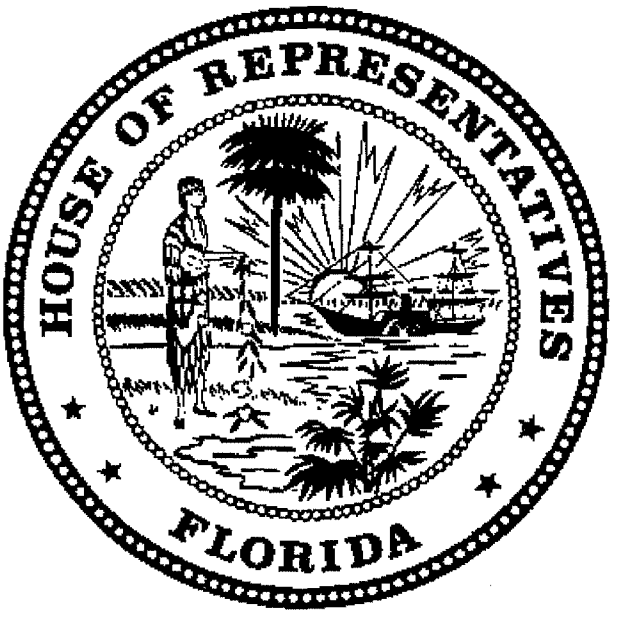

Insurance & Banking Subcommittee

Wednesday, March 30, 2011
10:00 AM - 2:00 PM
404 HOB

Dean Cannon
Speaker

Bryan Nelson
Chair

The Florida House of Representatives

Economic Affairs Committee

Insurance & Banking Subcommittee

Dean Cannon
Speaker

Bryan Nelson
Chair

AGENDA

March 30, 2011
404 House Office Building
10:00 a.m. – 2:00 p.m.

I. Introductory Remarks

II. CS/HB 97 **Health Insurance** *by Health & Human Services Access Subcommittee; Rep. Gaetz*

III. CS/HB 677 **Pub. Rec./Office of Financial Regulation** *by Government Operations Subcommittee; Rep. Pilon*

IV. PCS for HB 885 **Residential Property Insurance**

V. HB 999 **Public Depositories** *by Rep. Ingram*

VI. HB 1087 **Persons Designated To Receive Insurer Notifications** *by Rep. Holder*

VII. CS/HB 1125 **Florida Health Choices Program** *by Health & Human Services Quality Subcommittee; Rep. Corcoran*

VIII. PCS for HB 1229 **Title Insurance**

IX. PCS for HB 1243 **Citizens Property Insurance Corporation**

204 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850)414-7365 Fax: (850)414-5048

X. PCB INBS 11-02 **The Uniform Home Grading Scale**

XI. PCB INBS 11-03 **Repeal of a Workers' Compensation Reporting Requirement**

XII. Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 97 Health Insurance
SPONSOR(S): Health & Human Services Access Subcommittee; Gaetz
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Access Subcommittee	10 Y, 5 N, As CS	Prater	Schoolfield
2) Insurance & Banking Subcommittee		Barnum	Cooper
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Under the Patient Protection and Affordable Care Act (PPACA), the state is required to create an insurance exchange by 2014. If the state does not take the necessary steps to create the exchange, as determined by the United States Secretary of Health and Human Services, the Secretary will establish and operate the exchange. The exchange will provide an insurance market place whereby individuals and small business can purchase health insurance. Under the PPACA, most citizens will be required to purchase health insurance, or will be required to pay a tax penalty. Certain individuals who meet certain income thresholds will be given premium tax credits and cost sharing subsidies to help them purchase their health insurance.

The Hyde Amendment, first passed by Congress in 1976, prevents federal funds from being used to pay for abortion under the joint federal-state Medicaid programs. Exceptions are provided for rape, incest, and to save the life of the mother.

According to the PPACA, states are permitted to prohibit plans participating in the insurance exchange from providing coverage for abortions. Without such prohibition, plans are permitted to offer insurance providing abortion coverage, but must provide for a separate accounting mechanism.

Under the PPACA, states are given the express right to prohibit abortion coverage for any health plans offered through an exchange if the state enacts a law to provide for such prohibition. Additionally, the PPACA specifies that the Act shall not preempt or have any effect on state laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions.

CS/HB 97 makes substantial changes to the insurance code and creates sections 627.64995, 641.31099, and 627.66996, and amends section 627.6515 Florida Statutes.

This bill prohibits the use of state or federal funds to provide coverage for abortions in health insurance policies purchased through health insurance exchanges created under the PPACA.

The bill provides exceptions for abortions in situations of rape or incest, or if a physician certifies in writing that the abortion is necessary to save the life of the mother.

The bill clarifies that it does not prohibit insurance plans from providing separate coverage for abortion, as long as that coverage is not purchased in whole or in part with any federal or state funds.

The bill appears to have no fiscal impact on state or local governments.

The effective date for the bill is July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama on March 23, 2010.[1]

Under PPACA, the state is required to create an insurance exchange by 2014. If the state does not take the necessary steps to create the exchange, as determined by the United States Secretary of Health and Human Services, the Secretary will establish and operate the exchange.[2] The exchange will provide an insurance market place whereby individuals and small business can purchase health insurance. Under the PPACA, most citizens will be required to purchase health insurance, or will be required to pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. Certain individuals who meet certain income thresholds will be given premium tax credits and cost sharing subsidies to help them purchase their health insurance.[3] Any household earning between 133% and 400% of the federal poverty level ($29,326 to $88,200 annual income for a family of 4) will be eligible for the premium tax credits and cost sharing subsidies.[4].

Federal Funding of Abortions

The Hyde Amendment, first passed by Congress in 1976, prevents federal funds from being used to pay for abortion under the joint federal-state Medicaid programs. Exceptions are provided for rape, incest, and to save the life of the mother.[5] The Hyde Amendment is a rider to the annual Labor/Health and Human Services/Education appropriations bill which has to be approved by Congress each year. The specific language of Hyde can vary each year.

According to the PPACA, states are permitted to prohibit plans participating in the insurance exchange from providing coverage for abortions. Without such prohibition, plans are permitted to offer insurance providing abortion coverage but must provide for a separate accounting mechanism. The plan must collect from each enrollee, two separate payments; one specifically for the abortion coverage and the other for all the other services provided. All individuals enrolled in the plan providing abortion coverage would be required to pay the separate abortion fee (without regard to the enrollee's age, sex, or family status).[6]

Under the PPACA, states are given the express right to prohibit abortion coverage for any health plans offered through an exchange if the state enacts a law to provide for such prohibition.[7] Additionally, the PPACA specifies that the Act shall not preempt or have any effect on state laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions.

---

[1] See Constitutional Notes.
[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Section 1321 (c)
[3] A premium tax credit is an amount taken out of the taxes you paid the previous year and given back to the payer. For tax credits given by the Patient Protection and Affordable Care Act, the credits will be sent directly to the issuer of the health insurance plan from the federal government. A cost sharing reduction is a reduction in out-of-pocket expenses paid by the health plan member such as co-pays.
[4] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Section 1401 & 1402
[5] Departments of Labor, Health and Human Services and Education and Related Agencies Appropriations Act of 2010, HR 3293, 111th Cong., 1st session
[6] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, section 1303(b) (2) (B) (i)
[7] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, section 1303 (a) (1)

Abortion Statistics

- In 2008, there were 1.21 million abortions nationwide.[8]
- 22% of all pregnancies (excluding miscarriages) resulted in abortion nationwide.[9]
- In Florida, there were 94,360 abortions in 2008[10] and 231,657 live births,[11] which is approximately 2 abortions for every 5 births.

Proposed Changes

This bill creates three new sections and amends one section of law to prohibit the sale of insurance policies covering abortions, offered through a health insurance exchange created by the PPACA. This applies to policies purchased in whole or in part with federal or state subsidies.[12] The bill provides an exception that health insurance coverage may be provided in cases of rape, incest, or if a physician certifies in writing that the abortion is necessary to save the life of the mother.

The bill does not prevent any person from purchasing separate coverage for abortion through an insurance exchange as long as that coverage is not purchased in whole or in part with state or federal funds. The bill provides that state and federal funds would include any tax credit or cost sharing reductions applied. The bill defines "state funds" to include both state and local funds.

The proposed changes in the bill create new sections of statute in Chapter 627, Part VI, relating to Health Insurance Policies, Chapter 627, Part VII, relating to Group, Blanket, and Franchise Health Insurance Policies and Chapter 641, Part I, relating to Health Maintenance Organizations; and amends s. 627.6515, F.S., relating to out-of-state group insurance policies.

B. SECTION DIRECTORY:

Section 1. Creates s. 627.64995, F.S., relating to restrictions on use of funds for state exchanges.

Section 2. Creates s. 627.66996, F.S., relating to restrictions on use of funds for state exchanges.

Section 3. Creates s. 641.31099, F.S., relating to restrictions on use of funds for state exchanges.

Section 4. Amends s. 627.6515, F.S., relating to out-of-state groups.

Section 5. Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

[8] The Guttmacher Institute, Abortion Incidence and Access to Services in the United States, 2008
[9] *Id.*
[10] *Id.*
[11] Florida Department of Health, Department of Vital Statistics, 2008
[12] s. 390.011(1), F.S., defines "Abortion" to mean the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

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 any 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:

Florida and 25 other states brought an action in the United States District Court for the Northern District of Florida challenging the constitutionality of the Act. On January 31, 2011, Judge Roger Vinson found the Act unconstitutional.[13] On March 3, 2011, Judge Vinson granted a stay of his order on the condition that the federal government seek an immediate appeal and seek an expedited review. The federal government filed the appeal and motion for expedited review to the United States Court of Appeals for the Eleventh Judicial Circuit on March 8, 2011.[14] Florida and the other plaintiffs have filed a motion requesting a more condensed briefing and oral argument schedule than requested by the federal government. The Eleventh Circuit responded on March 11, 2011, setting the briefing schedule beginning on April 4, 2011 and ending May 25, 2011.[15]

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 16, 2011, the Health and Human Services Access Committee adopted one amendment to HB 97.

---

[13] State of Florida, et al. v. United States Department of Health and Human Services, et al., --- F.Supp.2d ----, 2011 WL 285683 (N.D.Fla.)

[14] Case No. 11-11021-HH

[15] State of Fla., et al. v. U.S. Dept. of Health & Human Serv., Nos. 11-11021-HH & 11-11067-HH, Order on Appellants' Mtn. to Expedite Appeal (11th Cir. March 11, 2011).

The amendment made the following changes:

Removed one of the exceptions in which an abortion can be provided through a health care plan created pursuant to the PPACA. The original bill included an exception to save the physical health of the mother. The amendment provides an exception only if a physician certifies in writing that an abortion is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

The amendment applied the bill language to the section of statute relating to group, franchise, or blanket health insurance as well as the section of statute relating to insurance policies issued outside of this state.

The bill was reported favorably as a Committee Substitute.

The analysis is drafted to the Committee Substitute.

A bill to be entitled

An act relating to health insurance; creating ss. 627.64995, 627.66996, and 641.31099, F.S.; prohibiting certain health insurance policies and health maintenance contracts from providing coverage for abortions; providing exceptions; defining the term "state"; amending s. 627.6515, F.S.; providing that certain restrictions on coverage for abortions apply to certain group health insurance policies issued or delivered outside the state which provide coverage to residents of the state; providing an effective date.

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

Section 1. Section 627.64995, Florida Statutes, is created to read:

627.64995 Restrictions on use of state and federal funds for state exchanges.—

(1) A health insurance policy or group health insurance policy under which coverage is purchased in whole or in part with any state or federal funds through an exchange created pursuant to the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, may not provide coverage for an abortion as defined in s. 390.011(1), except if the physician certifies in writing that an abortion is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. Coverage is deemed to be purchased with state or federal funds if any tax credit or cost-sharing credit is

applied toward the health insurance policy or group health insurance policy.

(2) This section does not prevent a health insurance policy or group health insurance policy from providing any person or entity with separate coverage for an abortion, if such coverage is not purchased in whole or in part with any state or federal funds.

(3) As used in this section, the term "state" means this state and includes any political subdivision of the state.

Section 2. Section 627.66996, Florida Statutes, is created to read:

627.66996 Restrictions on use of state and federal funds for state exchanges.—

(1) A group, franchise, or blanket health insurance policy under which coverage is purchased in whole or in part with any state or federal funds through an exchange created pursuant to the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, may not provide coverage for an abortion as defined in s. 390.011(1), except if the physician certifies in writing that an abortion is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. Coverage is deemed to be purchased with state or federal funds if any tax credit or cost-sharing credit is applied toward the group, franchise, or blanket health insurance policy.

(2) This section does not prevent a group, franchise, or blanket health insurance policy from providing any person or entity with separate coverage for an abortion, if such coverage is not purchased in whole or in part with any state or federal

funds.

(3) As used in this section, the term "state" means this state and includes any political subdivision of the state.

Section 3. Section 641.31099, Florida Statutes, is created to read:

641.31099 Restrictions on use of state and federal funds for state exchanges.—

(1) A health maintenance contract under which coverage is purchased in whole or in part with any state or federal funds through an exchange created pursuant to the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, may not provide coverage for an abortion as defined in s. 390.011(1), except if the physician certifies in writing that an abortion is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. Coverage is deemed to be purchased with state or federal funds if any tax credit or cost-sharing credit is applied toward the health maintenance contract.

(2) This section does not prevent a health maintenance contract from providing any person or entity with separate coverage for an abortion, if such coverage is not purchased in whole or in part with any state or federal funds.

(3) As used in this section, the term "state" means this state and includes any political subdivision of the state.

Section 4. Paragraph (c) of subsection (2) of section 627.6515, Florida Statutes, is amended to read:

627.6515 Out-of-state groups.—

(2) Except as otherwise provided in this part, this part

does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage if:

(c) The policy provides the benefits specified in ss. 627.419, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675, 627.6691, ~~and~~ 627.66911, and 627.66996.

Section 5. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 677 Pub. Rec./Office of Financial Regulation
SPONSOR(S): Government Operations Subcommittee, Pilon
TIED BILLS: **IDEN./SIM. BILLS:** SB 1328

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Government Operations Subcommittee	10 Y, 0 N, As CS	Williamson	Williamson
2) Insurance & Banking Subcommittee		Barnum	Cooper
3) State Affairs Committee			

SUMMARY ANALYSIS

Current law provides public record exemptions for the Office of Financial Regulation (OFR or office) for certain information obtained or created by OFR pursuant to its involvement in the charter, examination, or investigation of financial institutions. The exemptions vary among OFR's regulatory programs. Currently, the office does not have a public record exemption that would allow it to receive information from another state or federal government that is confidential or exempt pursuant to the laws of that state or pursuant to federal law.

The bill creates a public record exemption for the following information held by OFR:

- Information received from another state or federal regulatory, administrative, or criminal justice agency that is otherwise confidential or exempt pursuant to the laws of that state or pursuant to federal law.
- Information that is received or developed by OFR as part of a joint or multiagency investigation or examination.

The bill authorizes OFR to obtain and use information in accordance with the requirements imposed as a condition of participating in a joint or multiagency examination or investigation.

The bill provides for retroactive application of the exemption. It provides for repeal of the exemption on October 2, 2016, unless reviewed and saved from repeal by the Legislature. The bill also provides a statement of public necessity as required by the State Constitution.

Article I, s. 24(c) of the State Constitution, requires a two-thirds vote of the members present and voting for final passage of a newly created public record or public meeting exemption. The bill creates a new public record exemption; thus, it requires a two-thirds vote for final passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Public Records Law

Article I, s. 24(a) of the State Constitution sets forth the state's public policy regarding access to government records. The section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government. The Legislature, however, may provide by general law for the exemption of records from the requirements of Article I, s. 24(a) of the State Constitution. The general law must state with specificity the public necessity justifying the exemption (public necessity statement) and must be no broader than necessary to accomplish its purpose.[1]

Public policy regarding access to government records is addressed further in the Florida Statutes. Section 119.07(1), F.S., guarantees every person a right to inspect and copy any state, county, or municipal record. Furthermore, the Open Government Sunset Review Act[2] provides that a public record or public meeting exemption may be created or maintained only if it serves an identifiable public purpose. In addition, it may be no broader than is necessary to meet one of the following purposes:

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption.
- Protects sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety; however, only the identity of an individual may be exempted under this provision.
- Protects trade or business secrets.

Office of Financial Regulation

The Office of Financial Regulation (OFR or office) has regulatory oversight of banks, credit unions, trust companies, securities brokers, investment advisers, mortgage loan originators, money services businesses, retail installment sellers, consumer finance companies, debt collectors, and other financial service providers. The office has licensing authority and the authority to conduct examinations and investigations.

Other states and federal agencies also have regulatory oversight of many of these entities and individuals. In addition, many of the regulated entities operate in multiple states, thus, making inter-state cooperation essential to achieving comprehensive, efficient, and effective regulatory oversight.[3]

Current Public Record Exemptions

Current law provides public record exemptions for certain information obtained or created by OFR pursuant to its involvement in the charter, examination, or investigation of financial institutions.[4] The exemptions vary among OFR's regulatory programs.

Currently, the office does not have a public record exemption that would allow it to receive information from another state or federal government that is confidential or exempt pursuant to the laws of that state or pursuant to federal law. As such, OFR is limited in its capacity to participate in out-of-state or federal investigations due to its limited public record exemptions.

---

[1] Section 24(c), Art. I of the State Constitution.
[2] Section 119.15, F.S.
[3] Office of Financial Regulation Bill Analysis of HB 677, at 1.
[4] *See* ss. 560.129, 494.00125, 517.2015, 520.9965, and 655.057, F.S.

Effect of Bill

The bill creates a public record exemption for the following information held by OFR:

- Information received from another state or federal regulatory, administrative, or criminal justice agency that is otherwise confidential or exempt pursuant to the laws of that state or pursuant to federal law.
- Information that is received or developed by OFR as part of a joint or multiagency investigation or examination.

Such information is confidential and exempt[5] from public records requirements.

The bill authorizes OFR to obtain and use information in accordance with the requirements imposed as a condition of participating in a joint or multiagency examination or investigation.

The bill provides for retroactive application of the public record exemption.[6] It provides for repeal of the exemption on October 2, 2016, unless reviewed and saved from repeal by the Legislature. The bill also provides a statement of public necessity as required by the State Constitution.[7]

B. SECTION DIRECTORY:

Section 1 amends s. 119.0712, F.S., to create a public record exemption for the office.

Section 2 provides a public necessity statement.

Section 3 provides an effective date of July 1, 2011.

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.

---

[5] There is a difference between records the Legislature designates as exempt from public record requirements and those the Legislature deems confidential and exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances. (*See WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48, 53 (Fla. 5th DCA 2004), review denied 892 So.2d 1015 (Fla. 2004); *City of Riviera Beach v. Barfield*, 642 So.2d 1135 (Fla. 4th DCA 1994); *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential and exempt from public disclosure, such record may not be released, by the custodian of public records, to anyone other than the persons or entities specifically designated in the statutory exemption. (*See* Attorney General Opinion 85-62, August 1, 1985).

[6] The Supreme Court of Florida ruled that a public record exemption is not to be applied retroactively unless the legislation clearly expresses intent that such exemption is to be applied retroactively. *Memorial Hospital-West Volusia, Inc. v. News-Journal Corporation*, 729 So.2d. 373 (Fla. 2001).

[7] Section 24(c), Art. I of the State Constitution.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

Vote Requirement

Article I, s. 24(c) of the State Constitution, requires a two-thirds vote of the members present and voting for final passage of a newly created public record or public meeting exemption. The bill creates a new public record exemption; thus, it requires a two-thirds vote for final passage.

Public Necessity Statement

Article I, s. 24(c) of the State Constitution, requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill creates a new public record exemption; thus, it includes a public necessity statement.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The First Amendment Foundation's position on the bill is "neutral".

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 23, 2011, the Government Operations Subcommittee adopted a strike-all amendment and reported the bill favorably with committee substitute. The committee substitute clarifies that the public record exemption for information received from another state or a federal agency may only be protected if such information is confidential or exempt pursuant to the laws of that state or pursuant to federal law.

The analysis is drafted to the Committee Substitute.

