim than is allowed under current law could reduce the amount of the claim payment or settlement allocated to the Citizens' policyholder.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to delivery of insurance policies; amending s. 627.421, F.S.; authorizing an insurer to electronically transmit an insurance policy to the insured or other person entitled to receive the policy; providing construction for specified types of insurance policies delivered electronically; providing an exception to electronic transmission for specified policies; providing requirements for electronic transmission of a policy; requiring that a paper copy of the policy be provided upon request of the insured or other person entitled to receive the policy; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (1) of section 627.421, Florida Statutes, is amended to read:

627.421 Delivery of policy.—

(1) Subject to the insurer's requirement as to payment of premium, every policy shall be mailed, ~~or~~ delivered, or electronically transmitted to the insured or to the person entitled thereto not later than 60 days after the effectuation of coverage. Electronic transmission of a policy for commercial risks including, but not limited to, workers' compensation and employers liability, commercial automobile liability, commercial automobile physical damage, commercial lines residential property, commercial nonresidential property, farm owners

insurance, and the types of commercial lines risks set forth in s. 627.062(3)(d) shall constitute delivery to the insured or to the person entitled to delivery, unless the insured or the person entitled to delivery communicates to the insurer in writing or electronically that he or she does not agree to delivery by electronic means. Electronic transmission shall include a notice to the insured or to the person entitled to delivery of a policy of his or her right to receive the policy via U.S. mail, rather than via electronic transmission. A paper copy of the policy shall be provided to the insured or to the person entitled to delivery at his or her request.

Section 2. This act shall take effect July 1, 2013.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 157 Delivery of Insurance Policies
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Callaway	Cooper

SUMMARY ANALYSIS

Section 627.421, F.S., requires every insurance policy to be mailed or delivered to the insured (policyholder) or any other person entitled to delivery of the policy within 60 days after the insurance takes effect. Insurance policies are typically delivered when the policy is issued and are not delivered each time the policy is renewed.

The PCS allows insurers to deliver insurance policies by electronic transmission. The PCS further specifies electronic transmission of an insurance policy related to commercial risks constitutes deliver of the policy to the policyholder unless the policyholder tells the insurance company in writing or in an electronic format that they do not agree to have their policy delivered by electronic transmission. If a policy covering commercial risks is transmitted to the policyholder electronically, then the transmission must include a notice to the policyholder indicating the policyholder has a right to receive the policy by mail instead of electronic transmission. In addition, a paper copy of the policy must be provided to policyholders upon request.

Electronic transmission of insurance documents is governed by the Federal Electronic Signatures in Global and National Commerce Act (E-SIGN) and Florida's adoption of the Uniform Electronic Transactions Act (UETA) as adopted by the National Conference of Commissioners on Uniform State Laws, which is Florida's Uniform Electronic Transaction Act (FUETA). Under E-SIGN, if a statute requires information to be provided or made available to a consumer in writing, the use of an electronic record to provide or make the information available to the consumer will satisfy the statute's requirement of writing if the consumer affirmatively consents to use of an electronic record. However, FUETA should preempt the provisions of the E-SIGN law because Florida substantively adopted UETA and E-SIGN allows for state preemption if UETA is adopted by the state.

FUETA specifically applies to insurance. One provision of FUETA provides if parties have agreed to conduct a transaction by electronic means and a provision of law requires a person to deliver information in writing to another person, that delivery requirement is satisfied if the information is delivered in an electronic record capable of retention by the recipient. Furthermore, whether parties have agreed to conduct a transaction by electronic means is determined from the context and surrounding circumstances, including the parties' conduct. No affirmative consent is required. In addition, another provision of FUETA provides if a Florida law other than FUETA requires a record to be sent or transmitted by a certain method, the record must be sent or transmitted by the method provided in the other law. The PCS could implicate either of these two provisions. If either is implicated, then affirmative consent of the policyholder is not required for the insurer to electronically transmit the insurance policy to the policyholder.

The PCS has no fiscal impact on state or local government. Insurers emailing policies to policyholders instead of mailing them will save costs associated with printing and mailing insurance policies to policyholders. The exact amount of savings cannot be calculated as it is unknown how many insurers will opt to email policies. Any savings realized by insurers should be passed through to policyholders. If insurers incur computer reprogramming costs associated with emailing policies, any increased costs will be passed through to policyholders.

The PCS is effective upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Section 627.421, F.S., requires every insurance policy[1] to be mailed or delivered to the insured (policyholder) or any person entitled to delivery of the policy within 60 days after the insurance takes effect. Insurance policies are typically only delivered when the policy is issued and are not delivered each time the policy is renewed.

The PCS allows insurers to deliver insurance policies by electronic transmission. The PCS further specifies electronic transmission of an insurance policy related to commercial risks[2] constitutes deliver of the policy to the policyholder or any other person entitled to delivery of the policy unless the policyholder or other person tells the insurance company in writing or in an electronic format that they do not agree to have their policy delivered by electronic transmission. If a policy covering commercial risks is transmitted to the policyholder or other person entitled to delivery of the policy electronically, then the transmission must include a notice to the policyholder or other person indicating the policyholder has a right to receive the policy by mail instead of electronic transmission. In addition, a paper copy of the policy must be provided to the policyholder or other person upon request.

Applicability of Federal and State Law Relating to Electronic Transactions

The Federal Electronic Signatures in Global and National Commerce Act (E-SIGN) applies to electronic transactions involving interstate commerce.[3] Insurance is specifically included in E-SIGN.[4] E-SIGN provides contracts formed using electronic signatures on electronic records will not be denied legal effect only because they are electronic. However, E-SIGN requires consumer disclosure and consent to electronic records in certain instances before electronic records will be given legal effect. Under E-SIGN, if a statute requires information to be provided or made available to a consumer in writing, the use of an electronic record to provide or make the information available to the consumer will satisfy the statute's requirement of writing if the consumer affirmatively consents to use of an electronic record. The consumer must also be provided with a statement notifying the consumer of the right to have the electronic information made available in a paper format and of the right to withdraw consent to electronic records, among other notifications.

E-SIGN allows state law to preempt the E-SIGN law in certain circumstances. State law addressing electronic transmission can preempt E-SIGN if the state law is an enactment of the Uniform Electronic Transactions Act (UETA) as adopted by the National Conference of Commissioners on Uniform State Laws. Alternatively, a state law that is not an enactment of UETA but is not inconsistent with E-SIGN and does not give greater legal status or effect to a specific form of technology or signature can preempt E-SIGN.[5] Florida adopted the substantive provisions of UETA in 2000 and has not substantively changed the provisions since they were adopted.[6] Thus, the Florida adoption of UETA

---

[1] s. 627.402, F.S., defines policy to include endorsements, riders, and clauses. Reinsurance, wet marine and transportation insurance, title insurance, and credit life or credit disability insurance policies do not have to be mailed or delivered. (see s. 627.401, F.S.)

[2] Commercial risks specified in the PCS are: workers' compensation and employers liability, commercial automobile liability, commercial automobile physical damage, commercial lines residential property, commercial nonresidential property, farm owners insurance, and commercial risks listed in s. 627.062(3)(d), F.S. which do not file rates with the OIR for approval for use.

[3] Section 101, Electronic Signatures in Global and National Commerce Act, Pub. L. no. 106-229, 114 Stat 464 (2000). Many of the provisions of E-SIGN took effective October 1, 2000.

[4] *Id.*

[5] 15 USC 7002

[6] http://www.uniformlaws.org/Act.aspx?title=Electronic Transactions Act (last viewed March 15, 2013), http://www.ncsl.org/issues-research/telecom/uniform-electronic-transactions-acts.aspx (last viewed March 17, 2013), and Final Staff Analysis for CS/CS/SB 1334 prepared by the House of Representatives Committee on Utilities & Communications, available at http://archive.flsenate.gov/session/index.cfm?BI_Mode=ViewBillInfo&Mode=Bills&ElementID=JumpToBox&SubMenu=1&Year=2000&billnum=1334 (last viewed March 17, 2013) indicating on page 10 that "the bill is identical to the act recommended by the National Commissioners for Uniform State Laws except for provisions that were added to conform to Florida law and provisions added to subsection (11) requiring a first time notary to complete certain training requirements." Although Florida's adoption of the UETA has been amended five times since adoption in 2000, none of the amendments were substantive.

should preempt E-SIGN. Section 668.50, F.S., Florida's Uniform Electronic Transaction Act (FUETA), is Florida's adoption of UETA.

Although UETA and E-SIGN overlap in some areas, they differ on some consumer protection issues. E-SIGN focuses on regulating the manner of consent to deal electronically, while UETA focuses on how the parties are to comply with state consumer protections laws.[7] By adopting the official version of UETA, states can modify, limit, or supersede some E-SIGN provisions, including its consumer protection issues, which includes E-SIGN's requirement of consumer disclosure and affirmative consent for electronic records.[8]

FUETA specifically applies to insurance. One provision provides if parties have agreed to conduct a transaction by electronic means and a provision of law requires a person to deliver information in writing to another person, that delivery requirement is satisfied if the information is delivered in an electronic record capable of retention by the recipient.[9] Furthermore, whether parties have agreed to conduct a transaction by electronic means is determined from the context and surrounding circumstances, including the parties' conduct.[10]

Emailing an insurance policy to the policyholder could fall under this provision of FUETA, in part, because in order to email a policy, the policyholder must provide an email address to the insurer which could be construed to mean the parties have agreed to conduct a transaction by electronic means. If this is the case, then current law requiring delivery of an insurance policy by mail or other delivery may be satisfied by emailing the policy. The consent of the policyholder to receive the policy by email would not be required in this case because under FUETA, consent is not required when the parties agree to conduct a transaction electronically. Additionally, the PCS requires the insurer to notify the policyholder when the insurance policy is emailed that the policyholder can elect to receive the policy by mail in lieu of email. Once this notice is given, a policyholder's action to not elect to receive the policy by mail may be construed to mean the parties have agreed to conduct a transaction by electronic means and thus, under FUETA, consent is not required for electronic delivery of the policy to the policyholder.

In addition, another provision of FUETA provides if a Florida law other than FUETA requires a record to be sent or transmitted by a certain method, the record must be sent or transmitted by the method provided in the other law.[11] This provision may allow an insurance policy to be emailed to a policyholder if the current law requiring delivery of an insurance policy to the policyholder is amended to allow electronic delivery, as the PCS proposes, because the amended law allowing electronic delivery of a policy may control over FUETA.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.421, F.S., relating to delivery of policy.

Section 2: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

[7] Fry, Patricia Bumfield, *A Preliminary Analysis of Federal and State Electronic Commerce Laws*, available at http://uniformlaws.org/Narrative.aspx?title=UETA%20and%20Preemption%20Article (last viewed March 14, 2013).
[8] http://www.ncsl.org/issues-research/telecom/uniform-electronic-transactions-acts.aspx (last viewed March 17, 2013).
[9] s. 668.50(8)(a), F.S.
[10] s. 668.50(5)(b), F.S.
[11] s. 668.50(8)(b), F.S.

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Insurers emailing policies to policyholders instead of mailing them will save costs associated with printing and mailing insurance policies to policyholders. The exact amount of savings cannot be calculated as it is unknown how many insurers will opt to email rather than by mail. However, any savings realized by insurers should be passed through to policyholders.

If insurers incur computer reprogramming costs associated with emailing policies, any increased costs will be passed through to policyholders.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This PCS does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided in the PCS.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to property insurance; amending s. 627.0629, F.S.; revising the criteria for when the office may hold a public hearing regarding a rate filing; amending s. 627.351, F.S.; requiring the corporation to prepare a report for each calendar year relating to the loss ratio attributable to losses that are not catastrophic losses for residential coverage provided by the corporation; amending s. 627.422, F.S.; allowing a property insurance policy to prohibit the post loss assignment of rights, causes or action, or benefits with an exception; amending s. 627.706, F.S.; requiring insurers to offer sinkhole loss coverage with specified coverage limits; requiring discounts for the coverage limits; requiring insurers to offer sinkhole loss deductibles in specified percentages of policy dwelling limits; amending s. 627.707, F.S.; revising provisions relating to the payment of lienholders and other persons for stabilization and repair; amending s. 627.7074, F.S.; deleting a provision that allows a policyholder to obtain attorney fees under certain circumstances; providing for construction; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (6) of s. 627.0629, Florida Statutes, is amended to read:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

V

627.0629 Residential property insurance; rate filings.—

(6) The office may hold a public hearing for a ~~Any~~ rate filing that is based in whole or in part on data from a computer model ~~may not exceed 15 percent unless there is a public hearing~~.

Section 2. Paragraph (gg) is added to subsection (6) of section 627.351, Florida Statutes, to read:

627.351 Insurance risk apportionment plans.-

(6) CITIZENS PROPERTY INSURANCE CORPORATION.-

(gg) The corporation must prepare a report for each calendar year outlining both the statewide average and county-specific details of the loss ratio attributable to losses that are not catastrophic losses for residential coverage provided by the corporation, which information must be presented to the office and available for public inspection on the Internet website of the corporation by January 15th of the following calendar year.

Section 3. Section 627.422, Florida Statutes, is amended to read:

627.422 Assignment of policies.—

(1) A policy may be assignable, or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or health insurance policy under the terms of which the beneficiary may be changed upon the sole request of the policyowner may be assigned either by pledge or transfer of title, by an assignment executed by the policyowner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle

the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

(2) A property insurance policy may prohibit the post loss assignment of rights, benefits, causes of action, chose in action or other contractual rights under the policy, except for the limited purpose permitted by 626.854(11) of compensating of a public adjuster for services. Except as provided in this subsection, any post loss assignment of rights, benefits, causes of action, chose in action or other contractual rights under a property insurance policy which prohibits such assignment shall render the assignment void.

Section 4. Paragraph (b) of subsection (1) of section 627.706, Florida Statutes, is amended to read:

627.706 Sinkhole insurance; catastrophic ground cover collapse; definitions.—

(1)

(b) The insurer shall make available, for an appropriate additional premium, coverage for sinkhole losses on any structure, including the contents of personal property contained therein, to the extent provided in the form to which the coverage attaches. The insurer must offer sinkhole loss coverage for 50%, 75%, and 100% of the policy dwelling limits, with appropriate premium discounts offered with each coverage limit. The insurer may require an inspection of the property before issuance of sinkhole loss coverage. For ~~A policy for~~ residential

property insurance the insurer must offer ~~may include~~ a deductible amount applicable to sinkhole losses equal to ~~1 percent,~~ 2 percent, 5 percent, or 10 percent of the policy dwelling limits, with appropriate premium discounts offered with each deductible amount.