A bill to be entitled

An act relating to public records; amending s. 119.0712, F.S.; providing an exemption from public records requirements for information held by the Office of Financial Regulation that is received from another state or federal regulatory, administrative, or criminal justice agency and that is otherwise confidential or exempt pursuant to the laws of that state or pursuant to federal law; providing an exemption from public records requirements for information held by the office that is received or developed by the office as part of a joint or multiagency examination or investigation with another state or federal regulatory, administrative, or criminal justice agency; specifying conditions under which the Office of Financial Regulation may obtain and use such information; providing for retroactive application; providing for future review and repeal of the exemptions; providing a statement of public necessity; providing an effective date.

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

Section 1. Subsection (3) is added to section 119.0712, Florida Statutes, to read:

119.0712 Executive branch agency-specific exemptions from inspection or copying of public records.—

(3) OFFICE OF FINANCIAL REGULATION.—

(a) The following information held by the Office of

Financial Regulation before, on, or after July 1, 2011, is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

1. Any information received from another state or federal regulatory, administrative, or criminal justice agency that is otherwise confidential or exempt pursuant to the laws of that state or pursuant to federal law.

2. Any information that is received or developed by the office as part of a joint or multiagency examination or investigation with another state or federal regulatory, administrative, or criminal justice agency. The office may obtain and use the information in accordance with the conditions imposed by the joint or multiagency agreement. This exemption does not apply to information obtained or developed by the office that would otherwise be available for public inspection if the office had conducted an independent examination or investigation under Florida law.

(b) This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2016, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that information held by the Office of Financial Regulation before, on, or after July 1, 2011, that is received from another state or federal regulatory, administrative, or criminal justice agency that is confidential or exempt pursuant to the laws of that state or pursuant to federal law be made confidential and exempt from public records requirements.

Without the exemption, the office will be unable to obtain information that could assist it in pursuing violations of law under its jurisdiction. Without this exemption, the effective and efficient administration of the regulatory programs administered by the Office of Financial Regulation would be significantly impaired.

(2) The Legislature finds that it is a public necessity that information held by the Office of Financial Regulation that is received or developed by the office as part of a joint or multiagency examination or investigation with another state or federal regulatory, administrative, or criminal justice agency be made confidential and exempt from public records requirements. The exemption is necessary to enable the office to participate in joint or multiagency investigations and examinations. Without the exemption, the office will be unable to participate in these activities, which impairs its ability to leverage its limited resources. Without the sharing and coordination of information, governmental agencies may be required to conduct duplicative independent investigations or examinations in order to meet their regulatory responsibilities. With the exemption, that burden can be reduced or eliminated through joint or alternating investigations or examinations, or by off-site reviews of other governmental agency investigations or examinations.

Section 3. This act shall take effect July 1, 2011.

PCS for HB 885

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 885 Residential 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

Section 627.0645, F.S, requires property insurance companies to make a rate filing containing the company's proposed rates with the Office of Insurance Regulation (OIR) each year (base rate filing). The OIR reviews the rate filing and either approves or disapproves the proposed rates.

Section 627.062(2)(k), F.S., enacted in 2009, allows property insurers to make a rate filing that is separate from the insurer's annual base rate filing and that is approved or disapproved by the OIR on an expedited basis. The OIR reviews the expedited rate filing within 45 days, rather than 90 days, to make sure the rates proposed are not excessive, inadequate, or unfairly discriminatory. Costs that can be included in an expedited rate filing to justify a rate change are more limited than those that can be included in a base rate filing. An expedited rate filing can only request rate changes due to the:

- recovery of reinsurance or financing costs to replace or finance payment of amounts covered by the Florida Hurricane Catastrophe Fund Temporary Increase in Coverage Limit (TICL) option coverage;
- recovery of reinsurance or financing costs to replace TICL option coverage due to the yearly TICL option coverage reductions;
- costs of the price increase of TICL option coverage; and
- costs of the price increase of Florida Hurricane Catastrophe Fund (FHCF) mandatory option coverage.

Reinsurance costs to be recouped by an expedited filing may not be more than 10 percent for any individual policyholder. An insurer can only make an expedited rate filing once every 12 months. Furthermore, an insurer cannot file an expedited rate filing if the insurer has implemented a rate increase in the six months before the expedited filing. In addition, an insurer cannot increase rates using the annual base rate filing for six months after the expedited rate filing.

The bill broadens the types of costs to be included in an expedited rate filing. All reinsurance costs, the cost of financing products used to replace reinsurance, the financing costs incurred in the purchase of reinsurance, or the costs of the price increase of the FHCF mandatory option coverage are allowed.

The bill also allows an insurer to request a rate increase of a maximum of 15 percent per policy, rather than 10 percent. Current law prohibiting insurers from including expenses or profits paid by the insurer in an expedited rate filing is deleted by the bill. As under current law, an insurer can only file an expedited rate filing once every 12 months. However, the bill removes current law that restricts insurers from using an expedited rate filing if the insurer has implemented a rate increase in the prior six months and restricts insurers from making any other rate filing for six months after the expedited rate filing.

The bill has no fiscal impact on state or local government. Policyholders may incur rate increases of 15 percent, rather than 10 percent, under the bill and may incur 15 percent rate increases more frequently than under current law. However, policyholders can incur a 15 percent rate increase under the expedited rate filing only once a year. Insurers will have more flexibility in rate making and will be able to increase rates up to 15 percent more quickly than under current law, if the insurer incurs the costs allowed to justify the rate increase.

The effective date of the bill is upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

"Property insurance," as defined by s. 624.604, F.S., includes insurance covering personal lines residential risks, commercial lines residential risks, and commercial nonresidential risks as follows:

- Personal lines residential coverage - homeowner's, mobile home owner's, dwelling, tenant's, condominium unit owner's, cooperative unit owner's and similar policies,
- Commercial lines residential coverage - coverage provided by condominium association, cooperative association, apartment building and similar policies, and
- Commercial nonresidential coverage - coverage provided by commercial business policies.[1]

Generally, residential property insurance covers a policyholder's residence or business, providing reimbursement due to damages sustained by the residence or business, including windstorm damage.

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 property insurance companies to make a rate filing with the Office of Insurance Regulation (OIR) each year (base rate filing).[2] 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.

Property insurance rate filings can be made on a "file and use" or "use and file" basis.[3] Under a "file and use" rate filing, an insurer submits the rate filing to the OIR for approval before implementing the rate. The OIR has 90 days to review the rate filing and approve or disapprove the filing. The rate filing is deemed approved by the OIR if the OIR does not approve or disapprove the filing during the 90-day period. Under a "use and file" rate filing, an insurer implements the rate and submits the filing to the OIR for approval no more than 30 days after implementing the rate. Refunds to policyholders are required if the OIR disapproves the rate.

Expedited Rate Filing

Section 627.062(2)(k), F.S., enacted in 2009,[4] allows property insurance companies to make a rate filing that is separate from the insurer's annual base rate filing and that is approved or disapproved by the OIR on an expedited basis (i.e., within 45 days of the filing, rather than 90 days). The OIR reviews the expedited rate filing to make sure the rates proposed in the filing are not excessive, inadequate, or unfairly discriminatory, the same review standards that apply to a base rate filing. Unlike a base rate filing, if the OIR does not approve or disapprove the expedited rate filing within the 45-day period, the rate requested is not deemed approved.

---

[1] s. 627.4025, F.S.

[2] Property or casualty insurers do not have to make an annual rate filing for workers' compensation, employer's liability, and commercial property and casualty insurance (except commercial motor vehicle and multi-line insurance).

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

[4] Section 7, Ch. 2009- 87, L.O.F.

Costs that can be included in an expedited rate filing to justify a rate change are more limited than those that can be included in a base rate filing. An expedited rate filing can only request rate changes due to:

- the recovery of reinsurance or financing costs to replace or finance payment of amounts covered by the Florida Hurricane Catastrophe Fund Temporary Increase in Coverage Limit (TICL) option coverage;[5]
- the recovery of reinsurance or financing costs to replace TICL option coverage due to the yearly TICL option coverage reductions;[6]
- the costs of the price increase of TICL option coverage;[7] and
- the costs of the price increase of the Florida Hurricane Catastrophe Fund mandatory option coverage.[8]

Reinsurance costs to be recouped by an expedited filing may not be more than 10 percent for any individual policyholder. Thus, the maximum rate increase that can be implemented with an expedited rate filing is 10 percent per policyholder.

The insurance company must submit proof of the purchase of reinsurance or other financing product in order to recoup these costs in an expedited rate filing. The insurer cannot use company expenses or profits to justify a rate increase with an expedited rate filing. The OIR may disapprove an expedited rate filing as excessive, inadequate or unfairly discriminatory. An insurer can only make an expedited rate filing once every 12 months. Furthermore, an insurer cannot file an expedited rate filing if the insurer has implemented a rate increase in the six months before the expedited filing. In addition, an insurer cannot increase rates using the annual base rate filing for six months after the expedited rate filing.

Expedited Rate Filings Approved in 2010

In 2010, property insurers submitted 20 expedited rate filings to increase rates for property insurance. Nine of the 20 filings were withdrawn before the OIR made a decision on them. The remaining 11 rate filings were approved by the OIR. In every approved rate filing, the rate increase approved by the OIR equaled the rate increase the insurer requested. None of the expedited rate filings requested rate increases more than the 10 percent allowed by law. The following expedited rate increases were approved in 2010:

9.9 percent increase for two filings;
7.2 percent increase for two filings;
6.2 percent increase for two filings;
4.6 percent increase for one filing; and
3.9 percent increase for four filings.

For the 11 expedited rate increases approved in 2010, the fastest approval time by the OIR was 13 days from the date the filing was received by the OIR to the final approval and the longest approval time was 44 days. The average approval time was 37 days. By law, the OIR has 45 days to approve an expedited rate filing, so all expedited rate filings were approved by the OIR within the required statutory time.

Effect of Bill

The bill amends the expedited rate filing law enacted in 2009. The bill allows more types of costs to be included in an expedited rate filing than under current law. All reinsurance costs, the cost of financing

[5] The Temporary Increase in Coverage Limit option coverage offers reinsurance from the Florida Hurricane Catastrophe Fund for insurers above the Fund's mandatory coverage. When this coverage was initially enacted in 2007, it provided an additional $12 billion in coverage. Starting in 2009, however, the coverage amount is decreased each year by $2 billion until it reaches zero in 2013.

[6] Legislation enacted in 2009 (Ch. 2009-87, L.O.F.) reduced the TICL option $2 billion a year for six years starting in the 2009-2010 contract year (June 1, 2009-May 31, 2010).

[7] Legislation enacted in 2009 (Ch. 2009-87, L.O.F.) increased the price for TICL coverage each year for five years. The price increase is in conjunction with the TICL coverage decreases discussed in prior footnotes.

[8] Legislation enacted in 2009 (Ch. 2009-87, L.O.F.) increased the price of the mandatory coverage from the Florida Hurricane Catastrophe Fund by requiring the Fund to include a cash build up factor of 5 percent in its reimbursement premium each year until the factor reaches 25 percent. When the factor reaches 25 percent (in 2013), it becomes a permanent part of the Fund's rate and is put into the rate yearly.

products used to replace reinsurance, the financing costs incurred in the purchase of reinsurance, or the costs of the price increase of the FHCF mandatory option coverage are allowed to justify an expedited rate increase rate filing.

The bill allows an insurer to request a rate increase of a maximum of 15 percent per policy, rather than 10 percent, using an expedited rate filing. Current law prohibiting insurers from including expenses or profits paid by the insurer in an expedited rate filing is deleted by the bill. Thus, these expenses or profits will be allowed to justify an expedited rate increase.

As under current law, an insurer can only file an expedited rate filing once every 12 months. However, the bill removes current law that restricts insurers from using an expedited rate filing if the insurer has implemented a rate increase in the prior six months and restricts insurers from making any other rate filing for six months after the expedited rate filing.

Under current law, despite the two six month limitations in the expedited rate filing statute, an insurer can increase rates two times in a 12 month period - once with an expedited filing and once with an annual base rate filing. For example, under current law and in accordance with the two six month limitations in the expedited rate filing statute, an insurer can *implement* a base rate filing in January, *file and implement* an expedited rate filing in July, but cannot file another base rate filing until January of the next year. In this example, a consumer who renews a policy after July could incur two rate increases at renewal, one from the January base rate implementation and one from the July expedited rate implementation. However, according to the OIR, common practice is for insurers to file and implement only one rate filing in a 12 month period so that policyholders incur only one rate increase at renewal, with the insurer each year choosing whether to file an expedited rate filing or an annual base rate filing.

One advantage of an annual base rate filing is that the insurer can request a rate increase higher than 10 percent and can include numerous costs to justify an increase, but the compilation of data needed for the rate filing and assembly of the rate filing is time consuming and extensive and the OIR has 90 days to approve or disapprove the rate filing. Some advantages of an expedited rate filing are that the data compilation and assembly is easier and quicker than that needed in an annual base rate filing because only limited costs are included in the filing and the OIR has 45 days to approve or disapprove the rate filing (half the approval time for the annual base rate filing). Some disadvantages of an expedited rate filing are the filing can only request a rate increase up to 10 percent and limited costs can be used to justify the rate filing.

The bill repeals the restrictions in current law allowing an expedited rate filing only when insurers have not implemented a rate increase in the six months before the expedited rate filing and only if insurers do not file for a rate increase with an annual base rate filing for six months after the expedited filing. Repealing the six month restrictions allows insurers to continue to file an expedited and an annual rate filing in a 12 month period, but the rate filings no longer have to be six months apart and could occur closer together, with a 15 percent maximum rate increase allowed with an expedited rate filing.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.062(2)(k), F.S., relating to expedited rate filings.

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:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Because the bill allows residential property insurers to increase rates a maximum of 15 percent, rather than 10 percent, using an expedited rate filing, policyholders could incur increased property insurance costs.

Because the bill allows additional types of costs and allows expenses and profits to justify an expedited rate filing, more expedited rate filings requesting the maximum rate increase allowed under an expedited rate filing (15 percent under the bill) could be filed and approved by the OIR.

Some policyholders could incur two rate increases at renewal because the bill repeals the two six month filing restrictions in current law for expedited rate filings. However, any rate increase due to the expedited rate filing is limited to 15 percent. In addition, under current law policyholders can incur two rate increases at renewal, but it is the practice of insurers to require policyholders to incur one rate increase.

Allowing more types of costs to be included in an expedited rate filing and raising the rate increase amount allowed by the filing to 15 percent allows property insurers more flexibility in ratemaking with a faster rate approval time.

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 and none repealed by the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to residential property insurance; amending s. 627.062, F.S.; revising costs to be included in a rate filing; revising the overall premium increase for a rate filing; revising the information that must be included in a rate filing relating to reinsurance; deleting a provision prohibiting an insurer from implementing a rate increase within 6 months before it makes certain rate filings; deleting a provision prohibiting an insurer from filing for a rate increase within 6 months after it makes certain rate filings; providing an effective date.

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

Section 1. Paragraph (k) of subsection (2) of section 627.062, Florida Statutes, is amended to read:

627.062 Rate standards.—

(2) As to all such classes of insurance:

(k)1. A residential property ~~An~~ insurer may make a separate filing limited solely to an adjustment of its rates for reinsurance, the cost of financing products used as a replacement for reinsurance, ~~or~~ financing costs incurred in the purchase of reinsurance, ~~or financing products to replace or finance the payment of the amount covered by the Temporary Increase in Coverage Limits (TICL) portion of the Florida Hurricane Catastrophe Fund including replacement reinsurance for the TICL reductions made pursuant to s. 215.555(17)(e); the~~

~~actual cost paid due to the application of the TICL premium factor pursuant to s. 215.555(17)(f);~~ and the actual cost paid due to the application of the cash build-up factor pursuant to s. 215.555(5)(b) if the insurer:

a. Elects to purchase financing products such as a liquidity instrument or line of credit, in which case the cost included in ~~the~~ filing for the liquidity instrument or line of credit may not result in a premium increase exceeding 3 percent for any individual policyholder. All costs contained in the filing may not result in an overall premium increase of more than 15 ~~10~~ percent for any individual policyholder.

b. Includes in the filing a copy of all of its reinsurance, liquidity instrument, or line of credit contracts; proof of the billing or payment for the contracts; and the calculation upon which the proposed rate change is based demonstrating ~~demonstrates~~ that the costs meet the criteria of this section ~~and are not loaded for expenses or profit for the insurer making the filing~~.

~~c. Includes no other changes to its rates in the filing.~~

~~d. Has not implemented a rate increase within the 6 months immediately preceding the filing.~~

~~e. Does not file for a rate increase under any other paragraph within 6 months after making a filing under this paragraph.~~

c.~~f.~~ An insurer that purchases reinsurance or financing products from an affiliated company may make a separate filing ~~in compliance with this paragraph does so~~ only if the costs for such reinsurance or financing products are charged at or below

charges made for comparable coverage by nonaffiliated reinsurers or financial entities making such coverage or financing products available in this state.

2. An insurer may ~~only~~ make only one filing per ~~in any~~ 12-month period under this paragraph.

3. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 45 days before the effective date of the rate change. After an insurer submits a complete filing that meets all of the requirements of this paragraph, the office has 45 days after the date of the filing to review the rate filing and determine if the rate is excessive, inadequate, or unfairly discriminatory.

The provisions of this subsection shall not apply to workers' compensation and employer's liability insurance and to motor vehicle insurance.

Section 2. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 999 Public Depositories
SPONSOR(S): Ingram
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Barnum	Cooper
2) Economic Affairs Committee			

SUMMARY ANALYSIS

State and local governments are authorized to deposit funds in excess of those required to meet disbursement needs or expenses in a qualified public depository. The term applies only to a bank, savings bank, or savings association which meets specific criteria. The criteria include designation as a qualified public depository by the Chief Financial Officer (CFO). Under current law, by statutory definition, a credit union cannot be a qualified public depository.

The law provides that funds deposited in a qualified public depository can then be placed in financial deposit instruments in one or more federally insured bank or savings and loan association. The full amount of the principal and accrued interest must be insured by the Federal Deposit Insurance Corporation. The standard maximum deposit insurance amount is $250,000.

When a qualified public depository accepts or retains a public deposit which is required to be secured, it deposits collateral with a custodian in an amount determined according to statutory guidelines. In lieu of utilizing a custodian, other collateral options include an irrevocable letter of credit and cash to be held in the Treasury Cash Deposit Trust Fund.

Public depositors are protected against loss caused by the default or insolvency of a qualified public depository. Losses are satisfied first through any applicable deposit insurance and then through demanding payment under letters of credit or the sale of collateral pledged or deposited by the defaulting depository. If that is insufficient, the CFO provides coverage through assessment against the other qualified public depositories.

Chapter 657, F.S. is the Florida Credit Union Act (Act). Per the Act, the purpose of a credit union is to encourage thrift among its members, create sources of credit at fair and reasonable rates of interest, and provide an opportunity for its members to use and control their resources on a democratic basis in order to improve their economic and social condition.

The shares in a credit union are insured by the National Credit Union Share Insurance Fund, which is managed by the National Credit Union Administration. The standard maximum share insurance amount is $250,000.

House Bill 999 expands the definition of "Qualified public depository", which will make a credit union eligible to apply for designation by the CFO as a qualified public depository. Approval for designation would be contingent upon meeting all provisions and requirements specified by law. After designation as a qualified public depository, a credit union will be eligible to receive deposits of state and local government funds in excess of those required to meet disbursement needs or expenses.

The bill expands the deposit insurance requirement for a qualified public depository to include the Federal Savings and Loan Insurance Corporation and the National Credit Union Share Insurance Fund.

The bill expands the current mutual responsibility and contingent liability provision to encompass any financial institution rather than only banks and savings associations.

The fiscal impact on state and local governments is indeterminate. The impact on a credit union which becomes a qualified public depository may be positive.

The bill provides for an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background:

State and local governments are authorized to deposit funds in excess of those required to meet disbursement needs or expenses in a qualified public depository. The term "qualified public depository" applies only to a bank, savings bank, or savings association which meets specific criteria. The criteria include designation as a qualified public depository by the Chief Financial Officer (CFO).[1,2] Under current law, by statutory definition, a credit union cannot be a qualified public depository.

The law provides that funds deposited in a qualified public depository can then be placed in financial deposit instruments[3] in one or more federally insured bank or savings and loan association.[4] The full amount of the principal and accrued interest must be insured by the Federal Deposit Insurance Corporation (FDIC), a federal government corporation created by the Glass-Steagall Act of 1933. FDIC insurance covers funds in deposit accounts, including checking and savings accounts, money market deposit accounts, and certificates of deposit in member banks. With enactment of the Dodd-Frank Wall Street Reform and Consumer Protection Act on July 21, 2010, the standard maximum deposit insurance amount was permanently raised to $250,000.[5] Banks are not mandated to be FDIC insured. FDIC insurance does not cover other financial products and services that insured banks may offer such as stocks, bonds, mutual fund shares, life insurance policies, annuities, or municipal securities.

When a qualified public depository accepts or retains a public deposit which is required to be secured, it must deposit collateral[6] with custodians in an amount determined according to statutory guidelines.[7] The collateral requirements include calculations based upon a financial condition ranking which is used to calculate the qualified public depository's financial strengths and weaknesses.[8] Two nationally recognized financial institution rating services are used to rank the financial condition of each participant and applicant. This ranking is based on a scale of 0 to 100. Currently, Financial Information Systems and IDC Financial Publishing rating services are used. Criteria for eligible collateral and restrictions are detailed in statute[9] and the Florida Administrative Code.[10]

Banks, savings associations, and trust companies that hold collateral for qualified public depositories pledged to secure public deposits are described as "regular" custodians. Qualified public depositories can select the "regular" custodians they wish to use and submit Collateral Control Agreement to them for signatures. These collateral control agreements, available through the Department of Financial Services website,[11] contain the requirements for custodians holding pledged collateral.

In lieu of utilizing a "regular" custodian, other collateral options include an irrevocable letter of credit and cash to be held in the Treasury Cash Deposit Trust Fund.[12] Interest earned on cash deposited into this Fund is to be prorated and paid to the depositing entities.[13]

---

[1] s. 280.02(26), F.S.

[2] 69C-2.005, F.A.C.

[3] Financial deposit instruments include checking and savings accounts, money market deposit accounts and certificates of deposit, as well as other financial instruments which are or may become eligible for insurance by the FDIC.

[4] s. 17.57(7), F.S.

[5] H.R. 4173, Public Law 111-203, Sec. 335.

[6] s. 280.13, F.S.

[7] s. 280.04(2), F.S.

[8] 69C-2.024, F.A.C.

[9] s. 280.13, F.S.

[10] 69C-2.007, F.A.C.

[11] https://apps.fldfs.com/CAP_Web/PublicDeposits/reg_custodian_info.aspx (Last visited on March 27, 2011).

[12] s. 280.13, F.S.

[13] s. 17.60(2), F.S.

A Qualified Public Depository Oversight Board is created in law for the purpose of safeguarding the integrity of the Public Deposits Program and preventing the need for loss assessments. The board consists of six members. The CFO nominates two members and alternates from each of three groups of eligible qualified public depositories, categorized by average asset size. If the qualified public depository fails to respond or declines the nomination, the Florida Bankers Association selects a member and alternate to represent that average asset category.[14]

Public depositors are protected against loss caused by the default or insolvency of a qualified public depository. Losses are satisfied first through any applicable deposit insurance and then through demanding payment under letters of credit or the sale of collateral pledged or deposited by the defaulting depository. If that is insufficient, the CFO provides coverage through assessment against the other qualified public depositories.[15, 16]

Chapter 657, F.S. is the Florida Credit Union Act (Act). Per the Act, the purpose of a credit union[17] is to encourage thrift among its members, create sources of credit at fair and reasonable rates of interest, and provide an opportunity for its members to use and control their resources on a democratic basis in order to improve their economic and social condition.[18] This is consistent with U.S. Congressional findings that their specified mission is to meet the credit and savings needs of consumers, especially persons of modest means.[19]

The shares in a credit union[20] are insured by the National Credit Union Share Insurance Fund (NCUSIF). Established by Congress in 1970 to insure member share accounts at federally insured credit unions, the NCUSIF is managed by the National Credit Union Administration (NCUA) under the direction of the three-person NCUA Board. NCUA regulates, charters, and insures the nation's federal credit unions. In addition, NCUA insures state-chartered credit unions that desire and qualify for federal insurance. The standard maximum share insurance amount is also $250,000.

Effect of the bill:

House Bill 999 expands the definition of "Qualified public depository" by substituting the term "financial institution" for "bank, savings bank, or savings association". This will make credit unions eligible to apply for designation by the CFO as a qualified public depository. Approval for designation would be contingent upon meeting all provisions and requirements specified by statute and the Florida Administrative Code. After designation as a qualified public depository, a credit union will be eligible to receive deposits of state and local government funds in excess of those required to meet disbursement needs or expenses.

The bill expands the deposit insurance requirement for a qualified public depository to include the Federal Savings and Loan Insurance Corporation and the National Credit Union Share Insurance Fund.

The bill expands the current mutual responsibility and contingent liability provision to encompass any financial institution rather than only banks and savings associations.

The bill provides for an effective date of July 1, 2011.

B. SECTION DIRECTORY:

Section 1. Amends s. 280.02(26), F.S., by revising the definition relating to a qualified public depository.

---

[14] s. 280.071, F.S.
[15] s. 280.07, F.S.
[16] s. 280.08, F.S.
[17] s. 657.002(4), F.S. – Credit union is defined as a cooperative society organized pursuant to the Florida Credit Union Act.
[18] s. 657.03, F.S.
[19] Pub. L. 105–219, § 2, Aug. 7, 1998, 112 Stat. 913.
[20] s. 657.02(10), F.S. - "Shares" means the money placed into the credit union by members on which dividends may be paid.

Section 2. Amends s. 280.07, F.S., by expanding entities operating under mutual responsibility and continent liability.

Section 3. Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Indeterminate. Accrued interest is dependent upon the amount of principal, interest rate, and protocols for crediting interest.

2. Expenditures: $4,000 per fiscal year for the cost of "credit union ranking" from two services that are used to calculate financial strengths and weaknesses in order to determine the pledge percent of the collateral requirement.[21]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   Indeterminate. Accrued interest is dependent upon the amount of principal, interest rate, and protocols for crediting interest.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

A credit union which becomes a qualified public depository and is utilized by state or local governments for the deposit of funds, may generate income for the credit union from those deposits.

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.

[21] Department of Financial Affairs HB 999 Bill Analysis dated March 8, 2011 on file with the Insurance & Banking Subcommittee.

C. DRAFTING ISSUES OR OTHER COMMENTS:

- Enactment of this legislation will necessitate rule-making. Chapter 69C-2, F.A.C. provides procedures for administering the Florida Security for Public Deposits Act. Almost all of the 20 rules contain specific reference to "a bank or savings association" rather than "a financial institution", the all-encompassing term substituted in the bill.
- Department of Financial Services has indicated that additional changes to ch. 280, F.S. will be required to accommodate credit unions in the Public Deposits Program.[22]
- Line 23 incorrectly includes a reference to the Federal Savings and Loan Insurance Corporation.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[22] Department of Financial Services HB 999 Bill Analysis dated March 8, 2011 on file with the Insurance & Banking Subcommittee.

A bill to be entitled

An act relating to public depositories; amending s. 280.02, F.S.; revising the definition of the term "qualified public depository"; amending s. 280.07, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Subsection (26) of section 280.02, Florida Statutes, is amended to read:

280.02 Definitions.—As used in this chapter, the term:

(26) "Qualified public depository" means any financial institution ~~bank, savings bank, or savings association~~ that:

(a) Is organized and exists under the laws of the United States, the laws of this state, or the laws of any other state or territory of the United States.

(b) Has its principal place of business in this state or has a branch office in this state which is authorized under the laws of this state or of the United States to receive deposits in this state.

(c) Is insured by the Federal ~~Has~~ Deposit Insurance Corporation, the Federal Savings and Loan Insurance Corporation, or the National Credit Union Share Insurance Fund ~~under the provision of the Federal Deposit Insurance Act, as amended, 12 U.S.C. ss. 1811 et seq~~.

(d) Has procedures and practices for accurate identification, classification, reporting, and collateralization

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

of public deposits.

(e) Meets all the requirements of this chapter.

(f) Has been designated by the Chief Financial Officer as a qualified public depository.

Section 2. Section 280.07, Florida Statutes, is amended to read:

280.07 Mutual responsibility and contingent liability.—Any financial institution ~~bank or savings association~~ that is designated as a qualified public depository and that is not insolvent shall guarantee public depositors against loss caused by the default or insolvency of other qualified public depositories. Each qualified public depository shall execute a form prescribed by the Chief Financial Officer for such guarantee which shall be approved by the board of directors and shall become an official record of the institution.

Section 3. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1087 Persons Designated To Receive Insurer Notifications
SPONSOR(S): Holder and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1252

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Philpot	Cooper
2) Economic Affairs Committee			

SUMMARY ANALYSIS

Current law requires insurers to provide certain policy notices to each "named insured" covered under a policy. Notices for renewal premium, nonrenewal, cancellation, or termination must be delivered to each "named insured" in policies that provide workers' compensation and employer's liability, property, casualty, homeowner's, mobile home owner's, farmowner's, condominium association, condominium unit owner's, and apartment building insurance. Additional notices for motor vehicle insurance must also be delivered to the "named insured," including advance notice of intention not to renew, advance notice of intention to transfer, and notice of eligibility for insurance through the Automobile Joint Underwriting Association in the event of cancellation or nonrenewal.

The bill revises the person identified by statute as the designated recipient for these required notices. Under the lines of insurance above, the bill changes the designated recipient of notice from the "named insured," including all persons named on a policy, to the "first named insured," typically the policy holder appointed as the primary contact for administrative matters on the policy.

The bill does not appear to have a fiscal impact on state or local government. The bill should provide cost savings to the private sector.

The bill takes effect July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Introduction

Chapter 627, Florida Statutes, specifies requirements for notification to a policy holder, or the "named insured," regarding renewal premium,[1] nonrenewal,[2] cancellation[3] or termination under particular lines of personal and commercial insurance, including workers' compensation and employer's liability, property, casualty, homeowner's, mobile home owner's, farmowner's, condominium association, condominium unit owner's, and apartment building insurance. Additionally, specific statutory provisions for motor vehicle insurance require notice to the "named insured" regarding: intent not to renew;[4] intent to transfer a policy;[5] and eligibility for insurance through the Automobile Joint Underwriting Association in the event of cancellation or nonrenewal.[6]

The party designated to receive these notices under current law is the "named insured," the persons or entities listed on the policy declaration page. For personal property or motor vehicle coverage, "named insured" may include one or more individuals. In commercial coverage, particularly in the context of a partnership or corporation, the "named insured(s)" of a policy may often include persons or entities related by common ownership or common enterprise.

A "first named insured" is generally the first named insured included in the policy declaration, the person who assumes the legal authority to act on the policy with regard to cancellation, policy changes, reporting losses, and other administrative functions. Generally, in a policy that covers more than one "named insured," the "first named insured" is designated by the policy holder(s) on an application at the time the policy is adopted.

For example, a company operating multiple retail locations may purchase a worker's compensation policy identifying the company headquarters as the "first named insured" and each retail store location as a "named insured."[7] Even if the company's headquarters assumes responsibility for all premium payments, policy changes and other administrative matters as the designated "first named insured," current law requires insurers to deliver certain policy notices to each individual store location listed as a "named insured."

Language for insurance policy provisions is developed and submitted by insurers for approval by the Office of Insurance Regulation (OIR). Many insurance companies, especially domestic insurers, rely on ratemaking organizations like the Insurance Services Office (ISO)[8] that have drafted and secured approval for standard form language. In effect, ISO forms generally reflect industry practice. Among the form language provisions drafted by ISO and approved by OIR, requirements for notice to policy holders are included.

Previously, common industry practice for delivery of cancellation and nonrenewal notices included only the "first named insured," reflected in part by OIR's approval of form language[9] submitted by the ISO.

---

[1] FLA. STAT. § 627.4133(1)(a); FLA. STAT. § 627.4133(2)(a); FLA. STAT. § 627.7277(2).
[2] FLA. STAT. § 627.4133(1)(a); FLA. STAT. § 627.4133(2)(b).
[3] FLA. STAT. § 627.4133(1)(b); FLA. STAT. § 627.4133(2)(b); FLA. STAT. § 627.7278(3)(a); FLA. STAT. § 627.7281.
[4] FLA. STAT. § 627.728(4)(a).
[5] FLA. STAT. § 627.728(4)(d).
[6] FLA. STAT. § 627.728(6).
[7] Rule 3(D) of the National Council on Compensation Insurance's Experience Rating Plan Manual (2003) requires that in order to combine two or more entities under one policy, the same person, group of persons or corporation must own more than 50% of each entity.
[8] For more information, visit www.iso.com.
[9] Form language in the ISO forms cited herein is not applicable to all forms of insurance implicated by changes to this bill. Rather, these forms are indicative of the current interpretation of statutory requirements for notice to the "named insured" that is included in other ISO forms approved by OIR for additional lines of insurance. *See also* Form IL 02 55 01 10 (amending Form IL 02 55 09 08).

In Form CG 02 20 12 07, effective December 2007 and approved by OIR, common policy conditions provided that notices of cancellation and nonrenewal shall be mailed or delivered to the "first Named Insured."[10]

Subsequently, ISO has instituted Form CG 02 20 04 11, effective April 2011 and approved by OIR, providing common policy conditions for cancellation and nonrenewal consistent with current statutes requiring delivery of notice to the "Named Insured(s)."[11] Language in Form CG 02 20 04 11 is consistent with an effort by OIR to conform review and approval of standard policy language regarding policyholder notice to the current statutory requirement of notice to the "named insured." Under current law and OIR interpretations, when notice is delivered to the "named insureds" on a policy, multiple copies of each notice must be delivered, even if all "named insureds" are located at the same address.

Industry representatives have indicated that insurance policies usually incorporate lending institutions as loss payees by endorsement rather than as a "named insured."[12] As a loss payee under a policy endorsement, the lending institution qualifies for notice from the insurer notwithstanding the provisions for notices to "named insured(s)."[13]

Effect of Proposed Changes

The bill adopts the previous industry practice of delivering certain required policy notices to only the party with administrative authority on the policy, the "first named insured." In effect, the bill requires the following policy notices to be delivered to only the "first named insured" rather than all "named insured(s):"[14]

- notices of nonrenewal or renewal premium for worker's compensation, employer's liability, property, and casualty insurance;
- notices of cancellation or termination for property and casualty insurance;
- notices of renewal premium, nonrenewal, cancellation, or termination for any personal lines or commercial residential property insurance policy, including, but not limited to, homeowner's, mobile home owner's, farmowner's, condominium association, condomiunium unit owner's, and apartment building; and
- notices of renewal premium, cancellation, intent not to renew, intent to transfer, and eligibility for insurance through the Automobile Joint Underwriting Association in policies providing motor vehicle insurance.

For example, in the context of a worker's compensation policy, this bill limits notice of renewal premium or nonrenewal to the "first named insured,"[15] usually the administrative office or primary center of operations for a business that has included multiple "named insured" entities on a policy.

The bill takes effect July 1, 2011.

B. SECTION DIRECTORY:

Section 1 amends s. 627.4133(1), F.S., relating to the required notice an insurer must provide to policy holders regarding nonrenewal, renewal premium, cancellation, or termination in policies providing coverage for workers' compensation and employer's liability, property, and casualty insurance.

---

[10] Insurance Services Office, Form CG 02 20 12 07: Florida Changes – Cancellation and Nonrenewal (December 2007).
[11] Insurance Services Office, Form CG 02 20 04 11: Florida Changes – Cancellation and Nonrenewal (April 2011).
[12] *See, e.g.*, Insurance Services Office, Form CP 12 18 06 95: Loss Payable Provisions (June 1995); additional industry information provided to Subcommittee staff, on file with Insurance and Banking Subcommittee.
[13] *Id.*
[14] Provisions relating to lines of property and casualty insurance through surplus lines carriers are not impacted by this bill. In effect, notice of cancellation and nonrenewal of property or casualty policies through surplus lines carriers will continue to be required to be delivered to the "named insured(s)" as provided in s. 626.9201, F.S.
[15] Cancellation notices for worker's compensation insurance policies are not impacted by this bill. Requirements for cancellation notices in a worker's compensation policy are provided in s. 440.42(3), F.S.

Section 1 also amends s. 627.4133(2), F.S., relating to the required notice an insurer must provide to policy holders regarding renewal premium, nonrenewal, cancellation, or termination in policies providing coverage for personal lines or commercial residential property, including but not limited to, homeowner's, mobile home owner's, farmowner's, condominium association, condominium unit owner's, apartment building, or other policy covering a residential structure or its contents.

Section 2 amends s. 627.7277, F.S., relating to the required notice an insurer must deliver to a policy holder regarding renewal premium for motor vehicle and casualty insurance contracts.

Section 3 amends s 627.728, F.S., relating to required notices surrounding cancellation and nonrenewal of motor vehicle insurance contracts, including notice of cancellation, advance notice of intention not to renew, advance notice of intention to transfer, and notice of eligibility for insurance through the Automobile Joint Underwriting Association in the event of cancellation or nonrenewal.

Section 4 amends s. 627.7281, F.S., relating to the required notice an insurer must provide to policy holders regarding cancellation of motor vehicle insurance not covered under cancellation provisions of s. 627.728, F.S.

Section 5 provides that the bill becomes effective on July 1, 2011.

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:

Insurance industry representatives suggest that limiting notice requirements to include only the "first named insured" will reduce significant administrative costs associated with sending multiple certified mail notices to all named insureds typically located at the same address.[16]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

[16] Industry information provided to Subcommittee staff, on file with Insurance and Banking Subcommittee.

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:

   Insurance industry representatives have identified other states that have adopted statutory provisions requiring notice of cancellation and nonrenewal to be delivered to the "first named insured," including but not limited to New York and Louisiana.[17]

B. RULE-MAKING AUTHORITY:

   None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

   None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[17] *See* N.Y. INSURANCE LAW § 3426 (McKinney 2011); LA. REV. STAT. ANN. § 22:1267 (2011).

A bill to be entitled

An act relating to persons designated to receive insurer notifications; amending s. 627.4133, F.S.; changing the designated person or persons who must be notified by an insurer from the "insured" to the "first-named insured" in situations involving the nonrenewal, renewal premium, cancellation, or termination of workers' compensation, employer liability, or certain property and casualty insurance coverage; amending s. 627.7277, F.S.; making a conforming change that specifies the "first-named insured" as the person who is to receive notification of a renewal premium; amending s. 627.728, F.S.; changing the designated person or persons who must be notified by an insurer from the "insured" to the "first-named insured" in certain situations involving the cancellation or nonrenewal of motor vehicle insurance coverage; making a conforming change that specifies the "first-named insured's insurance agent" as a person who is to receive certain notifications relating to motor vehicle insurance coverage; amending s. 627.7281, F.S.; making a conforming change that specifies the "first-named insured" as the person who is to receive notification of cancellation of motor vehicle insurance coverage; providing an effective date.

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

Section 1. Paragraphs (a) and (b) of subsection (1) and paragraphs (a) and (b) of subsection (2) of section 627.4133, Florida Statutes, are amended to read:

627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(1) Except as provided in subsection (2):

(a) An insurer issuing a policy providing coverage for workers' compensation and employer's liability insurance, property, casualty, except mortgage guaranty, surety, or marine insurance, other than motor vehicle insurance subject to s. 627.728, shall give the first-named ~~named~~ insured at least 45 days' advance written notice of nonrenewal or of the renewal premium. If the policy is not to be renewed, the written notice shall state the reason or reasons as to why the policy is not to be renewed. This requirement applies only if the insured has furnished all of the necessary information so as to enable the insurer to develop the renewal premium prior to the expiration date of the policy to be renewed.