Section 5. Paragraph (e) of subsection (5) of section 627.707, Florida Statutes, is amended to read:

627.707 Investigation of sinkhole claims; insurer payment; nonrenewals.—Upon receipt of a claim for a sinkhole loss to a covered building, an insurer must meet the following standards in investigating a claim:

(5) If a sinkhole loss is verified, the insurer shall pay to stabilize the land and building and repair the foundation in accordance with the recommendations of the professional engineer retained pursuant to subsection (2), with notice to the policyholder, subject to the coverage and terms of the policy. The insurer shall pay for other repairs to the structure and contents in accordance with the terms of the policy. If a covered building suffers a sinkhole loss or a catastrophic ground cover collapse, the insured must repair such damage or loss in accordance with the insurer's professional engineer's recommended repairs. However, if the insurer's professional engineer determines that the repair cannot be completed within policy limits, the insurer must pay to complete the repairs recommended by the insurer's professional engineer or tender the policy limits to the policyholder.

(e) If there is any lienholder, upon the insurer's obtaining the written approval of the ~~any~~ lienholder, the

insurer must ~~may~~ make all payments ~~payment~~ directly to the persons selected by the policyholder to perform the land and building stabilization and foundation repairs. If there is no lienholder, the insurer must make all payments directly to the persons selected by the policyholder to perform the land and building stabilization and foundation repairs. The decision by the insurer to make payment to such persons does not hold the insurer liable for the work performed.

Section 6. Paragraph (b) of subsection (15) of section 627.7074, Florida Statutes, is amended to read:

627.7074 Alternative procedure for resolution of disputed sinkhole insurance claims.—

(15) If the insurer timely agrees in writing to comply and timely complies with the recommendation of the neutral evaluator, but the policyholder declines to resolve the matter in accordance with the recommendation of the neutral evaluator pursuant to this section:

(b) The actions of the insurer are not a confession of judgment or admission of liability, and the insurer is not liable for attorney ~~attorney's~~ fees under s. 627.428 or other provisions of the insurance code ~~unless the policyholder obtains a judgment that is more favorable than the recommendation of the neutral evaluator~~.

Section 7. This act shall take effect July 1, 2013.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 909 Property Insurance
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Callaway	Cooper

SUMMARY ANALYSIS

The PCS contains a myriad of changes to current law relating to property insurance. Specifically, the PCS addresses: public hearings on rate filings, assignment of post-loss benefits, reporting on non-catastrophic losses for Citizens Property Insurance Corporation (Citizens), and sinkholes.

Current law requires every property insurance company to make an annual rate filing with the Office of Insurance Regulation (OIR) setting out the company's proposed rates. The OIR reviews the rate filing and either approves or disapproves the proposed rates. The OIR must hold a public hearing for any rate filing exceeding 15 percent that is based in whole or in part on data from a computer model. Instead of requiring a public hearing on these rate filings, the PCS gives the OIR discretion to hold a public hearing on them.

Generally, an assignment of benefits allows a third party to collect insurance proceeds owed to the policyholder directly from the insurance company. Thus, the proceeds are not paid to the policyholder. Assignment of benefits can be made in two circumstances, pre-loss assignment of benefits and post-loss assignment of benefits. Pre-loss assignments are made before a claim arises and post-loss assignments are made after a first party loss. Under current law, insurers can include a provision prohibiting the policyholder from making pre-loss assignments without consent of the insurer, but post-loss assignments are not prohibited. The PCS allows a property insurance policy to prohibit the policyholder from post-loss assignment of rights, causes of action, or benefits under the policy. An exception is made for assignment of public adjuster fees. A post-loss assignment made is void if the policy prohibits the assignment.

The PCS requires Citizens to prepare a report by January 15th of each year on non-catastrophic losses.

The PCS also makes changes to the sinkhole law. Insurers are allowed to offer sinkhole loss coverage limits in specified amounts which are lower than the policy limit. Insurers are required to offer sinkhole deductibles of two percent, five percent, and 10 percent of the policy dwelling limits. Current law does not require various sinkhole deductibles to be offered, although the law allows insurers to include various sinkhole deductibles in insurance policies. In addition, current law allowing a one percent sinkhole deductible is repealed by the PCS. The PCS requires insurers to make payments for sinkhole repairs directly to the repair contractor selected by the policyholder if the property has no liens against it. Finally, the PCS repeals current law allowing a policyholder in a sinkhole claim to collect attorney fees if the claim goes to neutral evaluation and the insurer timely complies with the neutral evaluator's recommendation, but the policyholder declines to resolve the claim and opts to proceed to court and obtains a judgment more favorable than the recommendation.

The PCS has no fiscal impact on state or local governments. Policyholders with insurance policies that prohibit post-loss assignments may incur out of pocket expenses to pay the repair contractor or vendor up front; however, the policyholder should be reimbursed for these expenses by the property insurer when the claim is paid and settled. Citizens may incur additional costs, including staff time, to calculate and publish the report required for non-catastrophic losses. The changes to the sinkhole deductible and coverage limit could increase or decrease a homeowner's out of pocket expenses for a sinkhole claim and the premium for sinkhole loss coverage, depending on which deductible or coverage limit the homeowner chooses. The change to the attorney fee provision relating to neutral evaluations may reduce legal expenses for sinkhole claims incurred by insurers. The PCS is effective July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Ratemaking Regulation for Property, Casualty, and Surety Insurance

The Rating Law for property, casualty, and surety insurance is located in Part I of ch. 627, F.S., (ss. 627.011 – 627.311, F.S.). The primary purpose of the Rating Law is to ensure insurance rates are not excessive, inadequate, or unfairly discriminatory. This standard applies to every property insurance rate.

Section 627.0645, F.S, requires every property insurance company to make a rate filing with the Office of Insurance Regulation (OIR) each year. The rate filing contains the insurance company's proposed rates. The OIR reviews the rate filing and either approves or disapproves the proposed rates. If an insurance company does not want to change its rates one year, instead of a rate filing, the insurer can file a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate.

An insurer has two options for a rate filing: a "file and use" rate filing or a "use and file" rate filing. If an insurer opts to file rates using a "file and use" rate filing, the rates must be filed for approval 90 days before the proposed effective date. OIR must finalize its review of the filing by issuing a notice of intent to approve or disapprove the rate filing within 90 days after receipt of the filing or the filing is deemed approved. If an insurer opts to file rates using a "file and use" rate filing, the rates must be filed for approval 30 days after the rate filing is implemented. If the OIR determines the rates already implemented are excessive, the insurer must refund that part of the rate found to be excessive to the policyholder.