(b) An insurer issuing a policy providing coverage for property, casualty, except mortgage guaranty, surety, or marine insurance, other than motor vehicle insurance subject to s. 627.728 or s. 627.7281, shall give the first-named ~~named~~ insured written notice of cancellation or termination other than nonrenewal at least 45 days prior to the effective date of the cancellation or termination, including in the written notice the reason or reasons for the cancellation or termination, except that:

1. When cancellation is for nonpayment of premium, at

least 10 days' written notice of cancellation accompanied by the reason therefor shall be given. As used in this subparagraph, the term "nonpayment of premium" means failure of the named insured to discharge when due any of her or his obligations in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit, or failure to maintain membership in an organization if such membership is a condition precedent to insurance coverage. "Nonpayment of premium" also means the failure of a financial institution to honor an insurance applicant's check after delivery to a licensed agent for payment of a premium, even if the agent has previously delivered or transferred the premium to the insurer. If a dishonored check represents the initial premium payment, the contract and all contractual obligations shall be void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified mail or registered mail, and if the contract is void, any premium received by the insurer from a third party shall be refunded to that party in full; and

2. When such cancellation or termination occurs during the first 90 days during which the insurance is in force and the insurance is canceled or terminated for reasons other than nonpayment of premium, at least 20 days' written notice of cancellation or termination accompanied by the reason therefor shall be given except where there has been a material

misstatement or misrepresentation or failure to comply with the underwriting requirements established by the insurer.

After the policy has been in effect for 90 days, no such policy shall be canceled by the insurer except when there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days of the date of effectuation of coverage, or a substantial change in the risk covered by the policy or when the cancellation is for all insureds under such policies for a given class of insureds. This subsection does not apply to individually rated risks having a policy term of less than 90 days.

(2) With respect to any personal lines or commercial residential property insurance policy, including, but not limited to, any homeowner's, mobile home owner's, farmowner's, condominium association, condominium unit owner's, apartment building, or other policy covering a residential structure or its contents:

(a) The insurer shall give the first-named ~~named~~ insured at least 45 days' advance written notice of the renewal premium.

(b) The insurer shall give the first-named ~~named~~ insured written notice of nonrenewal, cancellation, or termination at least 100 days prior to the effective date of the nonrenewal, cancellation, or termination. However, the insurer shall give at least 100 days' written notice, or written notice by June 1, whichever is earlier, for any nonrenewal, cancellation, or termination that would be effective between June 1 and November

30. The notice must include the reason or reasons for the nonrenewal, cancellation, or termination, except that:

1. The insurer shall give the first-named ~~named~~ insured written notice of nonrenewal, cancellation, or termination at least 180 days prior to the effective date of the nonrenewal, cancellation, or termination for a first-named ~~named~~ insured whose residential structure has been insured by that insurer or an affiliated insurer for at least a 5-year period immediately prior to the date of the written notice.

2. When cancellation is for nonpayment of premium, at least 10 days' written notice of cancellation accompanied by the reason therefor shall be given. As used in this subparagraph, the term "nonpayment of premium" means failure of the named insured to discharge when due any of her or his obligations in connection with the payment of premiums on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit, or failure to maintain membership in an organization if such membership is a condition precedent to insurance coverage. "Nonpayment of premium" also means the failure of a financial institution to honor an insurance applicant's check after delivery to a licensed agent for payment of a premium, even if the agent has previously delivered or transferred the premium to the insurer. If a dishonored check represents the initial premium payment, the contract and all contractual obligations shall be void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the

applicant or 15 days after notice is sent to the applicant by certified mail or registered mail, and if the contract is void, any premium received by the insurer from a third party shall be refunded to that party in full.

3. When such cancellation or termination occurs during the first 90 days during which the insurance is in force and the insurance is canceled or terminated for reasons other than nonpayment of premium, at least 20 days' written notice of cancellation or termination accompanied by the reason therefor shall be given except where there has been a material misstatement or misrepresentation or failure to comply with the underwriting requirements established by the insurer.

4. The requirement for providing written notice of nonrenewal by June 1 of any nonrenewal that would be effective between June 1 and November 30 does not apply to the following situations, but the insurer remains subject to the requirement to provide such notice at least 100 days prior to the effective date of nonrenewal:

a. A policy that is nonrenewed due to a revision in the coverage for sinkhole losses and catastrophic ground cover collapse pursuant to s. 627.706, as amended by s. 30, chapter 2007-1, Laws of Florida.

b. A policy that is nonrenewed by Citizens Property Insurance Corporation, pursuant to s. 627.351(6), for a policy that has been assumed by an authorized insurer offering replacement or renewal coverage to the policyholder.

After the policy has been in effect for 90 days, the policy

shall not be canceled by the insurer except when there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days of the date of effectuation of coverage, or a substantial change in the risk covered by the policy or when the cancellation is for all insureds under such policies for a given class of insureds. This paragraph does not apply to individually rated risks having a policy term of less than 90 days.

Section 2. Subsection (2) of section 627.7277, Florida Statutes, is amended to read:

627.7277 Notice of renewal premium.—

(2) An insurer shall mail or deliver to the first-named insured ~~its policyholder~~ at least 30 days' advance written notice of the renewal premium for the policy.

Section 3. Paragraph (a) of subsection (3), paragraphs (a) and (d) of subsection (4), and subsections (5) and (6) of section 627.728, Florida Statutes, are amended to read:

627.728 Cancellations; nonrenewals.—

(3)(a) No notice of cancellation of a policy to which this section applies shall be effective unless mailed or delivered by the insurer to the first-named ~~named~~ insured and to the first-named ~~named~~ insured's insurance agent at least 45 days prior to the effective date of cancellation, except that, when cancellation is for nonpayment of premium, at least 10 days' notice of cancellation accompanied by the reason therefor shall be given. No notice of cancellation of a policy to which this section applies shall be effective unless the reason or reasons for cancellation accompany the notice of cancellation.

(4)(a) No insurer shall fail to renew a policy unless it mails or delivers to the first-named ~~named~~ insured, at the address shown in the policy, and to the first-named ~~named~~ insured's insurance agent at her or his business address, at least 45 days' advance notice of its intention not to renew; and the reasons for refusal to renew must accompany such notice. This subsection does not apply:

1. If the insurer has manifested its willingness to renew; or

2. In case of nonpayment of premium.

Notwithstanding the failure of an insurer to comply with this subsection, the policy shall terminate on the effective date of any other automobile liability insurance policy procured by the insured with respect to any automobile designated in both policies. Unless a written explanation for refusal to renew accompanies the notice of intention not to renew, the policy shall remain in full force and effect.

(d) Instead of canceling or nonrenewing a policy, an insurer may, upon expiration of the policy term, transfer a policy to another insurer under the same ownership or management as the transferring insurer, by giving the first-named ~~named~~ insured at least 45 days' advance notice of its intent to transfer the policy and of the premium and the specific reasons for any increase in the premium.

(5) United States postal proof of mailing or certified or registered mailing of notice of cancellation, of intention not to renew, or of reasons for cancellation, or of the intention of

the insurer to issue a policy by an insurer under the same ownership or management, to the first-named ~~named~~ insured at the address shown in the policy shall be sufficient proof of notice.

(6) When a policy is canceled, other than for nonpayment of premium, or in the event of failure to renew a policy to which subsection (4) applies, the insurer shall notify the first-named ~~named~~ insured of her or his possible eligibility for insurance through the Automobile Joint Underwriting Association. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew and shall state that such notice of availability of the Automobile Joint Underwriting Association is given pursuant to this section.

Section 4. Section 627.7281, Florida Statutes, is amended to read:

627.7281 Cancellation notice.—An insurer issuing a policy of motor vehicle insurance not covered under the cancellation provisions of s. 627.728 shall give the first-named ~~named~~ insured notice of cancellation at least 45 days prior to the effective date of cancellation, except that, when cancellation is for nonpayment of premium, at least 10 days' notice of cancellation accompanied by the reason therefor shall be given. As used in this section, "policy" does not include a binder as defined in s. 627.420 unless the duration of the binder period exceeds 60 days.

Section 5. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1125 Florida Health Choices Program
SPONSOR(S): Health & Human Services Quality Subcommittee; Corcoran
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee	12 Y, 0 N, As CS	Poche	Calamas
2) Insurance & Banking Subcommittee		Barnum	Cooper
3) Appropriations Committee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

In 2008, the Florida Legislature created the Florida Health Choices Program (Program). It includes a single, centralized market for the sale and purchase of health care products including, but not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts.

Florida Health Choices, Inc., is established in law as a not-for-profit corporation responsible for administering the Program and may function as a third-party administrator for employers participating in the Program. It is governed by a 15-member board of directors (Board).

The law specifies which entities are eligible to purchase products through, and participate in, the Program. Employees of the following employers are eligible to purchase coverage through the Program if their employers participate in the Program:

- Employers with 1 to 50 employees.
- Cities with a population of less than 50,000 residents.
- Fiscally constrained counties.
- School districts located in fiscally constrained counties.

Under current law, the following individuals are eligible to enroll:

- Individual employees of enrolled employers.
- State employees ineligible for state employee health benefits.
- State retirees.
- Medicaid reform participants who select the opt-out provision of reform.
- Statutory rural hospitals.

CS/HB 1125 makes a number of changes to the Florida Health Choices Program. The bill:

- Expands the eligibility requirements for employers to participate in the Program by removing the 50-employee upper limit.
- Allows all Medicaid recipients who opt out of Medicaid to participate in the Program.
- Streamlines the process by which new health benefit plans, services, and other contracts are approved to be included in the marketplace.
- Simplifies the procedure by which the Board approves vendors for participation.
- Requires vendors to submit data annually to the Corporation so that premium payments to vendors by enrollees may be risk adjusted to ensure that risk is pooled appropriately and prevent selection bias.
- Eliminates the requirement to develop a plan for tax credits to be made available to employers participating in the marketplace.

The bill appears to have no direct fiscal impact on state or local government. Individuals may benefit from increased choices and marketplace competition.

The bill provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Florida Health Choices Program

In 2008, the Florida Legislature created the Florida Health Choices Program (Program).[1] The Program includes a single, centralized market for the sale and purchase of health care products including, but not limited to, health insurance plans, health maintenance organization (HMO) plans, prepaid services, service contracts, and flexible spending accounts.[2] Policies sold as part of the Program are exempt from regulation under the Florida Insurance Code[3] and laws governing HMOs.[4] The following entities are authorized to be eligible vendors of these products and plans:

- Insurers authorized under ch. 624, F.S.;
- HMOs authorized under ch. 641, F.S.;
- Prepaid health clinics licensed under part II, ch. 641, F.S.;
- Health care providers, including hospitals and other licensed health facilities, health care clinics, pharmacies, and other licensed health care providers;
- Provider organizations, including services networks, group practices, and professional associations; and
- Corporate entities providing specific health services.[5]

Under s. 408.910(11), F.S., Florida Health Choices, Inc., (Corporation) is established as a not-for-profit corporation under ch. 617, F.S. The Corporation is responsible for administering the Program and may function as a third-party administrator (TPA) for employers participating in the Program.[6] In its capacity as a TPA, the Corporation is not subject to the licensing requirements for insurance administrators under Part VII, Chapter 626, F.S. The Corporation is authorized to collect premiums and other payments from employers. In addition, the Corporation is not required to maintain any level of bonding. The Corporation is responsible for certifying vendors and ensuring the validity of their offerings. Lastly, the Corporation is not subject to the provisions of the Unfair Insurance Trade Practices Act.[7]

The Corporation is governed by a 15-member board of directors (Board): Three ex-officio members representing the Agency for Health Care Administration (AHCA), Department of Management Services, and the Office of Insurance Regulation (OIR); four appointed by the Governor; four appointed by the President of the Senate; and, four appointed by the Speaker of the House of Representatives.[8] The board members are protected from liability created by any member of the board or its employees or agents for any action taken by them in the performance of the powers and duties as board members.[9] No cause of action may rise against a board member in that circumstance.[10]

---

[1] S. 4, ch. 2008-32, Laws of Fla. (2008); *see also* s. 408.910, F.S.
[2] S. 408.910(5), F.S.
[3] Ch. 624, F.S.
[4] Part I, Ch. 641, F.S.; *see also* s. 408.910(10)(a), F.S.
[5] S. 408.910(4)(d), F.S
[6] S. 408.910(10)(b), F.S.
[7] Part IX, Ch. 626, F.S.
[8] S. 408.910(11)(a), F.S.
[9] S. 408.910(11)(e), F.S.
[10] *Id.*

The law specifies which entities are eligible to purchase products through, and participate in, the Program. Employees of the following employers are eligible to purchase coverage through the Program if their employers participate in the Program:

- Employers with 1 to 50 employees;
- Cities with a population of less than 50,000 residents;
- Fiscally constrained counties[11]; and
- School districts located in fiscally constrained counties.[12]

The following vendors are eligible to participate in the Program:

- Insurers licensed under ch. 624, F.S.;
- HMOs licensed under part I of ch. 641, F.S.;
- Prepaid health clinic providers licensed under part II of ch. 641, F.S.;
- Health care providers;
- Provider organizations; and
- Corporate entities providing specific services via service contracts.[13]

The following individuals are eligible to enroll in the Program:

- Individual employees of enrolled employers;
- State employees ineligible for state employee health benefits;
- State retirees;
- Medicaid reform participants who select the opt-out provision of reform; and
- Statutory rural hospitals.[14]

Employers are required to establish section 125 plans in order to participate in, and allow their employees to enroll in, the Program.[15] This allows both employers and employees to purchase insurance coverage through the Program using pre-tax dollars.

In 2008, the Legislature appropriated $1,000,000 in non-recurring General Revenue to the Corporation to initially implement the Program.[16]

In the summer of 2011, phase one of the Program, known as Florida's Marketplace and dubbed "Quick Start", will be operational. It will offer a central web portal to access and compare multiple insurance

---

[11] S. 218.67(1), F. S. - Each county that is entirely within a rural area of critical economic concern as designated by the Governor pursuant to s. 288.0656 or each county for which the value of a mill will raise no more than $5 million in revenue, based on the taxable value certified pursuant to s. 1011.62(4)(a)1.a., from the previous July 1, shall be considered a fiscally constrained county.

[12] S. 408.910(4)(a), F.S.

[13] S. 408.910(4)(d), F.S.

[14] S. 408.910(4)(b), F.S

[15] Section 125 of the Internal Revenue Code allows employers to offer a cafeteria plan to employees for payment of qualified benefits. A cafeteria plan is a separate written plan maintained by an employer for employees that meets the specific requirements of and regulations of section 125. It provides participants an opportunity to receive certain benefits on a pretax basis. Participants in a cafeteria plan must be permitted to choose among at least one taxable benefit (such as cash) and one qualified benefit.
A qualified benefit is a benefit that does not defer compensation and is excludable from an employee's gross income under a specific provision of the Code, without being subject to the principles of constructive receipt. Qualified benefits include:

- Accident and health benefits (but not Archer medical savings accounts or long-term care insurance);
- Adoption assistance;
- Dependent care assistance;
- Group-term life insurance coverage;
- Health savings accounts, including distributions to pay long-term care services.

The written plan must specifically describe all benefits and establish rules for eligibility and elections. A section 125 plan is the only means by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice causing the benefits to become taxable. A plan offering only a choice between taxable benefits is not a section 125 plan. *See* http://www.irs.gov/govt/fslg/article/0,,id=112720,00.html. (last viewed March 27, 2011).

[16] Ch. 2008-152, Laws of Fla. (2008).

products.[17] The web portal will also be accessible by employers, vendors and insurance agents.[18] Midterm and long term phases are expected to be completed in late 2011 and late 2012, providing more features and easier access for employers, enrollees, and vendors.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA")[19], as amended by the Health Care and Education Reconciliation Act of 2010[20]. One of the essential elements of the PPACA is the requirement that all U.S. citizens have health insurance. Beginning in 2014, for U.S. citizens who cannot purchase health insurance through an employer because it is not offered, health insurance exchanges will be established, from which citizens can purchase health insurance coverage that meets the minimum essential coverage provisions of PPACA.

The constitutionality of PPACA is currently being challenged in federal court[21] by Florida, 25 other states, the National Federation of Independent Business, and private citizens, and the outcome is uncertain. If Florida were required to establish an exchange pursuant to PPACA, some of the products currently authorized by law to be available in the Program would not meet the minimum benefit requirements of PPACA.

Effect of Proposed Changes

The bill defines the "Corporation's marketplace" as a single, centralized market established by the Program to facilitate the purchase of products made available in the marketplace. The bill also adds HMOs, licensed under part I of Chapter 641, to the definition of "insurer".

The bill expands the eligibility requirements for employers to participate in the Program. An employer that seeks to enter the marketplace must meet all criteria established by the Board and intend to make employees eligible for one, or more, health plan, product or service contract offered by the Program. Currently, only employers with 1 to 50 employees are eligible for participation in the Program. The limitation on the number of employees is deleted by the bill, thereby opening up participation in the Program to all employers in Florida, no matter the number of employees.

Increasing the size of employers that may participate in the marketplace may increase the attractiveness of the marketplace for insurers. Large numbers of potential insureds equates to a potentially larger market share for vendors who offer products in the marketplace. Additional insurers will create more choice for enrollees in the Program and may result in more affordable premium prices due to increased competition.

The bill changes the category of a "statutory rural hospital"[22] from an eligible individual to an eligible employer for participation in the marketplace.

The bill amends s. 408.910(4)(b)4., F.S., to allow all Medicaid recipients who opt out of Medicaid to participate in the Corporation marketplace. Currently, only Medicaid reform participants are eligible to participate in the marketplace. This proposed change in law anticipates proposed Medicaid reform provisions that would allow a Medicaid participant to opt out of the system and use the funds that would have been used by Medicaid to pay for coverage to purchase insurance coverage in the private market. The proposed changes allow those Medicaid dollars to be used to purchase any product offered for sale in the Corporation's marketplace.

The bill makes a technical change, permitting HMOs to sell health maintenance contracts and deleting insurance policies as a product to be sold by an HMO. HMOs market health maintenance contracts

---

[17] *See* http://myfloridachoices.org/about/ (last viewed March 27, 2011).
[18] S. 408.910(8), F.S.
[19] P.L. 111-148, 124 Stat. 119 (2010)
[20] P.L. 111-152, 124 Stat. 1029 (2010)
[21] *See* U.S Dept. of Health and Human Serv., et al., v. State of Fla., et al., Case No. 11-11021-HH (11th Cir. Ct.)(on appeal from United States District Court for the Northern District of Florida, Pensacola Division, Case No. 3:10-cv-91-RV/EMT)
[22] S. 395.602(2)(e), F.S., defines a "rural hospital".

rather than traditional insurance policies. The bill also includes health maintenance contracts on the list of products that may be sold in the Corporation's marketplace.

The bill streamlines the process by which new health insurance plans, services, and other contracts are approved to be included in the marketplace. The bill requires all risk-bearing products permitted to be sold by insurers and HMOs in the Corporation's marketplace to be approved by OIR. The bill removes the requirement that the Board develop a methodology by which it will evaluate the actuarial soundness of the products and premiums offered by the plan. The bill also eliminates the procedure for the Board to seek guidance from the OIR regarding the approval or denial of inclusion of a plan or product in the Corporation's marketplace. The OIR is charged with approving all health insurance policies and other health insurance products that are sold in the state of Florida. The bill allows for the initial approval of products for sale in Florida by the OIR to serve as approval for inclusion in the Corporation's marketplace. Products other than those listed in s. 408.910(4)(d)1., F.S., and s. 408.910(4)(d)2., F.S., are not subject to the licensing requirement of the Florida Insurance Code.[23]

The bill simplifies the procedure by which the Board approves vendors for participation in the Corporation's marketplace. The procedure may include the elements currently listed in the statute and may include medical underwriting for premium prices based on age, gender, and location of participant.

Currently, s. 408.910(5)(b), F.S., requires that policies, plans and other contracts for services purchased through the Program ensure availability of covered services for a period of at least one full enrollment year. The bill removes the one year requirement. As a result, policies, plans and other contracts for services may be able to offer covered services for time periods greater than or less than one full enrollment year.

The bill confirms that the Corporation has authority to approve all non-risk-bearing products to be sold in the Corporation's marketplace. Currently, OIR has the authority to approve all risk-bearing products to be sold through the marketplace.

The bill renames the "Exchange Process" to "The Marketplace Process." The bill requires the Corporation to establish initial, open, and special enrollment periods for enrollees in the marketplace.