The OIR may disapprove a rate filing if it determines the rates are excessive, inadequate, or unfairly discriminatory. In determining whether a rate is excessive, inadequate, or unfairly discriminatory, the OIR uses the following statutory factors.[1]

- Past and prospective loss experience in Florida and in other jurisdictions.
- Past and prospective expenses.
- Degree of competition to insure the risk.
- Investment income reasonably expected by the insurer.
- Reasonableness of the judgment reflected in the filing.
- Dividends, savings, or unabsorbed premium deposits returned to Florida insureds.
- Adequacy of loss reserves.
- Cost of reinsurance.
- Trend factors, including those for actual losses per insured unit.
- Catastrophe and conflagration hazards, when applicable.
- Projected hurricane losses, when applicable.
- A reasonable margin for underwriting profit and contingencies.
- Cost of medical services, when applicable.
- Other relevant factors impacting frequency and severity of claims or expenses.

The OIR must hold a public hearing for any rate filing exceeding 15 percent that is based in whole or in part on data from a computer model.[2] Instead of requiring a public hearing on these rate filings, the PCS gives the OIR discretion to hold a public hearing on them.

[1] s. 627.062(2), F.S.
[2] s. 627.0629(6), F.S.

Assignment of Benefits in Property Insurance

Generally, an assignment of benefits allows a third party to collect insurance proceeds owed to the policyholder directly from the insurance company. Thus, the proceeds are not paid to the policyholder. Assignment of benefits are commonly used in health insurance and personal injury protection insurance. In health insurance, a policyholder typically assigns his or her benefits to payment for a covered medical service to the health care provider. Thus, the treating physician gets paid directly from the insurer.

According to proponents of the PCS, assignment of benefits are becoming increasingly common in property insurance claims, especially in water damage claims where a homeowner assigns his or her right to receive benefits on their property insurance to a contractor or vendor who repairs the damaged property. Some insurers assert assignment of benefits to a contractor or vendor in a water damage claim can be problematic because if the contractor or vendor submits an invoice to the insurer that is more than what the insurer estimates it should cost to remediate and dry-out the policyholder's residence, the insurer must investigate the claim, determine why the invoice is higher than estimated by the insurer, and identify whether all the work indicated in the invoice was performed. Insurance policies typically provide authority for the insurer to take certain actions to investigate claims, such as requiring policyholders to file proofs of loss, to produce records, and to submit to examinations under oath. However, contractors or vendors obtaining an assignment of benefits for the claim many times allege they do not have to comply with the insurer's claims investigation authorized under the insurance policy because they agreed only to an assignment of the insurance benefits and did not agree to assume any of the duties under the insurance policy.

Assignment of benefits can be made in two circumstances, pre-loss assignment of benefits and post-loss assignment of benefits. Pre-loss assignments are made before a claim arises and post-loss assignments are made after a first party loss. Under Florida law[3], insurers can include a provision prohibiting the policyholder from making pre-loss assignments without consent of the insurer.[4] In other words, an insurer can include a prohibition in a property insurance policy that prohibits a policyholder from assigning his or her policy to a third party. However, such a prohibition does not prohibit the policyholder from assigning his or her rights under the policy once a claim arises.[5] Thus, even if the policy contains a provision prohibiting pre-loss assignment of benefits, the policyholder can still make a post-loss assignment of benefits.[6] One reason post-loss assignments are valid despite a provision prohibiting assignment without consent of the insurer in the policy is that once a loss occurs; the assignment is for moneys due under the policy and owed the policyholder (i.e., the policyholder's rights under the policy). If a post-loss assignment of benefits is made, the party receiving the assignment (assignee) cannot assert new rights of his or her own did not belong to the person assigning the rights (assignor). Also, the full extent of the assignor's claim is assignable so the assignee can collect the full value of the assignor's claim against the insurer.[7]

In addition, a contractual provision prohibiting an assignment of rights under the contract does not prohibit assignment of causes of action under the contract.[8]

The PCS allows a property insurance policy to prohibit the policyholder from post-loss assignment of rights, causes of action, or benefits under the policy. An exception is made for assignment of public adjuster fees. A post-loss assignment made is void if the policy prohibits the assignment.

---

[3] s. 627.422, F.S.

[4] This is usually done by an "consent to assignment clause." See Cordis Corporation v. Sonics International, 427 So.2d 782 (Fla. 3rd DCA 1983) noting "contractual provisions assignability are generally enforceable in Florida."

[5] Highlands Insurance Company v. Kravecas, 719 So.2d 320, (Fla. 3rd DCA 1998).

[6] Slominski v. Citizens Property Insurance Corporation, 99 So.3d 973(4th DCA 2012), citing Kroener v. Florida Insurance Guaranty Association, 63 Sol.3d 914 (Fla. 4th DCA 2011)).

[7] Highlands Insurance Company v. Kravecas, 719 So.2d 320, (Fla. 3rd DCA 1998).

[8] Cordis Corporation v. Sonics International, 427 So.2d 782 (Fla. 3rd DCA 1983).

Report by Citizens Property Insurance Corporation (Citizens) on Non-Catastrophic Losses

Currently, there is no required reporting on non-catastrophic losses for any insurer, including Citizens. The PCS requires Citizens to prepare a report by January 15th of each year on non-catastrophic losses. Specifically, the report must provide Citizens' loss ratio for non-catastrophic losses on a statewide and county basis. A loss ratio is the percentage of each premium dollar an insurer spends on claims.[9] For example, a loss ratio of 115 means for every $1 in premium collected by the insurer, the insurer pays out $1.15 in losses on a claim. The report must be provided to the OIR and posted on the Citizens Internet website.

Sinkholes

Background

A sinkhole is defined in Florida law as a landform created by subsidence of soil, sediment, or rock as underlying strata are dissolved by groundwater.[10] Sinkholes occur in certain parts of Florida due to the unique geological structure of the land. Sinkholes are geographic features formed by movement of rock or sediment into voids created by the dissolution of water-soluble rock. This type of subsidence formation may be aggravated and accelerated by urbanization and suburbanization, by water usage and changes in weather patterns.

Since 1981, insurers offering property coverage in Florida have been required by law to provide coverage for property damage from sinkholes.[11] In 2007, Florida law was amended to require insurers in Florida to cover only catastrophic ground cover collapse, rather than all sinkhole loss, in the base property insurance policy.[12] However, insurers must also offer policyholders, for an appropriate additional premium, sinkhole loss coverage covering any structure, including personal property contents.[13] At a minimum, sinkhole loss coverage includes repairing the covered building, repairing the foundation, and stabilizing the underlying land. By law, sinkhole loss coverage by Citizens does not cover sinkhole losses to appurtenant structures, driveways, sidewalks, decks, or patios. All property insurers can restrict catastrophic ground cover collapse and sinkhole loss coverage to the property's principal building. Furthermore, insurers can require an inspection of the property before providing sinkhole loss coverage.

For sinkhole loss coverage in residential property insurance, current law allows insurers to include a deductible that applies only to sinkhole loss in the following amounts: 1% of policy dwelling limits, 2% of policy dwelling limits, 5% of policy dwelling limits, or 10% of policy dwelling limits. The insurer has the option to choose which sinkhole loss deductible is offered to policyholders and currently, most insurers, including Citizens, offer policyholders only a 10% sinkhole loss deductible.

Property insurers can nonrenew policies that contain sinkhole loss coverage in the base property insurance policy and offer policyholders a base policy containing coverage for only catastrophic ground cover collapse and offer coverage for sinkhole loss as an endorsement to the base policy for an additional premium.

Notice of all sinkhole claims, including initial, reopened, or supplemental claims must be given to the insurer in accordance with policy terms within two years of the policyholder knowing about the sinkhole loss or within two years from when the policyholder reasonably should have known about the sinkhole loss.

Substantial changes to Florida's sinkhole law occurred in 2005, 2006, and 2011.[14] In 2011, the Legislature reviewed the sinkhole law and enacted comprehensive reforms addressing all areas of the law. Data collected by the Office of Insurance Regulation (OIR) in 2010, before the reforms were

[9] http://www2.iii.org/glossary/l/ (last viewed March 24, 2013).
[10] s. 627.706(2)(b), F.S.
[11] Ch. 1981-280, L.O.F.
[12] Section 30, Ch. 2007-1, L.O.F.
[13] s. 627.706, F.S.
[14] Ch. 2005-111, L.O.F.; Ch. 2006-12, L.O.F.; Ch. 2011-39, L.O.F.

enacted, showed a significant increase in the number and cost of sinkhole claims from 2006 to 2010.[15] These increases impacted the financial stability of property insurers in Florida, including Citizens Property Insurance Corporation (Citizens), and were used by insurers to justify property insurance rate increases.

The sinkhole reforms enacted in 2011 were in response to the increasing number and cost of sinkhole claims. The goal of the reforms was to keep sinkhole loss insurance available to homeowners while providing more certainty in sinkhole claims for homeowners and insurers in terms of coverage, costs, repairs, and exposure.

The first complete year the reforms were in effect was 2012.[16] No data has been collected on an industry-wide basis on the number of claims, claim severity, or claim costs since the reforms were enacted, so their impact on sinkhole claims and costs on an industry-wide basis is unknown. However, Citizens performed a sinkhole study in 2012 to compute the impact of the 2011 reforms on their policies.[17] This study looked at actual sinkhole claim files from Citizens and readjusted the losses and expenses associated with the claims as if the 2011 reforms had been in effect. The actuarial analysis which accompanied the study projected the 2011 reforms would reduce Citizens' expected incurred sinkhole losses for 2013 by almost 55 percent.

Insurance Adjusting of Sinkhole Claims

Under current law, when a claim is made for sinkhole loss, the insurer must inspect the property to determine if there is structural damage resulting from sinkhole activity.[18] The definition in current law for "structural damage" was enacted in 2011 and is based on descriptions of structural damage in the Florida Building Code that are applicable to sinkholes.

Following the insurer's initial inspection, the insurer must provide written notice to the policyholder detailing:[19]

- the insurer's initial determination of the cause of the damage, if a determination is made,
- when the insurer must hire a professional engineer or professional geologist to verify or eliminate sinkhole loss,
- when the insurer must hire an engineer to recommend land and building stabilization and foundation repairs,
- a statement of the policyholder's right to demand certain testing be conducted by a geologist or engineer,
- when the policyholder can demand testing, and
- when a policyholder has to pay for testing.

For insurance policies covering sinkhole loss, if the insurer's inspection of the damaged property confirms structural damage to the property, but does not identify the cause of the damage, or if the damage seen on inspection is consistent with sinkhole loss, the insurer must hire, and pay for, an engineer or geologist to conduct sinkhole testing to determine the cause of the damage to the property.[20] The engineer or geologist must issue a report on his or her findings (the report is discussed below).

If the insurer determines there is no sinkhole loss, the insurer can deny the sinkhole claim.[21] If an insurer determines there is no sinkhole loss and denies the sinkhole claim without sinkhole testing, the

---

[15] Report on Review of the 2010 Sinkhole Data Call by the Office of Insurance Regulation, dated November 8, 2010, link available at http://www.floir.com/Office/DataReports.aspx (last viewed March 10, 2013).
[16] The reforms were effective on May 17, 2011 when the bill (CS/CS/CS/SB 408) was signed by the Governor.
[17] Citizens Property Insurance Corporation Senate Bill 408 Sinkhole Analysis, prepared by Insurance Services Office, dated July 19, 2012, link available at https://www.citizensfla.com/about/mDetails_boardmtgs.cfm?event=419&when=Past (last viewed March 10, 2013).
[18] S. 627.707(1), F.S.
[19] S. 627.707(3), F.S.
[20] S. 627.708(2), F.S.
[21] S. 627.707(4)(a), F.S.

policyholder can demand testing. Policyholders can demand testing only if the insurance policy covers sinkhole loss. This prevents insurers from having to pay for sinkhole testing if the policy would not cover the damage. The policyholder's demand for testing must be communicated to the insurer within 60 days after the receipt of the denial of the sinkhole claim.[22] In addition, the policyholder demanding testing must pay the lesser of 50 percent of the sinkhole testing and sinkhole reporting costs or $2,500. But, the insurer must reimburse these costs to the policyholder if the testing reveals a sinkhole loss. However, if a policyholder submits a sinkhole claim without good faith grounds after sinkhole testing that reveals there is no sinkhole loss or that sinkhole activity did not cause the damage to the property, the policyholder must reimburse the insurer the lesser of 50 percent of the testing costs or $2,500.

Testing standards for sinkholes are established in s. 627.7072, F.S. The professional geologist or engineer must perform whatever tests are sufficient to determine the presence or absence of sinkhole loss or cause of damage within reasonable professional probability and to allow the engineer to make recommendations regarding any necessary building stabilization and foundation repair. Typically, the testing procedures used are shallow boring, ground penetrating radar, and deep boring.

Once testing is complete, the engineer or geologist performing the testing issues a report and certification to the insurance company and policyholder.[23] The requirements of the sinkhole report and certification are found in s. 627.7073(1), F.S. and are based upon sinkhole testing. If sinkhole loss is verified in the sinkhole report and certification, in addition to the other statements required by law, the report and certification must state structural damage to the covered building has been identified within a reasonable professional probability. In addition to other statements required by current law, if there is no structural damage or if sinkhole activity is eliminated as the cause of damage to a covered building, the report and certification must state there is no structural damage or the cause of structural damage found is not sinkhole activity within a reasonable professional probability. Florida law gives a presumption of correctness to specified information contained in the report.[24]

If the insurer verifies there is a sinkhole loss, the insurer must pay to stabilize the land and building and repair the foundation pursuant to the policy coverage and terms and in accordance with the recommendation of the professional engineer.[25] The policyholder is also given notice of the repairs to be done.

Regarding repair of sinkholes paid for by the insurer, the insurer can initially pay actual cash value of the sinkhole claim, except for the underpinning and other below foundation repair costs, until the policyholder enters into a contract to repair the sinkhole damage.[26] However, the insurer must pay for only repairs recommended in the sinkhole report prepared by the insurer's geologist or engineer.[27] The insurer must obtain approval of the property lienholder, and not the policyholder, in order to pay repair costs directly to the repair contractor. The policyholder chooses who makes the repairs.

For verified sinkholes, the policyholder must repair the property in accordance with the repair recommendations made by the insurer's engineer in the insurer's sinkhole report. The policyholder must enter into a contract to stabilize the building and repair the foundation within 90 days after the insurer confirms coverage for the sinkhole loss and notifies the policyholder of the confirmation.[28] Once the contract is entered into, the insurer pays the amount needed to begin repair work. The insurer continues to pay for repair work as the work is completed and repair costs incurred. The policyholder cannot be required to advance money for the repairs.