The bill requires the Corporation to inform individuals about other public health care programs that are available. Also, the bill requires the Corporation to operate a toll-free hotline to respond to requests for assistance from enrollees, prospective enrollees, vendors, and other participants in the Program.

The bill requires vendors to submit data annually to the Corporation so that premium payments to vendors by enrollees may be risk adjusted to ensure that risk is pooled appropriately and prevent selection bias. The bill also eliminates the plan for tax credits to be made available to employers participating in the marketplace.

Lastly, for administration of the Program, the bill requires the disclosure of personal identifying information about a Florida Kidcare Program applicant or enrollee to the Corporation by AHCA, the Department of Children and Families, the Department of Health, or the Florida Healthy Kids Corporation.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.910, F.S., relating to Florida Health Choices Program.

Section 2: Amends s. 409.821, F.S., relating to Florida Kidcare Program public records exemption.

Section 3: Provides an effective date of July 1, 2011.

[23] S. 624.01, F.S.

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 will likely open the Corporation's marketplace to more enrollees and offer more choice in affordable health care coverage. Also, a larger number of individuals enrolled in the Program with the ability to purchase health insurance policies, plans, and other contracts for services, should lower insurance premiums for all enrollees in the Program.

D. FISCAL COMMENTS:

The requirement that the Corporation operate a toll-free hotline to respond to requests for assistance regarding the marketplace carries an indeterminate, and possibly significant, fiscal impact. The Corporation will need to purchase hardware and software to establish, operate, manage, and maintaining the hotline. Additional staff will also need to be hired and trained. If the Corporation chooses to outsource the operation of the hotline, that action will also carry a fiscal impact on the Corporation.

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 state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Corporation must establish a procedure by which it can review products and vendors and make recommendations for approval or denial of inclusion in the Program. The procedure may require the hiring of personnel to complete all the review and to make recommendations. This will carry with it a fiscal impact similar to the impact discussed above in Fiscal Comments regarding the requirement that the Corporation operate a toll-free hotline to provide assistance to participants in the Program.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 22, 2011, the Health and Human Services Quality Subcommittee adopted two amendments. The amendments:

- Confirm that OIR has the authority to approve risk-bearing products to be included in the Program and that the Corporation has the authority to approve non-risk-bearing products to be included in the Program, and pairs that authority in the s. 408.910(4)(e), F.S.
- Delete language in sub-subsection (5)(e) that has been moved to sub-section (4)(e).

The bill was reported favorably as a Committee Substitute.

The analysis is drafted to the Committee Substitute.

A bill to be entitled

An act relating to Florida Health Choices Program; amending s. 408.910, F.S.; providing and revising definitions; revising eligibility requirements for participation in the Florida Health Choices Program; providing that statutory rural hospitals are eligible as employers rather than participants under the program; permitting specified eligible vendors to sell health maintenance contracts; requiring certain risk-bearing products offered by insurers to be approved by the Office of Insurance Regulation; providing requirements for product certification; providing duties of the Florida Health Choices, Inc., including maintenance of a toll-free telephone hotline to respond to requests for assistance; providing for enrollment periods; providing for certain risk pooling data used by the corporation to be reported annually; amending s. 409.821, F.S.; authorizing personal identifying information of a Florida Kidcare program applicant to be disclosed to the Florida Health Choices, Inc., to administer the program; providing an effective date.

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

Section 1. Section 408.910, Florida Statutes, is amended to read:

408.910 Florida Health Choices Program.—

(1) LEGISLATIVE INTENT.—The Legislature finds that a

significant number of the residents of this state do not have adequate access to affordable, quality health care. The Legislature further finds that increasing access to affordable, quality health care can be best accomplished by establishing a competitive market for purchasing health insurance and health services. It is therefore the intent of the Legislature to create the Florida Health Choices Program to:

(a) Expand opportunities for Floridians to purchase affordable health insurance and health services.

(b) Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits.

(c) Enable individual choice in both the manner and amount of health care purchased.

(d) Provide for the purchase of individual, portable health care coverage.

(e) Disseminate information to consumers on the price and quality of health services.

(f) Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

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

(a) "Corporation" means the Florida Health Choices, Inc., established under this section.

(b) "Corporation's marketplace" means the single, centralized market established by the program that facilitates the purchase of products made available in the marketplace.

(c) ~~(b)~~ "Health insurance agent" means an agent licensed

under part IV of chapter 626.

(d) ~~(c)~~ "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, ~~or~~ an exclusive provider organization as defined in s. 627.6472, or a health maintenance organization licensed under part I of chapter 641.

(e) ~~(d)~~ "Program" means the Florida Health Choices Program established by this section.

(3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health Choices Program is created as a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care. These products include, but are not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. The components of the program include:

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

4. Distribution of premiums to insurers and payments to other eligible vendors.

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

2. Assistance with assessing the benefits and limits of each product, including information necessary to distinguish between policies offering creditable coverage and other products available through the program.

3. Account information to assist individual participants with managing available resources.

4. Services that promote healthy behaviors.

(d) Recruitment of vendors, including insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.

(e) Certification of vendors to ensure capability, reliability, and validity of offerings.

(f) Collection of data, monitoring, assessment, and reporting of vendor performance.

(g) Information services for individuals and employers.

(h) Program evaluation.

(4) ELIGIBILITY AND PARTICIPATION.—Participation in the program is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(a) Employers eligible to enroll in the program include:

1. Employers meeting criteria established by the corporation and that elect to make employees of such employer eligible for one or more of the health plans offered through the program ~~have 1 to 50 employees~~.

2. Fiscally constrained counties described in s. 218.67.

3. Municipalities having populations of fewer than 50,000 residents.

4. School districts in fiscally constrained counties.

5. Statutory rural hospitals.

(b) Individuals eligible to participate in the program include:

1. Individual employees of enrolled employers.

2. State employees not eligible for state employee health benefits.

3. State retirees.

4. Medicaid ~~reform~~ participants who opt out ~~select the opt-out provision of reform~~.

~~5. Statutory rural hospitals.~~

(c) Employers who choose to participate in the program may enroll by complying with the procedures established by the corporation. The procedures must include, but are not limited to:

1. Submission of required information.

2. Compliance with federal tax requirements for the establishment of a cafeteria plan, pursuant to s. 125 of the Internal Revenue Code, including designation of the employer's plan as a premium payment plan, a salary reduction plan that has flexible spending arrangements, or a salary reduction plan that has a premium payment and flexible spending arrangements.

3. Determination of the employer's contribution, if any, per employee, provided that such contribution is equal for each eligible employee.

4. Establishment of payroll deduction procedures, subject to the agreement of each individual employee who voluntarily participates in the program.

5. Designation of the corporation as the third-party administrator for the employer's health benefit plan.

6. Identification of eligible employees.

7. Arrangement for periodic payments.

8. Employer notification to employees of the intent to transfer from an existing employee health plan to the program at least 90 days before the transition.

(d) Eligible vendors and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health maintenance contracts ~~insurance policies~~, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

4. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

5. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6. Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

A vendor described in subparagraphs 3.-6. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation under the provisions of the Florida Insurance Code. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

(e) Any risk-bearing product available under subparagraph (d)1. or subparagraph (d)2. must be approved by the Office of Insurance Regulation. Any non-risk-bearing product must be approved by the corporation.

(f) ~~(e)~~ Eligible individuals may voluntarily continue participation in the program regardless of subsequent changes in job status or Medicaid eligibility. Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures must include,

but are not limited to:

1. Submission of required information.

2. Authorization for payroll deduction.

3. Compliance with federal tax requirements.

4. Arrangements for payment in the event of job changes.

5. Selection of products and services.

(g) ~~(f)~~ Vendors who choose to participate in the program may enroll by complying with the procedures established by the corporation. These procedures may ~~must~~ include, but are not limited to:

1. Submission of required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product offered through the program.

2. Execution of an agreement to make all risk-bearing products offered through the program guaranteed-issue policies, subject to preexisting condition exclusions established by the corporation.

3. Execution of an agreement that prohibits refusal to sell any offered non-risk-bearing product to a participant who elects to buy it.

4. Establishment of product prices based on age, gender, and location of the individual participant, which may include medical underwriting.

5. Arrangements for receiving payment for enrolled participants.

6. Participation in ongoing reporting processes established by the corporation.

7. Compliance with grievance procedures established by the corporation.

(h) ~~(g)~~ Health insurance agents licensed under part IV of chapter 626 are eligible to voluntarily participate as buyers' representatives. A buyer's representative acts on behalf of an individual purchasing health insurance and health services through the program by providing information about products and services available through the program and assisting the individual with both the decision and the procedure of selecting specific products. Serving as a buyer's representative does not constitute a conflict of interest with continuing responsibilities as a health insurance agent if the relationship between each agent and any participating vendor is disclosed before advising an individual participant about the products and services available through the program. In order to participate, a health insurance agent shall comply with the procedures established by the corporation, including:

1. Completion of training requirements.

2. Execution of a participation agreement specifying the terms and conditions of participation.

3. Disclosure of any appointments to solicit insurance or procure applications for vendors participating in the program.

4. Arrangements to receive payment from the corporation for services as a buyer's representative.

(5) PRODUCTS.—

(a) The products that may be made available for purchase through the program include, but are not limited to:

1. Health insurance policies.

2. Health maintenance contracts.

3.~~2.~~ Limited benefit plans.

4.~~3.~~ Prepaid clinic services.

5.~~4.~~ Service contracts.

6.~~5.~~ Arrangements for purchase of specific amounts and types of health services and treatments.

7.~~6.~~ Flexible spending accounts.

(b) Health insurance policies, health maintenance contracts, limited benefit plans, prepaid service contracts, and other contracts for services must ensure the availability of covered services ~~and benefits to participating individuals for at least 1 full enrollment year~~.

(c) Products may be offered for multiyear periods provided the price of the product is specified for the entire period or for each separately priced segment of the policy or contract.

(d) The corporation shall provide a disclosure form for consumers to acknowledge their understanding of the nature of, and any limitations to, the benefits provided by the products and services being purchased by the consumer.

(e) The corporation must determine that making the plan available through the program is in the interest of eligible individuals and eligible employers in the state.

(6) PRICING.—Prices for the products sold through the program must be transparent to participants and established by the vendors based on age, gender, and location of participants. ~~The corporation shall develop a methodology for evaluating the actuarial soundness of products offered through the program. The methodology shall be reviewed by the Office of Insurance~~

~~Regulation prior to use by the corporation. Before making the product available to individual participants, the corporation shall use the methodology to compare the expected health care costs for the covered services and benefits to the vendor's price for that coverage. The results shall be reported to individuals participating in the program. Once established, the price set by the vendor must remain in force for at least 1 year and may only be redetermined by the vendor at the next annual enrollment period.~~ The corporation shall annually assess a surcharge for each premium or price set by a participating vendor. The surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives.

(7) THE MARKETPLACE ~~EXCHANGE~~ PROCESS.—The program shall provide a single, centralized market for purchase of health insurance, health maintenance contracts, and other health services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive Internet website. A participant needing personal assistance to select products and services shall be referred to a participating agent in his or her area.

(a) Participation in the program may begin at any time during a year after the employer completes enrollment and meets the requirements specified by the corporation pursuant to

paragraph (4)(c).

(b) Initial selection of products and services must be made by an individual participant within 60 days after the date the individual's employer qualified for participation. An individual who fails to enroll in products and services by the end of this period is limited to participation in flexible spending account services until the next annual enrollment period.

(c) Initial enrollment periods for each product selected by an individual participant must last at least 12 months, unless the individual participant specifically agrees to a different enrollment period.

(d) If an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participant, changes in selected products and services may only be made during the annual enrollment period established by the corporation.

(e) The limits established in paragraphs (b)-(d) apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(8) CONSUMER INFORMATION.—The corporation shall:

(a) Establish a secure website to facilitate the purchase

of products and services by participating individuals. The website must provide information about each product or service available through the program.

(b) Inform individuals about other public health care programs.

~~(a) Prior to making a risk-bearing product available through the program, the corporation shall provide information regarding the product to the Office of Insurance Regulation. The office shall review the product information and provide consumer information and a recommendation on the risk-bearing product to the corporation within 30 days after receiving the product information.~~

~~1. Upon receiving a recommendation that a risk-bearing product should be made available in the marketplace, the corporation may include the product on its website. If the consumer information and recommendation is not received within 30 days, the corporation may make the risk-bearing product available on the website without consumer information from the office.~~

~~2. Upon receiving a recommendation that a risk-bearing product should not be made available in the marketplace, the risk-bearing product may be included as an eligible product in the marketplace and on its website only if a majority of the board of directors vote to include the product.~~

~~(b) If a risk-bearing product is made available on the website, the corporation shall make the consumer information and office recommendation available on the website and in print format. The corporation shall make late-submitted and ongoing~~

~~updates to consumer information available on the website and in print format.~~

(9) RISK POOLING.—The program shall utilize methods for pooling the risk of individual participants and preventing selection bias. These methods shall include, but are not limited to, a postenrollment risk adjustment of the premium payments to the vendors. The corporation shall establish a methodology for assessing the risk of enrolled individual participants based on data reported annually by the vendors about their enrollees. Monthly distributions of payments to the vendors shall be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

(10) EXEMPTIONS.—

(a) Products, other than the risk-bearing products set forth in subparagraph (4)(d)1. or subparagraph (4)(d)2., ~~Policies~~ sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, as defined in s. 624.01 ~~chapter 641,~~ or the mandated offerings or coverages established in part VI of chapter 627 and chapter 641.

(b) The corporation may act as an administrator as defined in s. 626.88 but is not required to be certified pursuant to part VII of chapter 626. However, a third party administrator used by the corporation must be certified under part VII of chapter 626.

(11) CORPORATION.—There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter

112 and chapters 119, 286, and 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

(a) The corporation shall be governed by a 15-member board of directors consisting of:

1. Three ex officio, nonvoting members to include:

a. The Secretary of Health Care Administration or a designee with expertise in health care services.

b. The Secretary of Management Services or a designee with expertise in state employee benefits.

c. The commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.

2. Four members appointed by and serving at the pleasure of the Governor.

3. Four members appointed by and serving at the pleasure of the President of the Senate.

4. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

5. Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations, prepaid service providers, or any other entity, affiliate or subsidiary of eligible vendors.

(b) Members shall be appointed for terms of up to 3 years. Any member is eligible for reappointment. A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(c) The board shall select a chief executive officer for

the corporation who shall be responsible for the selection of such other staff as may be authorized by the corporation's operating budget as adopted by the board.

(d) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061. No other compensation is authorized.

(e) There is no liability on the part of, and no cause of action shall arise against, any member of the board or its employees or agents for any action taken by them in the performance of their powers and duties under this section.

(f) The board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the corporation and carrying out the purposes of this section. The bylaws shall:

1. Specify procedures for selection of officers and qualifications for reappointment, provided that no board member shall serve more than 9 consecutive years.

2. Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.

3. Specify policies and procedures regarding conflicts of interest, including the provisions of part III of chapter 112, which prohibit a member from participating in any decision that would inure to the benefit of the member or the organization that employs the member. The policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

(g) The corporation may exercise all powers granted to it

under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this section.

(h) The corporation may establish technical advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

(i) The corporation shall:

1. Determine eligibility of employers, vendors, individuals, and agents in accordance with subsection (4).

2. Establish procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

3. Arrange for collection of contributions from participating employers and individuals.

4. Arrange for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

5. Establish criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

6. Establish criteria for exclusion of vendors pursuant to

paragraph (4)(d).

7. Develop and implement a plan for promoting public awareness of and participation in the program.

8. Secure staff and consultant services necessary to the operation of the program.

9. Establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents, and employers.

10. Provide for the operation of a toll-free hotline to respond to requests for assistance.

11. Provide for initial, open, and special enrollment periods.

~~10. Develop a plan, in coordination with the Department of Revenue, to establish tax credits or refunds for employers that participate in the program. The corporation shall submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2009.~~

(12) REPORT.—Beginning in the 2009-2010 fiscal year, submit by February 1 an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives documenting the corporation's activities in compliance with the duties delineated in this section.

(13) PROGRAM INTEGRITY.—To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of

vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

Section 2. Section 409.821, Florida Statutes, is amended to read:

409.821 Florida Kidcare program public records exemption.—

(1) Personal identifying information of a Florida Kidcare program applicant or enrollee, as defined in s. 409.811, held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2)(a) Upon request, such information shall be disclosed to:

1. Another governmental entity in the performance of its official duties and responsibilities;

2. The Department of Revenue for purposes of administering the state Title IV-D program; ~~or~~

3. The Florida Health Choices, Inc., for the purpose of administering the program authorized pursuant to s. 408.910; or

4.~~3.~~ Any person who has the written consent of the program applicant.

(b) This section does not prohibit an enrollee's legal guardian from obtaining confirmation of coverage, dates of coverage, the name of the enrollee's health plan, and the amount of premium being paid.

(3) This exemption applies to any information identifying a Florida Kidcare program applicant or enrollee held by the Agency for Health Care Administration, the Department of

Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation before, on, or after the effective date of this exemption.

(4) A knowing and willful violation of this section is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 3. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1229 Title 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		Reilly RJR	Cooper

SUMMARY ANALYSIS

Title insurance protects owners of real property or others having an interest in real property against loss by encumbrance, defective title, invalidity, or adverse claim to title. Currently, policies of an insurer in rehabilitation can only remain in force as long as the insurer has sufficient assets to avoid liquidation, and assessments cannot be ordered against remaining title insurers when an insurer is in rehabilitation.

The bill requires the receiver of a title insurer in rehabilitation to file a rehabilitation plan that provides for the following:

- Title insurance policies on real property in Florida are to remain in force, unless assessments on other title insurers would be insufficient to pay the insurer's claims in the ordinary course of business.
- Title insurance policies on real property in other states ("out-of-state policies") that do not statutorily provide for payment of future losses of title insurers in receivership may be cancelled as of a date approved by the court, with a claims filing deadline established for such cancelled policies.
- Separate allocations of remaining estate assets to fund claims made on out-of-state policies that, respectively, have been cancelled or remain in force, and a formula for determining funds to be allocated to these claims.

When a title insurer is ordered into rehabilitation, all remaining title insurers are liable for an assessment to pay outstanding claims on the insurer's policies covering real property in Florida and associated administrative expenses. Upon the receiver's request, the Office of Insurance Regulation (OIR) is required to order an annual assessment sufficient to pay such amounts, and an annual assessment in subsequent years until the insurer in rehabilitation no longer has any policies in force or has satisfied the potential for future liability. Assessments are to be based on each title insurer's pro-rata share of direct title insurance premiums written in Florida in the previous calendar year, and cannot exceed specified levels. Assessments are payable within 90 days or under a quarterly installment plan. Proceeds of assessments may be used to keep Florida policies in force or to provide for the assumption of these policy obligations by another insurer. When an assessment has been ordered, the insurer in rehabilitation is barred from issuing new policies and may not be released from rehabilitation until all assessments have been repaid.

To reimburse insurers for assessments paid, the OIR is required to order a surcharge on all subsequently issued title insurance policies on Florida real property. The surcharge cannot exceed $25 per transaction for each impaired title insurer and must be sufficient to repay all assessments within 7 years.

When a foreign title insurer with Florida policies is placed in receivership by its domiciliary state, the Department of Financial Services (DFS) is authorized to apply for a court order appointing it ancillary receiver for purposes of making assessments on the insurer's Florida policies.

The bill authorizes the DFS to review the regulatory structure of the title insurance industry in Florida and to submit its findings and recommendations to the Legislature.

To the extent that the bill continues in force title insurance policies on real property in Florida, it provides consumer protections to Florida policyholders.