---

[22] ss. 627.707(4)(b) and (6), F.S.
[23] S. 627.7073(1), F.S.
[24] S. 627.7073(1)(c), F.S. See Universal Insurance Company of North America v. Warfel, 82 So.3d 47 (Fla. 2012) for a discussion of the presumption of correctness in sinkhole cases.
[25] S. 627.707(5),F.S.
[26] S. 627.707(5)(a), F.S.
[27] S. 627.707(5), F.S. Although a sinkhole report can be prepared by an engineer or a geologist, only an engineer can recommend sinkhole repairs. Furthermore, insurers are allowed in the law to hire professional structural engineers to recommend repairs on the damaged structure.
[28] The 90-day time period is tolled during the neutral evaluation and begins again 10 days after the neutral evaluation is completed.

Sinkhole repairs must be complete within 12 months after the repair contract is entered into. The exceptions to this 12-month limitation are: mutual agreement between the insurer and the policyholder, neutral evaluation of the claim, litigation of the claim, or appraisal or mediation of the claim. Once the repairs are completed, the engineer overseeing the repairs must issue a report certifying the repairs are properly performed.

If after repairs are started, the insurer's engineer determines that repairs cannot be completed within policy limits, the insurer must either complete the repairs or pay policy limits to the policyholder, without reducing the payment for repair costs already paid. In this case, insurers pay over policy limits on a sinkhole claim.

Although current law requires the homeowner to repair the property affected by a verified sinkhole, often times the insurer and homeowner settle the sinkhole claim before repair work is started.[29] Homeowners that settle sinkhole claims are not required to use claim settlements to repair or remediate the home and land. Thus, arguably, homeowners are incentivized to file sinkhole claims, reach a settlement with the insurer, and use the settlement proceeds for something other than repair and replacement of the sinkhole and resulting damage.

Insurers are not allowed to nonrenew a property insurance policy because a sinkhole claim is filed if the sinkhole claim payment equals or is less than policy limits or if the property was repaired. But, insurers can nonrenew a property insurance policy if policy limits or more are paid.

Insurers who pay a claim for sinkhole loss must file a copy of the engineer or geologist report and certification with the county clerk of court. Information filed must also include:

- the legal description of the property,
- the neutral evaluation report verifying sinkhole activity as the cause of the damage to the property, if the claim has gone to neutral evaluation,
- a copy of the certification indicating sinkhole stabilization has been completed, and
- the amount paid on the sinkhole claim.

The clerk must record the report and certification. The policyholder must also file a copy of any sinkhole report prepared for the policyholder with the clerk of court before accepting payment from the insurer on a sinkhole claim. When sinkhole repairs are completed, the engineer overseeing the repairs must issue a report to the property owner specifying what repairs were done and certifying the repairs were done properly. A copy of this report must also be filed by the engineer with the clerk of court who records the report.

When property that is the subject of a paid sinkhole claim is sold, the seller who filed the sinkhole claim must disclose to the buyer that a sinkhole claim has been paid. In addition, the seller must disclose whether or not the full amount of claim payment was used to repair the sinkhole damage.

The Alternative Dispute Resolution Process for Sinkhole Claims

Section 627.7074, F.S., provides an alternative dispute resolution process for sinkhole claims. The process supersedes the mediation procedures for property insurance claims contained in s. 627.7015, F.S., but does not invalidate the appraisal clause in the property insurance policy. Thus, a sinkhole claim can go through the neutral evaluation process and subsequently go through the appraisal process. The neutral evaluation process begins once an insurer receives the sinkhole report under s. 627.7073, F.S., or denies a sinkhole claim. When either occurs, the insurer must notify the policyholder of the right to participate in the neutral evaluation process. The insurer must also send a pamphlet on the neutral evaluation process prepared by the DFS to the policyholder.

Participation in the neutral evaluation process is mandatory if one party requests it, however, it is nonbinding. Either the policyholder or the insurer can request neutral evaluation of a sinkhole claim. At

[29] The OIR noted in its report on the 2010 data call sinkhole repairs were initiated in only 20 percent of the total claims reported.

the conclusion of the neutral evaluation, the neutral evaluator prepares a report containing recommendations about the validity of the sinkhole claim. The specific areas the neutral evaluator must opine on in the report is set forth in s. 627.7074(12), F.S. The recommendation of the neutral evaluator is not binding on either party, thus, either party can opt to litigate the sinkhole claim in court regardless of the neutral evaluator's recommendation on the claim. If the insurer timely agrees to comply with the neutral evaluator's recommendations in writing and does so, but the policyholder declines to resolve the claim and opts to proceed to court on the claim, the insurer is not liable for extracontractual damages for issues determined by the neutral evaluator and the insurer's actions to comply with the recommendation is not a confession of judgment that can be used in the court proceeding as an admission of liability on the part of the insurer. Furthermore, in the court proceeding, the insurer is not liable for attorney's fees unless the policyholder obtains a court judgment more favorable than the neutral evaluator's recommendation.

Effect of Proposed Changes Relating to Sinkhole Claims

The PCS makes several changes to current law relating to sinkhole claims. First, it requires insurers to offer a deductible amount of two percent, five percent, or 10 percent of the policy dwelling limits, with appropriate discounts offered with each deductible amount. This new requirement replaces the current statutory authorization which permits insurers to offer a deductible amount of one percent, two percent, five percent, or 10 percent. The effect of this change is that homeowners, if they choose a lower deductible, will pay more in premium, but will have to self-insure for less.

The PCS also requires insurers to offer sinkhole coverage for 50 percent, 75 percent, and 100 percent of the policy dwelling limits, with appropriate premium discounts offered with each coverage limit. Currently, insurers are not authorized to offer any limit on the amount of sinkhole loss coverage lower than 100 percent of the policy dwelling limit. With this change, homeowners will have a choice to accept an amount of sinkhole loss coverage lower than the insured value of the dwelling and will experience lower premium as a result. Conversely, if the sinkhole damage exceeds the coverage limits, the homeowner will not be insured for that amount over the limit.

The third change in the PCS relates to direct payments for repair work. Currently, if there is a lienholder on the damaged property, insurers, with the lienholder's approval, may make payments directly to the repair person. The PCS requires such direct payment if the lienholder approves. The PCS also makes insurers directly pay the repair person, if there is no lienholder.

The PCS also changes current law regarding attorney fees. In matters relating to the neutral evaluation process, insurers currently are not liable for attorney fees unless the policyholder obtains a judgment that is more favorable than the recommendation of the neutral evaluator. The PCS removes an insurer's liability for attorney fees in this situation.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.0629, F.S., relating to residential property insurance; rate filings.

Section 2: Amends s. 627.351, F.S., relating to insurance risk apportionment plans.

Section 3: Amends s. 627.422, F.S., relating to assignment of policies.

Section 4: Amends s. 627.706, F.S., relating to sinkhole insurance; catastrophic ground cover collapse; definitions.

Section 5: Amends s. 627.707, F.S., relating to investigation of sinkhole claims; insurer payment; nonrenewals.

Section 6: Amends s. 627.7074, F.S., relating to alternative procedure for resolution of disputed sinkhole insurance claims.

Section 7: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The OIR will no longer incur costs associated with conducting public rate hearings if it decides to forgo all or some rate hearings current law requires to be held.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Policyholders with insurance policies that prohibit post-loss assignments may incur out of pocket expenses to pay the repair contractor or vendor up front; however, the policyholder should be reimbursed for these expenses by the property insurer when the claim is paid and settled.

Citizens may incur additional costs, including staff time, to calculate and publish the report required for non-catastrophic losses.

The changes to the sinkhole deductible and coverage limit could increase or decrease a homeowner's out of pocket expenses for a sinkhole claim and the premium for sinkhole loss coverage, depending on which deductible or coverage limit the homeowner chooses.

The change to the attorney fee provision relating to neutral evaluations may reduce legal expenses for sinkhole claims incurred by insurers.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The PCS does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided by the PCS.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

PCS for HB 971

A bill to be entitled

An act relating to the Florida Fire Prevention Code; providing that authorities in rural areas or small communities may decrease fire flow requirements; providing that fire officials shall enforce Florida Building Code provisions for occupancy separation for certain occupancies; exempting certain farming and ranching structures from the code; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (16) is added to section 633.0215, Florida Statutes, to read:

633.0215 Florida Fire Prevention Code.—

(16)(a) Fire flow requirements may be decreased by the authority that has jurisdiction for isolated buildings or a group of buildings in rural areas or small communities, as defined in the Florida Fire Prevention Code, if that authority determines that the development of full fire flow requirements is impractical.

(b) For one-story or two-story structures that are less than 10,000 square feet, whose occupancy is defined in the Florida Building Code and the Florida Fire Prevention Code as business or mercantile, a fire official shall enforce the wall fire-rating provisions for occupancy separation as defined in the Florida Building Code.

(c) A farming or ranching structure, as part of an operation that employs fewer than 25 full-time equivalent workers, calculated as cumulative hours worked divided by 40 hours, which is not used by the public for direct sales or as an educational outreach facility, is exempt from the Florida Fire Prevention Code, including the national codes and Life Safety Code incorporated by reference. This paragraph does not include structures used for residential or assembly occupancies, as defined in the Florida Fire Prevention Code.

Section 2. This act shall take effect July 1, 2013.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 971 Florida Fire Prevention Code
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Vanlandingham	Cooper

SUMMARY ANALYSIS

The Florida Fire Prevention Code (FFPC) is a complex set of fire code provisions enforced by the local fire official within each county, municipality, and special fire district in the state. The most recent version of the FFPC adopted mandatory fire flow requirements intended to assure an adequate water supply for fire suppression. Some jurisdictions have said they are unwilling or unable to meet these standards and are continuing to build new homes that do not comply with the FFPC fire flow requirements. The Division of State Fire Marshall has begun a rulemaking process intended to resolve such disagreements.

The PCS preempts the rulemaking by providing that "in rural areas or small communities," fire flow requirements "may be decreased" by the authority that has jurisdiction for isolated buildings or a group of buildings, if that authority determines "that the development of full fire flow requirements is impractical." The PCS may significantly reduce costs for local governments that could opt out of costly infrastructure upgrades required to comply with current fire flow standards. It is unknown whether such opt-outs could result in increased risk to firefighters or higher local insurance rates for businesses and homeowners.

The PCS also addresses an apparent discrepancy between the FFPC and the Florida Building Code that currently requires costly upgrades of multiuse commercial buildings whenever a mercantile use (for the display and sale of merchandise) adjoins a business use (for the transaction of business other than mercantile). The FFPC requires a two-hour fire rated wall or partition between these two use groups, while the building code does not. The PCS provides that for structures of less than three storeys and 10,000 square feet, a fire official shall enforce the less stringent wall fire-rating provisions found in the building code. This may result in significant savings for commercial property owners no longer required to renovate, and it may help such owners to more easily find new tenants to occupy storefronts that may now be vacant. Whether this change may lead to higher insurance rates for owners or tenants of such properties has not been determined.

Existing law exempts "farm outbuildings" from the FFPC. The PCS expands this exemption to "farming or ranching structures", so long as they are part of an operation that employs fewer than 25 full-time equivalent workers, the structure is not used by the public for direct sales or as an educational outreach facility, and it is not used for residential or assembly occupancies. This change could result in significant cost savings for farmer or ranchers who own buildings that would no longer be required to comply with the FFPC. However, because it is not clear what type of buildings would be classified as "farming or ranching structures," nor how much broader this exemption would be than the current exemption for "farm outbuildings," the PCS's impact on insurance rates and associated fire risks cannot be assessed.

It does not appear that the PCS has any fiscal impact on state government.

The PCS has an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The Proposed Committee Substitute (PCS) and its changes to the Florida Fire Prevention Code

The Florida Fire Prevention Code (FFPC) is adopted by the Division of the State Fire Marshal (SFM), housed within the Department of Financial Services (DFS), at three year intervals as required by s. 633.0215, F.S.[1] This complex set of fire code provisions is enforced by the local fire official within each county, municipality, and special fire district in the state. The county, municipality or special district having jurisdiction within a specific community may also adopt local amendments that are applicable only within that community.

The PCS amends s. 633.0215, F.S., in three principal ways:

1) Fire flow requirements

Fire flow requirements are intended to assure an adequate water supply for fire suppression by establishing minimum water flow rates required to control and extinguish fires that may occur within certain types of property subject to specific occupancy classifications. The "required fire flow" is the rate of flow needed for firefighting purposes to confine a major fire to the buildings within a block or other contiguous grouping. The determination of this flow depends upon the size, construction, occupancy, and exposure of buildings within and surrounding the block or group of buildings.

Historically, the determination of required fire flow has been made by local fire authorities having jurisdiction. An important resource in making this determination has been the Guide for Determination of Required Fire Flow, published by the Insurance Services Office (ISO), a private ratings agency that measures the major elements of a community's fire suppression system, including its fire department, emergency communications, and water supply.[2] Following inspection and review of a community's firefighting capabilities, ISO issues a numerical grade, called a Public Protection Classification, which is often used by property and casualty insurers as a tool for calculating insurance rates. This means that a community's investment in fire protection infrastructure often has a direct impact in reducing the community's property insurance rates. In addition to this incentive for adopting adequate fire flow rates, the 2007 edition of the Florida Fire Prevention Code contained recommended standards for fire flow rates that communities were encouraged to adopt.[3]

However, the current 2010 edition of the FFPC, which went into effect on December 31, 2011, made fire flow requirements mandatory for the first time. These requirements apply to both residential and commercial buildings.[4] Some jurisdictions, such as the City of Naples, have said they are unwilling or unable to meet these standards and are continuing to build new homes that do not comply with the FFPC fire flow requirements.[5] This is partly because of aging infrastructure and partly because Naples is building some of the largest homes in Florida, often in excess of 7,000 square feet.[6] The FFPC requires new homes of 5,000 square feet or fewer to have access to water that flows at 1,000 gallons