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Overview of Title Insurance

Title insurance insures owners of real property (owner's policy) or others having an interest in real property against loss by encumbrance, defective title, invalidity, or adverse claim to title.[1] Title insurance is a policy issued by a title insurer that, after performing a search of title, represents the state of that title and insures the accuracy of its search against claims of title defects. It is usually taken out by the purchaser of property or an entity that is loaning money on a mortgage. Most lenders require title insurance when they underwrite loans for real property.[2]

Two state agencies provide regulatory oversight of the title insurance industry in Florida: the Department of Financial Services (DFS), which regulates title agents and agencies, and the Office of Insurance Regulation (OIR), which regulates title insurers, including licensing and promulgation of rates. Title insurers in Florida operate on a monocline basis, meaning that the insurer can only transact title insurance and no other type of insurance.[3]

Insurers in Receivership[4]

Insurance companies are exempted from federal bankruptcy jurisdiction and are instead subject to state law regarding receivership. Under Florida law, the Second Judicial Circuit Court in Leon County (the court) has oversight jurisdiction over insurance company receivership matters. In accordance with Part I of chapter 631, F.S., the "Insurers Rehabilitation and Liquidation Act," the DFS serves as receiver of any Florida insurer placed into receivership. The Division of Rehabilitation and Liquidation within DFS is responsible for performing the DFS's duties as receiver. The DFS as receiver administers the affairs of insurers placed into receivership by the court's conservation order,[5] rehabilitation order, or liquidation order.

Rehabilitation

The receiver of an impaired insurer, as the rehabilitator, prepares a plan to assist an insurer to resolve its difficulties, and is responsible for taking actions necessary to correct the conditions that necessitated the receivership as the court may direct. Generally, the receiver suspends all powers of the company's directors, officers, and managers.

By statute and court order:

- The receiver is authorized to conduct all business of the insurer.
- The receiver may direct, manage, hire, and discharge employees.
- The receiver is authorized to manage the property and assets of the insurer as it deems necessary.
- The receiver may file for release of the company from receivership if rehabilitation efforts are successful and grounds for receivership no longer exist.

---

[1] Section 624.608, F.S. Title insurance is also insurance of owners and secured parties of the existence, attachment, perfection and priority of security interests in personal property under the Uniform Commercial Code.

[2] See, e.g., the website of the American Land Title Association, http://www.alta.org (last accessed March 27, 2011). ALTA is the national trade association of the abstract and title insurance industry.

[3] Section 627.786, F.S.

[4] An overview of the receivership process, including rehabilitation and liquidation, is available from the Department of Financial Services' website at http://www.myfloridacfo.com/Receiver/, Additional information is provided in the "2010 Annual Report of the Division of Rehabilitation and Liquidation," also available at this website.

[5] Conservation is the regulatory process by which an insurance company's affairs are administered to preserve the company's assets.

If the receiver determines that further attempts to rehabilitate the insurer are futile or if continued rehabilitation would increase the risk of loss to policyholders, the receiver may file for liquidation of the insurer.

Liquidation

When the DFS determines that a Florida-domiciled insurer is insolvent or is operating in a financially hazardous manner, it petitions the court for an order requiring the insurer to show cause why it should not be placed into liquidation.[6] If the insurer's board of directors either joins in the petition or consents, a liquidation order is issued appointing DFS as receiver to liquidate the insurer; otherwise, a hearing is held to determine whether the petition should be granted.

Under the court's supervision, the receiver as liquidator is charged with gathering (marshaling) the company's assets, converting them into cash, and distributing the cash to the insurer's claimants in accordance with the priority for claims payment established by statute.

After issuance of the liquidation order, the DFS takes possession of the insurer's offices, equipment, records and assets, and notice of the liquidation is sent to all potential claimants advising them of the liquidation and the process to follow to perfect their claim against the insurer's estate. All property and casualty insurance policies are cancelled within 30 days of the liquidation order.

After all assets have been converted to cash, claims prioritized and valued, and any objections to the valuation of claims resolved, the receiver will file a petition with the court asking for authority to distribute the cash according to the priority scheme in statute.

Effect of the Bill

Title Insurers Ordered into Rehabilitation

The bill requires the receiver of a title insurer in rehabilitation to review the insurer's condition, and file a rehabilitation plan, subject to court approval, that provides for the following:

- Title insurance policies covering real property in Florida are to remain in force, unless assessments on other title insurers would be insufficient to pay the insurer's claims in the ordinary course of business.
- Title insurance policies covering real property in other states ("out-of-state policies") that do not statutorily provide for payment of future losses of title insurers in receivership may be cancelled as of a date proposed by the receiver (if approved by the court); with a claims filing deadline proposed for out-of-state policies that are cancelled.
- A proposed percentage of the remaining estate assets to fund out-of-state claims where policies have been cancelled, with any unused funds returned to the general assets of the insurer's estate.
- A proposed percentage of the remaining estate assets to fund out-of-state claims where policies remain in force.
- That funds allocated to pay claims on out-of-state policies are to be based on the pro-rata share of premiums written in each state over each of the 5 calendar years preceding the date of the order of rehabilitation.

Assessments

As a condition of doing business in the state, Florida title insurers are liable for an assessment to pay all unpaid title insurance claims on policies covering real property in Florida, and the expenses of administering and settling such claims, of a title insurer ordered into rehabilitation. The OIR, upon request of the receiver, is required to order an annual assessment in an amount the receiver considers sufficient to pay known claims, loss adjustment expenses, and the cost of administration of

[6] The grounds for liquidation are set forth in s. 631.061, F.S.

rehabilitation expenses. In requesting an assessment, the receiver is required to consider the remaining assets of the insurer in receivership. Annual assessments may be made until the insurer in rehabilitation does not have any policies in force or the potential for future liability has been satisfied. Assessments are to be based on each title insurer's pro-rata share of direct title insurance premiums written in Florida in the previous calendar year as reported to the OIR.

The assessment levied against a title insurer cannot exceed 3 percent of an insurer's surplus to policyholders at the end of the previous calendar year or 10 percent of an insurer's surplus to policyholders over any consecutive 5-year period. The 10 percent limitation is to be calculated as the sum of the percentages of surplus to policyholders assessed in each of those 5 years. An emergency assessment may also be ordered, if requested by the receiver. However, the total of the emergency assessment and any annual assessment to be paid by a title insurer in a single calendar year cannot exceed the cap applicable to the annual assessment alone. The OIR may exempt a title insurer from, or limit payment of, the assessment when such payment would reduce the insurer's surplus to policyholders below the minimum required for the insurer to maintain its certificate of authority in another state. Assessments are payable within 90 days or under a quarterly installment plan approved by the receiver, accompanied by applicable finance charges.

Proceeds of assessments may be used by the receiver in an effort to keep in force title policies on Florida real property, including purchasing reinsurance or otherwise providing for the assumption of policy obligations by another insurer. When an assessment has been ordered, the insurer in rehabilitation is barred from issuing new title insurance policies until it is released from rehabilitation. An insurer may not be released from rehabilitation until all title insurers have received full reimbursement for assessments paid.

Surcharges

To reimburse title insurers for assessments paid, the OIR is required to order a surcharge on all subsequently issued title insurance policies on Florida real property. The surcharge cannot exceed $25 per transaction for each impaired title insurer and the surcharge must be in an amount estimated to be sufficient to recover all amounts assessed within 7 years. If additional title insurers become impaired, the OIR is required to order an increase in the surcharge amount to reflect the aggregate surcharge. The surcharge is to be paid by the party responsible for payment of the title insurance premium, unless otherwise agreed between the parties. Title insurance agents and agencies are required to collect and remit the surcharges to the title insurer upon which a policy is written within 30 days. No surcharge is due or owing as to any policy of insurance issued at the simultaneous issue rate. The surcharge is to be considered a separate governmental assessment to be separately stated on any settlement statement, and is not subject to premium tax or reserve requirements. Title insurers are required to provide the OIR with an accounting, by March 1st of each year, of assessments paid and surcharges collected during the previous calendar year. Any surcharges collected by an insurer in excess of the assessment paid are to be paid into the Insurance Regulatory Trust Fund.

Foreign Title Insurers in Receivership[7]

When a foreign title insurer with policies in Florida is placed in receivership by its domiciliary state, the DFS may apply to the court for an order appointing it as ancillary receiver for the purpose of making assessments. The proceeds of such assessments may be used for the payment of claims, to acquire reinsurance, or otherwise provide for the assumption of Florida policy obligations by another insurer. If the assets in Florida are insufficient to pay the administrative costs of the ancillary receivership, the receiver may request additional funds from the Insurance Regulatory Trust Fund.

The bill is effective upon becoming law.

[7] "Foreign insurer" is defined in s. 624.06, F.S., as an insurer formed under the laws of any state, district, territory, or commonwealth of the United States other than Florida.

B. SECTION DIRECTORY:

Section 1: Sets forth the Legislature's intent that the Department of Financial Services review the regulatory structure of the title insurance industry in Florida and submit findings and recommendations by December 31, 2011.

Section 2: Repeals s. 627.7865, F.S., which provides for assessments against title insurers when a title insurer is liquidated with unpaid outstanding claims.

Section 3: Creates s. 631.400, F.S., providing for assessments (and emergency assessments) against title insurers when a title insurer is ordered into liquidation.

Section 4: Creates s. 631.401, F.S., providing for surcharges on title insurance policies to reimburse insurers for assessments paid as a result of an insurer being ordered into rehabilitation.

Section 5: Creates s. 631.402, F.S., concerning receivership of foreign title insurers.

Section 6: Provides that the bill is effective upon becoming law.

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:

Florida title insurers will be liable for assessments to pay all outstanding title insurance claims and expenses of administering and settling claims on real property in Florida when a title insurer is ordered into liquidation. Except as otherwise provided, title insurance policies on real property in Florida will remain in force when the insurer that issued the policy is ordered into rehabilitation.

D. FISCAL COMMENTS:

To the extent that a surcharge will be placed on title insurance policies after a title insurer has been ordered into rehabilitation and assessments have been paid by insurers, the cost of title insurance will increase for Florida consumers.

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.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to title insurance; stating legislative intent that the Department of Financial Services review the current regulatory structure of the title insurance industry and make recommendations to the Legislature; repealing s. 627.7865, F.S.; repealing certain assessments against title insurers; creating s. 631.400, F.S.; requiring rehabilitation plans for title insurers in receivership to provide for specified matters; providing that title insurance policies on real estate within the state remain in force when the insurer is in rehabilitation under certain conditions; authorizing cancellation of title insurance policies on property in other states when the insurer is in rehabilitation as specified; requiring rehabilitation plans for title insurers in receivership to allocate a percentage of estate assets to pay claims on policies in other states that are cancelled and to allocate a percentage of remaining estate funds to pay claims on out-of-state policies that remain in force; providing a methodology for determining the funds to be allocated to pay claims on policies located in other states; establishing procedures and requirements for the imposition of assessments, and emergency assessments, by the Office of Insurance Regulation and the payment of assessments by all title insurers relating to the rehabilitation of other title insurers; establishing a methodology for determining assessment amounts; requiring cessation of assessments

upon certain events; providing exemptions from or limitations upon the assessment amount otherwise payable by a title insurer under specified circumstances; authorizing the receiver of a title insurer in rehabilitation to use proceeds of an assessment to keep in force policies issued by the title insurer in rehabilitation or otherwise provide for the assumption of policy obligations by another insurer; requiring the receiver to make available information regarding unpaid claims on a quarterly basis; barring a title insurer's release from rehabilitation until all contributing title insurers have recovered assessments paid; prohibiting insurers in rehabilitation, when an assessment has been ordered, from issuing new policies until released from rehabilitation; creating s. 631.401, F.S., providing procedures, requirements, and criteria relating to the recovery of assessments for insurers in rehabilitation by contributing title insurers through surcharges on title insurance policies; specifying that surcharges are to be considered governmental assets to be separately stated on any settlement statement; prohibiting any insurer from retaining surcharges in excess of the assessment amount the insurer paid; providing for surcharges collected in excess of the amount assessed to be paid to the Insurance Regulatory Trust Fund; creating s. 631.402, F.S., providing procedures and requirements relating to foreign title insurers placed in receivership; providing an effective date.

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

Section 1. It is the intent of the Legislature that the Department of Financial Services undertake a review of the regulatory structure of the title insurance industry in Florida, whereby title insurance agents and agencies are regulated by the Department of Financial Services and title insurance companies are regulated by the Office of Insurance Regulation. The Department of Financial Services is to determine whether effective and efficient oversight may be provided under the existing regulatory structure, or if consolidation of all aspects of title insurance regulation under the Department of Financial Services provides a viable and more effective method of regulation. The Office of Insurance Regulation shall cooperate with the Department of Financial Services in this undertaking. The Department of Financial Services shall submit its findings and recommendations to the Speaker of the House of Representatives and the President of the Senate by December 31, 2011.

Section 2. Section 627.7865, Florida Statutes, is repealed.

Section 3. Section 631.400, Florida Statutes, is created to read:

631.400 Rehabilitation of title insurer.-

(1) After the entry of an order of rehabilitation the receiver shall review the condition of the insurer and file a plan of rehabilitation for approval with the court. Such plan of rehabilitation shall provide:

(a) that policies on real property in Florida issued by the title insurer in rehabilitation shall remain in force unless the receiver determines the assessment capacity provided by this section is insufficient to pay claims in the ordinary course of business;

(b) that policies on real property located outside the state of Florida may be cancelled as of a date provided by the receiver and approved by the court if the state in which the property is located does not have statutory provisions to pay future losses on these policies;

(c) a claims filing deadline for policies on real property located outside the state of Florida which are cancelled pursuant to paragraph (b);

(d) a proposed percentage of the remaining estate assets to fund out-of-state claims where policies have been cancelled, with any unused funds returned to the general assets of the estate;

(e) a proposed percentage of the remaining estate assets to fund out-of-state claims where policies remain in force; and

(f) that the funds allocated to pay claims on policies located outside of Florida shall be based on the pro-rata share of premiums written in each state over each of the 5 calendar years preceding the date of an order of rehabilitation.

(2) As a condition of doing business in this state, each title insurer shall be liable for an assessment to pay all unpaid title insurance claims and expenses of administering and settling those claims on real property in Florida for any title insurer that is ordered into rehabilitation.

(3) The office shall order an assessment, if requested by the receiver, on an annual basis in an amount that the receiver deems sufficient for the payment of known claims, loss adjustment expenses, and the cost of administration of the rehabilitation expenses. The receiver shall consider the remaining assets of the insurer in receivership when making its request to the office. Annual assessments may be made until no more policies of the title insurer in rehabilitation are in force or the potential future liability has been satisfied. The office may exempt or limit the assessment of a title insurer if such assessment would result in a reduction to surplus as to policyholders below the minimum required to maintain the insurer's certificate of authority in any state.

(4) Assessments shall be based on the total of direct title insurance premiums written in this state as reported to the office for the most recent calendar year. Each title insurer doing business in this state shall be assessed on a pro-rata share basis of the total direct title insurance premiums written in this state.

(5) Title insurers doing business in this state writing no premiums in the prior calendar year shall collect the same per transaction surcharge as provided by s. 631.401. Such surcharge collected shall be paid to the receiver within 60 days of receipt from the title agent or agency.

(6) Assessments shall be paid to the receiver within 90 days of notice of the assessment or pursuant to a quarterly installment plan approved by the receiver. Any insurer that

elects to pay an assessment on an installment plan shall also pay a financing charge to be determined by the receiver.

(7) The office shall order an emergency assessment if requested by the receiver. The total of any emergency assessment, when added to any annual assessment in a single calendar year, may not exceed the limitation in subsection (8).

(8) No title insurer shall be required to pay an assessment in any one year that exceeds 3 percent of its surplus to policyholders as of the end of the previous calendar year or more than 10 percent of its surplus to policyholders over any consecutive five year period. The 10 percent limitation shall be calculated as the sum of the percentages of surplus to policyholders assessed in each of those five years.

(9) Assessments and emergency assessments once ordered by the office shall be considered assets of the estate and subject to the provisions of s. 631.154.

(10) In an effort to keep in force the policies on real property issued by the title insurer in rehabilitation, the receiver may use the proceeds of an assessment to acquire reinsurance or otherwise provide for the assumption of policy obligations by another insurer.

(11) The receiver shall make available information regarding unpaid claims on a quarterly basis.

(12) A title insurer in rehabilitation may not be released from rehabilitation until all of the assessed insurers have recovered the amount assessed either through surcharges collected pursuant to s. 631.401 or payments from the insurer in rehabilitation.

(13) A title insurer in rehabilitation for which an assessment has been ordered pursuant to this section shall not issue any new policies until released from rehabilitation.

Section 4. Section 631.401, Florida Statutes, is created to read:

631.401 Recovery of assessments and assumed policy obligations.-

(1) Upon the making of any assessment allowed by s. 631.400, the office shall order a surcharge on each title insurance policy thereafter issued insuring an interest in Florida real property. The office shall set the per transaction surcharge at an amount estimated to generate sufficient funds to recover the amount assessed over a period of not more than seven years. The amount of the surcharge ordered under this section shall not exceed 25 dollars per transaction for each impaired title insurer. If additional surcharges are occasioned by additional title insurers becoming impaired, the office shall order an increase in the amount of the surcharge to reflect the aggregate surcharge.

(2) The party responsible for payment of the title insurance premium, unless otherwise agreed between the parties, shall be responsible for the payment of the surcharge. No surcharge will be due or owing as to any policy of insurance issued at the simultaneous issue rate. For all other purposes, the surcharge will be considered a governmental assessment to be separately stated on any settlement statement. The surcharge is not subject to premium tax or reserve requirements under chapter 625.

(3) Each title insurance agent or agency shall collect the surcharge as to each title insurance policy written and remit those surcharges within 30 days to the title insurer on which the policy was written.

(4) No title insurer may retain more in surcharges for an ordered assessment than the amount of assessment that title insurer paid.

(5) No later than March 1 of each year, each title insurer shall provide the office with an accounting of assessments paid and surcharges collected during the previous calendar year. Any surcharges collected in excess of the amount assessed shall be paid to the Insurance Regulatory Trust Fund.

Section 5. Section 631.402, Florida Statutes, is created to read:

631.402 Receivership of foreign title insurer.-

(1) After a foreign title insurer with policies in Florida is placed into receivership by its domiciliary state, the department may apply to the court for an order appointing it as ancillary receiver for the purpose of making an assessment pursuant to s. 631.400. The receiver may use the proceeds of the assessment for the payment of claims, to acquire reinsurance or otherwise provide for the assumption of Florida policy obligations by another insurer.

(2) In the event that the assets located in Florida are insufficient to pay the administrative costs of the ancillary receivership, the receiver may request additional funds as provided by s. 631.141(7)(b).

Section 6. This act shall take effect upon becoming law.

PCS for HB 1243

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1243 Citizens Property Insurance Corporation
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

Citizens Property Insurance Corporation (Citizens or corporation) 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, 2011, Citizens is the largest property insurer in Florida with over 1.3 million policies extending approximately $462 billion of property coverage to Floridians. As of June 30, 2010, Citizens represented approximately 18 percent of the residential property admitted market based on insured value for policies.

The bill makes numerous changes to Citizens Property Insurance Corporation (Citizens). Many of the changes will reduce the number of policies in Citizens, as well as reduce the exposure and losses of Citizens. The changes include:

- Changing legislative intent and findings relating to Citizens;
- Limiting the eligibility for Citizens based on premium amount charged by a private market insurer;
- Limiting the eligibility for Citizens based on the value of the property insured;
- Requiring flood insurance for certain Citizens' policyholders;
- Providing policyholders of Citizens assumed by a private market insurer are ineligible for insurance in Citizens until the end of the assumption agreement;
- Repealing a reduction of Citizens' wind-only zones;
- Adding parameters to voting by members of the Citizens' board;
- Allowing certain Citizens' board members to be exempt from the conflicting employment or contractual relationship law that applies to public officers and agency employees;
- Requiring additional reporting by the Citizens' Market Accountability Advisory Committee;
- Requiring a report on outsourcing Citizens' claims functions;
- Repealing the quota share program in Citizens;
- Amending the appointment requirements for insurance agents selling insurance in Citizens;
- Preventing Citizens' from insuring attached or detached screen enclosures;
- Increasing the rate cap for Citizens from 10 percent to 20 percent per rating territory or 25 percent per policyholder;
- Sunseting the rate cap on January 1, 2015;
- Exempting sinkhole coverage and the cost of reinsurance from the rate caps;
- Requiring an industry expense equalization factor in Citizens' rates;
- Requiring Citizens' applicants and policyholders be apprised of and acknowledge the assessment potential of an insurance policy written by Citizens;
- Amending the levy of and responsibility for a Citizens' Policyholder Surcharge;
- Increasing the amount of an emergency assessment levied against policyholders of Citizens;
- Specifying Citizens cannot be liable for bad faith or extra-contractual damages; and
- Prohibiting Citizens' from covering losses to appurtenant structures, driveways, sidewalks, decks, or patios caused by sinkholes.

The bill has no fiscal impact on state or local government. The bill will impact the private sector. This impact is addressed in the Fiscal Analysis section of the staff analysis.

The bill is effective upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Citizens Property Insurance Corporation

Citizens Property Insurance Corporation (Citizens or corporation) 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, 2011, Citizens is the largest property insurer in Florida with over 1.3 million policies extending approximately $462 billion of property coverage to Floridians.[1] As of June 30, 2010, Citizens represented approximately 18 percent of the residential property admitted market based on insured value for 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.

The bill repeals and rewrites much of the Legislative findings and intent relating to Citizens, in part, to be consistent with the changes made by the bill to the eligibility standards for Citizens. The changes made to these standards, detailed later in the analysis, move Citizens from a market of affordability to a market of last resort over a period of time.

Eligibility for Insurance in Citizens

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 High-Risk Account area; and
3. High-Risk Account (HRA) – 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.

Citizens does not insure damage from flooding. Most flood insurance is provided by the Federal Emergency Management Agency through the National Flood Insurance Program. Under current law, Citizens' policyholders do not have to purchase flood insurance in order to be insured by Citizens. However, if flood insurance is not purchased by the Citizens' policyholder, the policyholder must execute a form acknowledging the Citizens' policy does not cover flood damage. Starting January 1,

---

[1] https://www.citizensfla.com/ (last viewed February 27, 2011).

[2] Meeting materials from Citizens presented at the Insurance & Banking Subcommittee meeting held on January 12, 2011.

[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.

2012, the bill requires new applicants for Citizens' property insurance located in specified flood hazard areas to have flood insurance. The bill specifies the coverage limits required for the flood insurance. Exceptions to the flood insurance requirement are provided in the bill. Starting January 1, 2013, current Citizens' policyholders must have flood insurance in order to keep their property insurance with Citizens.

Eligibility Based on Premium Amount

An applicant for residential insurance coverage with Citizens is eligible even if the applicant has an offer of coverage from an insurer in the private market at its approved rates. In this case, a homeowner can buy insurance from Citizens if the premium for the offer of coverage in the private market is more than 15 percent than the premium Citizens would charge for comparable coverage.[5] There is no similar eligibility restriction for commercial non-residential property and none is provided in the bill.

For residential property insured by Citizens prior to January 1, 2015, the bill changes the premium eligibility threshold to 25 percent, allowing Citizens to insure property if the premium charged by a private insurer to insure the property is more than 25 percent than the premium Citizens would charge for comparable coverage. After January 1, 2015, no property can be insured by Citizens if an authorized insurer[6] in the private market offers to insure the property.

Eligibility Based on Value of Property Insured

Citizens currently has eligibility restrictions for homes and condominium units based on the value of the property insured. These restrictions are in addition to the 15 percent premium eligibility restriction. In the personal lines account (i.e., mostly inland areas), Citizens currently does not insure a home or condominium unit if the insured value of the dwelling is $1 million or more.[7]

In the high risk account (i.e., certain coastal areas), Citizens does not insure homes or condominium units if the insured value of the dwelling is $2 million or more.[8] Starting January 1, 2012, the bill reduces this insured value limit to $1 million, preventing Citizens from insuring homes or condominium units in certain coastal areas if the dwelling insured value is $1 million or more.

For property statewide, the bill reduces the insured value limit for personal lines residential property to $750,000 or more starting January 1, 2014 and $500,000 or more starting January 1, 2016. Thus, homes or condominium units, wherever located, cannot obtain insurance in Citizens if the home or condominium unit is insured for $750,000 or more starting in 2014 and $500,000 or more starting in 2016.

Citizens does not have any eligibility restrictions based on the value of the property insured for condominium association, homeowner association, or apartment building policies and the bill does not add any such restrictions for these properties.

Citizens has multiple eligibility and coverage restrictions for commercial businesses, depending on where the business is located and the type of policy the business purchases from Citizens. The restrictions are contained in the underwriting rules of Citizens, not in the statute. The bill does not add any eligibility restrictions based on the value of the property insured for commercial businesses.

Citizens' Wind-Only Policies

Citizens provides coverage in the high risk account for specially designated areas, called wind-only zones,[9] which have been determined to be particularly vulnerable to severe hurricane damage. In

---

[5] s. 627.351(6)(c)5.a., F.S. Commercial non-residential property is not subject to this eligibility restriction.

[6] Authorized insurer is defined in s. 624.09, F.S., as an insurer receiving a certificate of authority by the Office of Insurance Regulation to transact insurance in Florida. Florida law also recognizes surplus lines insurers. These insurers are not "authorized" insurers. Rather, surplus lines insurers are "unauthorized" insurers, but are eligible to transact surplus lines insurance under the surplus lines law as "eligible surplus insurers". Thus, a policyholder can remain eligible for insurance in Citizens after January 1, 2015 if the only offer of insurance the policyholder receives from the private market is one from a surplus lines insurer.

[7] This restriction is pursuant to an underwriting rule.

[8] This restriction is pursuant to statute. (s. 627.351(6)(a)3., F.S.)

[9] Also called windstorm areas or windstorm boundaries.

these areas, a property owner can obtain a property insurance policy from Citizens covering property damage from only wind events and can obtain a property insurance policy from a private market insurance company covering property damage and liability from non-wind events (other peril/non-wind coverage).

The wind-only zones that currently exist have evolved over three decades, but originated with the creation of the FWUA in 1970. The FWUA was created to cover residential and commercial policyholders unable to secure windstorm coverage in the voluntary market. This coverage was limited to defined geographical areas in the state determined by the then Department of Insurance (Department). Eligibility was limited to structures in areas found by the Department, after public hearings, to meet three criteria:

- the lack of windstorm coverage in the area was deterring development, causing mortgages to be in default, and causing financial institutions to deny loans;
- the area was subject to the requirements of the Southern Standard Building Code or its equivalent; and
- extending windstorm coverage to the area was consistent with the policies and objectives of environmental and growth management.

The wind-only zones currently apply to 29 Florida counties. When the wind-only zones were established, only Monroe County was included. In 1992, when Hurricane Andrew hit South Florida, the wind-only zone did not include Miami-Dade, Broward, or Palm Beach counties. After Hurricane Andrew, the Department and the Legislature expanded the boundaries of the wind-only zones to the current ones. In July 2002, when Citizens was created, Citizens maintained the wind-only zones from the FWUA.

As noted previously, in the wind-only zones private insurers may offer other peril/non-wind coverage, but are not required to provide windstorm coverage. Under current law,[10] beginning December 1, 2010, if Citizens' 100 year probable maximum loss[11] (PML) for the wind-only policies is not 25 percent less than the PML in February 2001, Citizens must reduce the boundaries of the wind-only zones so that the PML reaches that amount. Current law requires a further PML reduction by February 1, 2015. If Citizens' 100-year PML is not 50 percent less than the PML in February 2001 by February 1, 2015, the boundaries of the wind-only zones are restricted to only areas seaward of 1,000 feet from the Intercoastal Waterway.

Citizens was not able to reduce its PML by the required 25 percent by December 1, 2010. One reason Citizens could not reduce the PML is because Citizens has grown, in part, due to the reluctance of private insurers to expand their writings in Florida because of the significant losses sustained in the 2004 and 2005 hurricane seasons. Although Citizens developed a plan to reduce the wind-only zones as the statute directs, the plan has not been implemented. Once Citizens implements the plan, private insurers writing the other peril (non-wind coverage) in the current wind-only zones must either drop that coverage or write the windstorm coverage for policies.

The bill repeals current law requiring the Citizens to reduce the wind-only zones if the Citizens' PML is not reduced by December 1, 2010 and February 1, 2015.

Citizens' Board of Governors

Citizens operates under the direction of an 8-member Board of Governors. The Governor, Chief Financial Officer, Senate President, and Speaker of the House of Representatives each appoint two members of the Board. Board members serve 3-year staggered terms.[12] 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.

---

[10] s. 627.351(6)(y), F.S. This law was enacted in 2002.

[11] Probable maximum loss is an estimate of maximum dollar value that can be lost under realistic situations.

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

The bill prohibits Citizens' board members from voting on any measure before the board that would inure:

- to the gain or loss of the board member;
- to the gain or loss of any principal retaining the board member;
- to the gain or loss of a parent or subsidiary organization of the principal retaining the board member; or
- to the gain or loss of a relative or business associate of the board member.

When the board member abstains from voting, the member must state the nature of the interest in the matter which the member is abstaining from and disclose the nature of the interest in a memorandum filed with the person responsible for recording the Citizens' board meeting minutes.

The bill further provides Citizens' board members with the required insurance expertise fall within the exemption in the conflicting employment or contractual relationship statute that applies to public officers and agency employees.[13] Thus, the bill allows Citizens' board members with insurance expertise to maintain employment in the private sector in jobs involving business with Citizens without violating the conflict of interest statute because the board member is required by law to have insurance expertise in order to sit on the board.

Market Accountability Advisory Committee

Citizens' board must establish a Market Accountability Advisory Committee (Committee) to advise the board on the comparison of Citizens' rates and customer and agent service levels to the private market. The Committee gives the board a report on these issues at every board meeting. The bill requires the Committee to also advise and report to the board on insurance agent appointments and compensation.

Outsourcing of Claims Functions

As of December 2010, Citizens has over 1,160 employees in-house, and almost 8,500 insurance agents selling Citizens' insurance. Citizens handled almost 1.7 million calls in 2010. Citizens has in-house claims adjusters on staff and has contracts with external independent adjusting firms. Both in-house and outside adjusters handle daily claims for Citizens. Catastrophe claims are all handled by independent adjusters, with Citizens staff overseeing and directing the independent adjusters.[14]

Virtually all of Citizens' claims adjusting was outsourced prior to the 2004 and 2005 hurricanes. During the 2004 hurricane season, Citizens' Catastrophe Claims Team consisted of two Citizens' employees and 1,230 contracted independent adjusters. During the 2005 hurricane season, Citizens' Catastrophe Claims Team consisted of eight Citizens' employees and 2,001 contracted independent adjusters.[15] Although Citizens had a large number of claims adjusters under contract, after the 2004 and 2005 hurricanes, many of these adjusters broke their contracts with Citizens in order to adjust claims for private insurers. Thus, Citizens' policyholders experienced delays in claim adjusting and payment. To strengthen its ability to handle catastrophe claims, since 2005, Citizens has hired more in-house claims staff and contracted with many more independent adjusters. In 2010, Citizens' Catastrophe Claims Team consisted of 18 Citizens' employees and over 4,500 contracted independent adjusters.[16]

The bill requires a third party to report on the costs and benefits of outsourcing Citizens' policy issuance and service functions to outside parties for a fee. Service functions include claims handling. The outsourcing report is due to the Citizens' board by July 1, 2012. The board must develop a plan to implement the report and submit the implementation plan to the Financial Services Commission (Commission). Citizens must implement the plan by January 1, 2013, after the Commission's approval.

---

[13] Board members of Citizens fall under the definition of "public officer" in s. 112.313(1), F.S., because that definition includes any person appointed to hold office in any agency, including serving on an advisory board. "Agency" is defined in s. 112.312, F.S.

[14] Information obtained from a representative of Citizens, on file with the Insurance & Banking Subcommittee.

[15] Task Force on Citizens Property Insurance Claims Handling and Resolution, First Report, dated July 2, 2007, available at http://www.taskforceoncitizensclaimshandling.org/images/FirstReport.pdf (last viewed March 14, 2011).

[16] Citizens has other claims personnel that can be moved to catastrophe operations if needed. (Information received from Citizens on March 26, 2011).

Quota Share Program in Citizens
Under current law, Citizens must adopt a quota share program for hurricane coverage provided by Citizens. With a quota share program, Citizens is responsible for a specified percentage of hurricane coverage on a property and a private insurer is responsible for the remaining percentage. The Citizens' quota share program in current law is only available for residential properties located in the high-risk account and Citizens is responsible for either 90 percent or 50 percent of the hurricane coverage. Although authority for a quota share program is contained in law, Citizens does not have any insurer participating in the program and has never had an insurer participate in the program.[17] Thus, the bill repeals the authority for the quota share program in Citizens and the program requirements.

Citizens' Agent Appointments
Citizens sells insurance via licensed insurance agents appointed by the corporation. As of December 2010, almost 8,500 insurance agents were appointed by Citizens to sell insurance in Citizens. Under current law, in order for an agent to be appointed by Citizens, at the time of the agent's initial appointment with Citizens, the agent must also be appointed by a private insurer who is writing property insurance in Florida. The bill removes the requirement that the private insurer must be writing property insurance in Florida at the time of the agent's initial appointment with Citizens. Thus, each year in order for an agent to be appointed by Citizens, the agent must also be appointed by a private insurer who is writing property insurance in Florida.

Coverage Provided by Citizens for Screen Enclosures
Starting January 1, 2012, the bill prohibits Citizens from insuring attached or detached screen enclosures. Citizens currently insures screen enclosures. Although provisions in current law restrict the amount of Citizens' coverage for specific items, such as restricting coverage for mobile or manufactured homes built before 1994 to actual cash value, no provision in current law completely prohibits Citizens from covering specific items.

Rates Charged by Citizens
Current law requires Citizens' rates to be actuarially sound. Citizens' rates are set by the Office of Insurance Regulation (OIR) based on a rate filing made by Citizens setting out actuarially sound rates for the corporation. However, although current law requires Citizens' rates to be actuarially sound, the law also restricts Citizens' rates from increasing more than 10 percent a year per policy until the rates are actuarially sound. Once the rates are actuarially sound, the rate increase percentage is not capped.

Citizens' rates were frozen by law at 2005 levels from January 2007 to December 31, 2009.[18] Citizens implemented an overall statewide average rate increase of 10.3 percent to be implemented in 2011 for homeowners in the PLA and HRA.[19] Citizens implemented an overall statewide average rate increase of 5.4 percent for implementation in 2010 for homeowners in the PLA.[20] Citizens implemented an overall statewide average rate increase of 5.2 percent for implementation in 2010 for homeowners in the HRA.[21]

The bill revamps current law relating to Citizens' rates. The bill provides legislative intent that Citizens' rates are actuarially determined and not competitive with rates charged in the private market. The bill maintains current law requiring Citizens' rates to be actuarially sound. The bill requires the OIR to establish Citizens' rates each year based on recommended rates filed with the OIR by Citizens.

---

[17] Phone conversation with a representative of Citizens on March 9, 2011.

[18] s. 627.351(6)(m)4., F.S.

[19] Press Release from the OIR dated September 23, 2010 available at http://www.floir.com/PressReleases/viewmediarelease.aspx?ID=3699 (last viewed March 24, 2011).

[20] Press Release from the OIR dated October 30, 2009 available at http://www.floir.com/PressReleases/viewmediarelease.aspx?ID=3321 (last viewed March 24, 2011).

[21] Press Release from the OIR dated November 20, 2009 available at http://www.floir.com/PressReleases/viewmediarelease.aspx?ID=3339 (last viewed on March 24, 2011).

Starting July 1, 2011, the bill increases the current cap on Citizens' rate increases. The cap is increased from 10 percent a year per policy to 20 percent a year per rating territory, with a maximum increase of 25 percent a year per policy.

The new rate caps apply only from July 1, 2011 until January 1, 2015. After that date, there is no cap on Citizens' rate increases. In addition, the new rate caps do not apply to sinkhole coverage or costs for reinsurance. Thus, between July 1, 2011 and January 1, 2015, rates for a Citizens' policyholder can increase more than 25 percent per policy if the policyholder purchases sinkhole coverage from Citizens and a rate increase of more than 25 percent is actuarially justified for the sinkhole risk. Similarly, between July 1, 2011 and January 1, 2015, Citizens' rates for all policyholders can increase more than 20 percent per rating territory or 25 percent per policy if Citizens' purchases reinsurance and a rate increase in excess of the rate cap is actuarially justified due to the reinsurance purchase.

In addition, Citizens' required use of the public hurricane loss projection model to calculate the lowest rates for the windstorm portion of Citizens' rates is repealed.

The bill requires Citizens to include an industry expense equalization factor in rates. This factor must include a catastrophe risk load, taxes, reinsurance costs, general expenses, acquisition expenses, and commissions, even if Citizens does not incur these expenses. Because Citizens is a not for profit corporation, is tax exempt, and does not have to meet the solvency requirements like private insurers, Citizens' expenses are generally lower than that of private insurers. Including an industry expense equalization factor in Citizens' rates should equalize the expenses for Citizens with the expenses for private insurers. Higher expenses generally result in higher rates. Thus, an equalization of expense factors should provide a fairer comparison of Citizens' rates to the private insurers' rates and prevent Citizens' rates from being lower than the private market due to lower expenses incurred by the Citizens.

Financial Resources to Pay Claims[22]

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 $5.4 billion in surplus to pay claims during the 2011 hurricane season.[23] In addition, Citizens could be reimbursed another $6.35 billion for claims it pays by the Florida Hurricane Catastrophe Fund. Thus, the maximum amount Citizens has to pay claims for the 2011 hurricane season is approximately $11.75 billion.[24]

As of January 31, 2011, Citizens' total exposure is almost $462 billion. Citizens estimates the 1-in-100 year hurricane would cost over $23.4 billion.[25] The $11.65 billion difference between Citizens' resources to pay claims ($11.75 billion) and its 1-in-100 year exposure ($23.4 billion) would be covered

[22] All Citizens' projections about claims paying capacity for the 2011 hurricane season are found in meeting materials from Citizens presented at the Insurance & Banking Subcommittee meeting held on January 12, 2011.

[23] Meeting materials from Citizens presented at the Insurance & Banking Subcommittee meeting held on January 12, 2011.

[24] Although Citizens has another $2.9 billion in pre-event bonding that would be available to pay claims, this bonding would have to be repaid through assessments, so is not included in the calculations. If this amount were included, Citizens would have $14.672 billion to pay claims during the 2011 hurricane season.

[25] A 1-in-100 year hurricane has a 1 percent probability of occurring.

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.[26] The three Citizens' accounts calculate deficits and resulting assessment needs independently.

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. This surcharge is collected over twelve months and is collected at the time a new Citizens' policy is written or an existing Citizens" policy is renewed. Thus, a policyholder insured by Citizens when the Citizens Policyholder Surcharge is levied is subject to the surcharge only if the policyholder renews with Citizens during the 12 month surcharge collection period.

Regular Assessments

Upon the exhaustion of the Citizens Policyholder Assessment for a particular account, Citizens may levy a regular assessment of up to 6 percent of premium or 6 percent of the deficit per account, for a maximum total of 18 percent.[27] The regular assessment is levied on virtually all property and casualty policies in the state, but is not levied on Citizens' policies. The assessment is also not levied on workers' compensation, medical malpractice, accident and health, crop or federal flood insurance policies. Mechanically, property casualty insurers with policies subject to the regular assessment "front" the assessment to Citizens and recover it from their policyholders at the issuance of a new policy or at renewal of existing policies. Thus, Citizens will collect funds raised by a regular assessment quickly after the assessment is levied, usually within 30 days after levy.

Emergency Assessments

Upon the exhaustion of the Citizens Policyholder Assessment and regular assessment for a particular account, Citizens may levy an emergency assessment of up to 10 percent of premium or 10 percent of the deficit per account, for a maximum total of 30 percent.[28] 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. Mechanically, property and casualty insurers with policies subject to the emergency assessment collect the assessment from policyholders at the issuance of a new policy or at renewal of existing policies and then remit the assessments periodically to Citizens. Thus, Citizens will not collect funds raised by an emergency assessment immediately after the assessment is levied but will collect funds intermittently throughout the collection period as policies are renewed and new policies written.

Proposed Changes Relating to Assessments Levied by Citizens

Acknowledgment of Assessment Potential

Starting January 1, 2012, the bill requires insurance agents issuing property insurance in Citizens to obtain an acknowledgement signed by the applicant for insurance relating to the potential assessments imposed on the policy by Citizens. Citizens must keep a copy of the signed acknowledgement. Citizens must provide the same acknowledgement statement to existing Citizens' policyholders when the policy renews with Citizens. Thus, potential and current policyholders of Citizens will be informed about the potential assessments that can be imposed on their policy. The signed acknowledgement creates a conclusive presumption the policyholder understood and accepted the Citizens' assessment liability. However, only new policies issued by Citizens after January 1, 2012 will have a signed acknowledgment because Citizens is only required to provide a copy of the form to renewed policyholders.

---

[26] s. 627.351(6)(b)3.a.,d., and i., F.S.

[27] s. 627.351(6)(b)3.a. and b., F.S.

[28] s. 627.352(6)(b)3.d., F.S.

Levy of Assessment

Under current law, Citizens collects a Citizens Policyholder Surcharge (surcharge) for 12 months and can only collect the surcharge on new policies issued by Citizens during the 12 month collection period or on current policies renewed by Citizens during the 12 month collection period. Thus, under current law a policyholder insured in Citizens when the Citizens Policyholder Surcharge is levied can avoid paying the surcharge:

1. By canceling the Citizens' policy mid-term during the 12 month collection period and moving to a private company; and
2. By not renewing a Citizens' policy that ends during the 12 month collection period.

In both cases, a policyholder who was insured in Citizens when the Citizens Policyholder Surcharge was levied is not required to pay the surcharge.

The bill prevents the first scenario by requiring Citizens' policyholders to pay the surcharge when their Citizens' policy is cancelled. The second scenario is not addressed by the bill. The bill also requires the surcharge to be paid when a Citizens' policy is terminated or renewed or a new policy is issued within 12 months after a surcharge levy. If the surcharge is levied for less than 12 months, Citizens' policyholders must pay the surcharge during the collection period. Policyholders who are not insured by Citizens on the day of the order levying the surcharge are also responsible for paying the surcharge if they obtain insurance in Citizens during the 12 months after a surcharge levy or during the time the surcharge is collected.

Timing of Regular Assessments

The bill also clarifies current law relating to the timing of Citizens' levy of regular assessments against insurance companies. The bill does not allow Citizens to levy regular assessments against insurance companies until Citizens levies a Citizens Policyholder Surcharge in the maximum statutorily allowed amount against Citizens' policyholders. According to a representative of Citizens, this is consistent with how Citizens currently levies regular assessments.[29]

Amount of Emergency Assessments

The bill requires Citizens' policyholders to pay more in emergency assessments than non-Citizens' policyholders. Specifically, Citizens' policyholders will pay 1½ times the emergency assessment non-Citizens' policyholders will pay and the assessment percentage for Citizens' policyholders is increased from 10 percent to 15 percent.

Bad Faith Claims Against Citizens

Representatives of Citizens believe the corporation is immune from a bad faith claim under current law (s. 627.351(6)(s), F.S.).[30] The circumstances giving rise to bad faith claims are found in s. 624.155, F.S. This statute allows anyone to bring a civil action against an insurer when the person is damaged by specified acts or omissions of the insurer. Generally, the acts or omissions leading to a bad faith claim include: not attempting in good faith to settle a claim, making a claims payment without an accompanying statement of coverage relating to the payment, and not settling a claim when the insurer has a reasonably clear obligation to settle the claim in order to influence settlement of other portions of the claim. An insurer must pay damages, court costs, and reasonable attorney fees if the insurer loses a bad faith claim. Punitive damages can be awarded in specific instances.

Although Citizens has been sued for bad faith in the past, no court has ever rendered a decision on this issue.[31] The bill specifies that Citizens is not liable for bad faith or extra-contractual damages due to bad faith.

Sinkhole Coverage Offered by Citizens

---

[29] Conversation with a representative of Citizens on March 15, 2011.

[30] Testimony at Insurance & Banking Subcommittee meeting on March 15, 2011.

[31] Testimony at Insurance & Banking Subcommittee meeting on March 15, 2011.

Since 1981, insurers offering property coverage in Florida, including Citizens, have been required by law to provide coverage for property damage from sinkholes.[32] In 2007, the sinkhole coverage 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.[33] However, insurers must also offer policyholders, for an appropriate additional premium, sinkhole loss coverage covering any structure, including personal property contents.[34] Sinkhole loss coverage includes repairing the home, stabilizing the underlying land, and repairing the foundation.

The number and cost of sinkhole insurance claims have increased substantially over the last several years.[35] Like insurers in the private market, Citizens has seen an increase in the number of sinkhole claims filed in recent years. Statewide, the number of sinkhole claims filed on personal residential policies insured by Citizens increased from 660 in 2005 to 1,519 in 2009 and 1,145 in 2010.[36] The increase in sinkhole claims is the primary cost driver for Citizens' significant sinkhole losses. In 2009, Citizens incurred almost $84 million in sinkhole losses plus adjustment expenses, yet obtained a little over $22 million in earned sinkhole premium to cover those losses.[37]

The increase in sinkhole claims has occurred even though significant numbers of Citizens' policyholders dropped sinkhole coverage after it became an optional endorsement in 2007. The percent of Citizens' statewide policies with sinkhole coverage fell from 100 percent in 2006 (when it was mandatory) to 61 percent in 2009 and 60 percent in 2010.[38] In 2009, only 37 percent of policyholders in Hernando County and 22 percent of policyholders in Pasco County purchased Citizens' policies with sinkhole coverage. In 2010, these percentages increased slightly to 40 percent and 23 percent respectively.[39]

Citizens insured 4,261 claims (36 percent) of the 11,873 sinkhole claims in Hernando, Pasco, and Hillsborough counties reported to the OIR in a data call done by the OIR in 2010.[40] Citizens' data shows the sinkhole loss ratio for Hernando County in 2009 is 647 percent, meaning for every $1 in premium Citizens collects in Hernando County, $6.47 is paid for a sinkhole claim in the county. Citizens' 2009 loss ratio is almost 285 percent in Pasco County and is almost 526 percent in Hillsborough County. The loss ratio for all other counties combined is 175 percent.[41]

The bill prohibits policies issued by Citizens on or after January 1, 2012 covering sinkhole loss to cover losses to appurtenant structures, driveways, sidewalks decks, or patios directly or indirectly caused by sinkholes.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.351, F.S., relating to Citizens Property Insurance Corporation.

Section 2: Amends s. 627.712, F.S., relating to residential windstorm coverage required to correct cross-references to s. 627.351, F.S.

Section 3: Provides the bill is effective upon becoming a law.

---

[32] Ch. 1981-280, L.O.F.

[33] Section 30, Ch. 2007-1, L.O.F.

[34] s. 627.706, F.S.

[35] The increase in claims frequency and severity is based on data collected from 211 insurers, including Citizens, by the Office of Insurance Regulation (OIR) in the Fall of 2010, (*Report on Review of the 2010 Sinkhole Data Call* (OIR Report).

[36] Information received from Citizens on March 2, 2011, on file with the Insurance & Banking subcommittee. In 2009, Citizens received 118 sinkhole claims on commercial residential and commercial non-residential policies located outside the wind zones and in 2010 received 57 claims on these policies.

[37] Information received from Citizens on March 2, 2011, on file with the Insurance & Banking subcommittee.

[38] Information received from Citizens on March 2, 2011, on file with the Insurance & Banking subcommittee.

[39] Information received from Citizens on March 2, 2011, on file with the Insurance & Banking subcommittee.

[40] *Report on Review of the 2010 Sinkhole Data Call* by the Office of Insurance Regulation, pg 12.

[41] Information received from Citizens on March 2, 2011, on file with the Insurance & Banking subcommittee.

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:

Impact of Changing the Eligibility for Insurance in Citizens
Further restricting eligibility for insurance in Citizens, either by premium comparison or by the insured value of the property, will force some Citizens' policyholders into the private or surplus lines market for property insurance. These markets could charge more for insurance than Citizens which would increase the premiums for some Citizens' policyholders.

According to Citizens, since October 1, 2009, Citizens has insured over 78,000 policies (18 percent of the personal residential multiperil policies written since October 1, 2009) due to the current 15 percent eligibility restriction. Citizens does not collect this data for commercial residential property, so it is unknown how many policies Citizens insures due to the current 15 percent eligibility restriction that applies to commercial residential property.

Impact of Changing Eligibility Based on Insured Value
As of December 31, 2010, Citizens writes almost 5,000 policies in the personal lines account with an insured value of over $500,000. Starting January 1, 2016, these policies will no longer obtain coverage in Citizens (after the phase out period in the bill fully takes effect).[42]

As of December 31, 2010, Citizens writes around 6,500 policies with an insured value of from $1 million to $2 million in the high risk account. Starting January 1, 2012, these policies will no longer obtain coverage in Citizens. Citizens writes over 22,000 policies with an insured value of over $500,000 in the high risk account. Starting January 1, 2016, these policies will no longer obtain coverage in Citizens (after the phase out period in the bill fully takes effect).

Starting January 1, 2016, the total effect of the changes in the bill restricting the eligibility based on insured value is a reduction of about 33,500 Citizens' policies.

Impact of Changing Flood Insurance Requirement
Requiring some Citizens' policyholders to purchase flood insurance means increased out-of-pocket expenses for these policyholders, if the policyholder does not currently purchase flood insurance. However, the policyholders will be paid by the insurer for property damage caused by flooding which means less out-of-pocket expenses when there is damage.

---

[42] All information on the number of policies written by Citizens based on insured value was received from Citizens and is on file with the Insurance & Banking Subcommittee. 791 policies are insured for over $750,000 and would not be eligible for Citizens' coverage starting January 1, 2014. 4,156 policies are insured for $500,001 to $750,000 and would not be eligible for Citizens' coverage starting January 1, 2016.

Impact of Changing the Coverage Provided by Citizens for Screen Enclosures
Because Citizens will not cover screen enclosures starting January 1, 2012, policyholders with screen enclosures will no longer be paid for damage to the enclosures. However, the policyholder's rate and premium should decrease due to damage to screen enclosures being excluded in the policy.

Citizens cannot quantify the number of screen enclosures the corporation currently insures as enclosures are included in the base property insurance policy in the coverage for Coverage A[43] or Coverage B[44] and are not covered by an endorsement.

If excluding coverage for screen enclosures reduces Citizens' exposure, expected losses should also decrease. This decrease reduces the likelihood and amount of assessments on Citizens' and non-Citizens' policyholders.

Impact of Changing the Rates Charged by Citizens
Because the bill increases the rate caps for Citizens' policies, Citizens' policyholders will have larger rate increases than under current law, with maximum rate increases of 25 percent a year per policy, instead of 10 percent a year per policy.

Rates and premiums for an individual Citizens' policyholder could increase more than the rate cap if the policyholder chooses to purchase sinkhole loss coverage for an additional premium. The increase will be the amount commensurate with the sinkhole risk Citizens is insuring and will be actuarially determined.

Rates and resulting premiums for all Citizens' policyholders could increase more than the rate cap if Citizens' buys reinsurance and the cost of that purchase justifies a rate increase more than the cap.

Impact of Changing the Collection of Citizens Policyholder Surcharges
Some Citizens' policyholders that can avoid paying the Citizens Policyholder Surcharge under current law will no longer be able to avoid the surcharge and will have to pay the surcharge if Citizens incurs a deficit during the policy term. This should result in Citizens collecting more money via a Citizens Policyholder Surcharge which, in turn, reduces the likelihood and amount of regular and emergency assessments.

Impact of Changing the Amount of Emergency Assessments
Increasing the emergency assessment against Citizens' policyholders requires Citizens' policyholders to pay more for emergency assessments than under current law. Furthermore, the maximum amount of an emergency assessment that can be levied against Citizens' policyholders is increased from 10 percent to 15 percent.

Impact of Changing the Sinkhole Coverage Offered by Citizens
Prohibiting Citizens' sinkhole coverage from covering losses to appurtenant structures, driveways, sidewalks decks, or patios should reduce Citizens' sinkhole exposure so expected losses should also decrease. This decrease reduces the likelihood and amount of assessments on Citizens' and non-Citizens' policyholders. The decrease may also reduce rates and premiums.

Impact of Clarifying Bad Faith Exemption for Citizens
If the bill's clarification on the application of the bad faith law to Citizens reduces the number of or eliminates bad faith suits filed against Citizens, Citizens will see reduced legal fees associated with defending these suits and should not incur future legal fees to defend such suits.

D. FISCAL COMMENTS:

The bill does not specify who pays for the outsourcing cost-benefit study required for Citizens' policy issuance and service functions. Thus, it is assumed Citizens will pay for this study.

[43] Coverage A is the coverage on the building or dwelling.

[44] Coverage B is the coverage on other structures on the property (e.g., shed, detached garage).

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:

Conclusive Presumptions
A statutory presumption is conclusive if it prevents a party from proving or disproving the presumed fact. Conclusive presumptions can raise constitutional due process concerns but are permissible in some circumstances. The constitutionality of a conclusive presumption under the due process clause is measured by determining:

1) Whether the concern of the Legislature was reasonably aroused by the possibility of an abuse which it legitimately desired to avoid;
2) Whether there was a reasonable basis for a conclusion that the statute would protect against its occurrence; and
3) Whether the expense and other difficulties of individual determinations justify the inherent imprecision of a conclusive presumption.[45]

Florida insurance statutes contain conclusive presumptions related to selection or rejection of homeowner's law and ordinance coverage,[46] a motor vehicle insurance policyholder's election to purchase uninsured motorist coverage at lower limits than the insured's bodily injury coverage,[47] the assessment liability of the policyholders of a worker's compensation self insurance fund,[48] informed consent of HIV and AIDS testing for insurance purposes,[49] and the possibility that a Citizens Property Insurance Corporation policy could be replaced by a policy from an authorized insurer that does not provide identical coverage.[50] The bill provides a signed acknowledgement form by a Citizens' policyholder about the assessable nature of the Citizens' policy creates a conclusive presumption a Citizens' policyholder understood and accepted their liability for a surcharge or assessment levied by Citizens.

B. RULE-MAKING AUTHORITY:

None provided in the bill and none repealed by the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The language in the bill relating to an acknowledgement form about the assessable nature of a Citizens' policy is similar to, but is not identical to, language in HB 885. The language on this issue should be consistent in both bills. Otherwise, the language in the last passed bill controls.

In addition, HB 803 contains language relating to Citizens' levy of the Citizens Policyholder Surcharge that is different than the language on this issue contained in this bill. The language on this issue should be consistent in both bills. Otherwise, the language in the last passed bill controls.

---

[45] Hall v. Recchi America, Inc., 671 So.2d 197, 200 (Fla 1st DCA 1996).
[46] s. 627.7011(2), F.S.
[47] s. 627.727(1), F.S.
[48] s. 440.585, F.S.
[49] s. 627.429, F.S.
[50] s. 627.351(6)(c)11., F.S.

HB 803 also contains the exact language relating to the levy of regular assessments that is contained in this bill and makes other changes to the Citizens' statute. Some of the changes to the Citizens' statute made by HB 803 are not made in this bill. The changes to the Citizens' statute in both bills should match to ensure consistency. Otherwise, the changes in the last passed bill control.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Citizens Property Insurance Corporation; amending s. 627.351, F.S.; revising legislative intent; providing that certain residential structures are not eligible for coverage by the corporation after a certain date; specifying the percentage amount of emergency assessments; revising provisions relating to policyholder surcharges; prohibiting the corporation from levying certain assessments with respect to a year's deficit until the corporation has first levied a specified surcharge; deleting obsolete provisions relating to the corporation's plan of operation; requiring the corporation to commission a consultant to prepare a report on outsourcing various functions and to submit such report to the Financial Services Commission by a certain date; revising provisions relating to wind coverage; requiring the policyholders to sign a statement acknowledging that they may be assessed surcharges to cover corporate deficits; providing for termination of an agent for violation of provisions relating to unlawful rebates; providing that policies do not include coverage for screen enclosures and limiting coverage for damage from sinkholes after a certain date; requiring members of the board of governors to abstain from voting on issues on which they have a personal interest; requiring such members to disclose the nature of their interest as a public record; providing that the corporation operates as a residual market mechanism;

revising provisions relating to corporation rates; clarifying that the corporation is immune from certain liabilities; deleting a requirement for an annual report to the Legislature on losses attributable to wind-only coverages; requiring owners of properties in Special Flood Hazard Areas to maintain a separate flood insurance policy after a certain date; providing exceptions; deleting a provision relating to a pilot program for optional sinkhole coverage; amending s. 627.712, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Paragraphs (a), (b), (c), (d), (n), (o), (s), (w), (y), (aa), and (ee) of subsection (6) of section 627.351, Florida Statutes, are amended to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(a) ~~1. It is~~ The public purpose of this subsection is to ensure that there is ~~the existence of~~ an orderly market for property insurance for residents ~~Floridians~~ and ~~Florida~~ businesses of this state.

1. The Legislature finds that actual and threatened catastrophic losses to property from hurricanes in this state have caused insurers to be unwilling or unable to provide property insurance coverage to the extent sought and needed. The Legislature declares that it is in the public interest and serves a public purpose that property in this state be

adequately insured in order to facilitate the remediation, reconstruction, and replacement of damaged or destroyed property. Such efforts are necessary in order to avoid or reduce negative effects to the public health, safety, and welfare; the economy of the state; and the revenues of state and local governments. It is necessary, therefore, to provide property insurance to applicants who are entitled to procure insurance through the voluntary market but who, in good faith, are unable to do so. ~~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, ~~by this subsection~~ 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, Citizens Property Insurance 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 Citizens Property Insurance 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.~~

a. It is also the intent of the Legislature that policyholders, applicants, and agents of the corporation receive service and treatment of the highest possible level and never less than that generally provided in the voluntary market. The corporation must 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. It is also the intent of the Legislature that the corporation operate efficiently and economically.

b. Because it is essential that the corporation have the maximum financial resources necessary to pay claims following a

catastrophic hurricane, the Legislature also intends that the income of the corporation and 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 of July 1, 2002,~~ as the Citizens Property Insurance Corporation. The corporation shall provide insurance for residential and commercial property, for applicants who are ~~in good faith~~ 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. ~~The corporation shall continue to operate pursuant to the plan of operation approved by the Office of Insurance Regulation until October 1, 2006.~~ 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. With respect to coverage for personal lines residential

structures:

a. 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 ~~content~~ 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 ~~that are insured by the corporation and become ineligible for coverage due to the provisions of this subparagraph~~ 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.~~

b. Effective January 1, 2012, a structure that has a dwelling replacement cost of $1 million or more, or a single

condominium unit that has a combined dwelling and contents replacement cost of $1 million or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2011, may continue to be covered by the corporation only until the end of the policy term.

c. Effective January 1, 2014, a structure that has a dwelling replacement cost of $750,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $750,000 or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2013, may continue to be covered by the corporation until the end of the policy term.

d. Effective January 1, 2016, a structure that has a dwelling replacement cost of $500,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $500,000 or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2015, may continue to be covered by the corporation until the end of the policy term.

~~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 also is 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.~~

4.~~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 ~~the requirements of~~ 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.

(b)1. All insurers authorized to write one or more subject lines of business in this state are subject to assessment by the corporation and, for the purposes of this subsection, are referred to collectively as "assessable insurers." Insurers writing one or more subject lines of business in this state pursuant to part VIII of chapter 626 are not assessable insurers, but insureds who procure one or more subject lines of business in this state pursuant to part VIII of chapter 626 are subject to assessment by the corporation and are referred to collectively as "assessable insureds." An ~~authorized~~ insurer's assessment liability begins ~~shall begin~~ on the first day of the calendar year following the year in which the insurer was issued a certificate of authority to transact insurance for subject lines of business in this state and terminates ~~shall terminate~~ 1 year after the end of the first calendar year during which the insurer no longer holds a certificate of authority to transact

insurance for subject lines of business in this state.

2.a. All revenues, assets, liabilities, losses, and expenses of the corporation shall be divided into three separate accounts as follows:

(I) A personal lines account for personal residential policies issued by the corporation, or issued by the Residential Property and Casualty Joint Underwriting Association and renewed by the corporation, which provides ~~that provide~~ comprehensive, multiperil coverage on risks that are not located in areas eligible for coverage by ~~in~~ the Florida Windstorm Underwriting Association as those areas were defined on January 1, 2002, and for ~~such~~ policies that do not provide coverage for the peril of wind on risks that are located in such areas;

(II) A commercial lines account for commercial residential and commercial nonresidential policies issued by the corporation, or issued by the Residential Property and