[1] The FFPC is available online at http://www.myfloridacfo.com/Division/SFM/BFP/FloridaFirePreventionCode.htm.
[2] http://www.isomitigation.com/fsrs/Fire-Suppression-Rating-Schedule-Overview.html
[3] NFPA 1, Annex H.
[4] NFPA 1:18.4
[5] http://www.naplesnews.com/news/2013/jan/29/naples-officials-push-for-changes-to-water-flow/
[6] *Id.*

per minute for one hour, but larger homes must meet higher requirements on a sliding scale for different gallon and duration requirements.[7]

a. Pending rulemaking

The SFM has begun rulemaking to help resolve this conflict. After conferring with stakeholders, the agency has issued a Notice of Proposed Rule to amend the FFPC to clarify that heightened fire flow requirements "shall be considered a recommendation for construction of one and two-family dwellings located on in-fill lots in existing neighborhoods and subdivisions."[8] SFM is holding a hearing on the proposed rule, which is scheduled for March 27, 2013.[9]

b. Effect of the PCS on fire flow requirements

The PCS effectively preempts the rulemaking by amending s. 633.0215, F.S., governing the Florida Fire Prevention Code, to provide that "in rural areas or small communities," fire flow requirements "may be decreased" by the authority that has jurisdiction for isolated buildings or a group of buildings, if that authority determines "that the development of full fire flow requirements is impractical."

"Rural areas" is defined by the FFPC as "areas that are not unsettled wilderness or uninhabitable territory but are sparsely populated with densities below 500 persons per square mile."[10] However, "small community" appears to be undefined in the code, presenting a potential drafting issue that is discussed below.

The PCS may result in significant cost savings for local governments that opt out of fire flow requirements and avoid costly infrastructure upgrades to boost water flow pressures to current standards.

It is unknown whether such opt-outs could result in increased risk to firefighters or higher local insurance rates for businesses and homeowners.

2) Wall fire-rating requirements

Both the Florida Fire Prevention Code[11] and the Florida Building Code[12] require that where different parts of a building comprise different categories of occupancy, those buildings must passive fire protection systems to slow or prevent a fire from spreading from one part of the building to another. For example, if a restaurant abuts a day care center or a hotel, the codes will require a fire wall between the two occupancies rated to certain wall fire-rating. These fire ratings are often expressed in "hours," expressing how long the wall can resist a fire of a certain temperature. The rules are intended to protect life safety, slow the spread of fire, and reduce insurance rates by restricting the ability of a commercial tenant to offload his or her fire risk onto adjoining tenant occupancies.

The FFPC and the Florida Building Code generally agree on occupancy separation requirements. However, one apparent discrepancy between the codes has perplexed managers of multiuse commercial buildings and apparently has constrained their ability to attract new tenants without engaging in costly building renovations. The two codes differ on the separation between a mercantile occupancy (defined as use for the display and sale of merchandise) and a business occupancy (defined as use for the transaction of business other than mercantile). The FFPC requires a two-hour

---

[7] *Id.*
[8] Notice of Proposed Rule, published in FAR Feb. 7, 2013, amending rule 69A-60.003.
[9] Scheduled for 1 p.m., at the Alexander Building, Conference Room, Suite 230A, 2020 Capital Circle SE, Tallahassee.
[10] NFPA s. 3.3.18
[11] NFPA 101 s. 6.1.14.4.1, as specified in 6.1.14.4.2 and 6.1.14.4.3, and tables 6.1.14.4.1(a) and (b).
[12] Florida Building Code sections 508.1, 508.2, 508.3 and 508.4.

fire rated wall or partition between these two use groups, while the Florida Building Code does not require separation between business and mercantile uses.

This discrepancy can have consequences for building managers seeking to lease commercial space in multiuse buildings. If a single storefront with two commercial tenancies leases its space to two shops, then no fire-wall separation is required because the occupancies are both classified as mercantile. However, if one shop goes out of business and the building leases its space to a barber shop or a law office, then the FFPC requires the wall between the two spaces to be renovated to provide 2-hour rated fire wall protection. Because a fire marshal or inspector could cite the building owner for failing to comply with the code, the FFPC as it currently exists arguably makes it more difficult for building owners to find new tenants for vacant storefronts.

a. Effect of the PCS on wall fire-rating requirements

The PCS provides that for one-story or two-story structures that are less than 10,000 square feet, whose occupancy is business or mercantile, a fire official shall enforce the less stringent wall fire-rating provisions for occupancy separation as defined in the Florida Building Code. This will remove the apparent discrepancy between the two codes and address the specific problem of vacant storefronts, which may reduce instances where costly renovations are required and make it easier for owners of vacant commercial buildings to find new tenants.

Whether this change may lead to increased fire risks or higher insurance rates for owners or tenants of such properties has not been determined.

3) Farming and ranching structures

Section 633.557(1), F.S., already provides that "owners of property who are building or improving farm outbuildings" are exempt from the FFPC. This means that structures such as barns need not be constructed to the fire code nor are they subject to fine by fire marshals or inspectors. However, it is possible that certain farming and ranching structures that are not deemed to be "outbuildings" are still subject to fire protection standards.

a. Effect of the PCS on farming and ranching structures

The PCS provides that a "farming or ranching structure" is exempt from the FFPC, so long as it is part of an operation that employs fewer than 25 full-time equivalent workers. Further, the structure must not be used by the public for direct sales or as an educational outreach facility. Moreover, under no circumstances may the structures be used for either residential or assembly occupancies.[13]

This change could result in significant cost savings for farmer or ranchers who own buildings that would no longer be required to comply with the FFPC.

However, because it is not clear what type of buildings would be classified as "farming or ranching structures," nor how much broader this exemption would be than the current exemption for "farm outbuildings," the PCS's impact on insurance rates and associated fire risks cannot be assessed.

B. SECTION DIRECTORY:

Section 1. Amends s. 633.0215, F.S., to relax fire prevention standards with regard to fire flow water standards, fire separation in multiuse buildings, and farming or ranching structures.

Section 2. Establishes an effective date of July 1, 2013.

[13] Assembly occupancy includes any gathering of 50 people or more.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   The PCS may significantly reduce costs for local governments that could opt out of costly infrastructure upgrades required to comply with current fire flow standards.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The PCS may result in significant savings for commercial property owners no longer required to upgrade fire walls between separate occupancies within the same building. This change may also allow such property owners to more easily find new tenants to occupy storefronts that are currently vacant.

The PCS may also result in cost savings for owners of farming or ranching structures that are no longer required to comply with the fire code.

It is unknown whether the PCS may result in increased insurance rates for local property owners impacted by reduced fire flow rates, for commercial building owners and tenants in multiuse buildings, and for farmers and ranchers whose properties may become exempt from the FFPC.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The PCS does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or, reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

"Small community" appears to be undefined in the FFPC, which could lead to disputes between the SFM and local authorities having jurisdiction, which may argue they are entitled to opt out of the fire flow requirements. Moreover, "isolated buildings" or "group of buildings" are similarly undefined by the code. Further, the language providing that "fire flow requirements may be decreased ... if that authority determines that the development of full fire flow requirements is impractical" fails to communicate how much these flow requirements may be decreased, or what standards the local authority having jurisdiction should use for determining impracticability. To address these issues and to balance the need for state fire flow standards against flexibility for local governments to whom those standards may be ill suited, rulemaking may offer an additional approach.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES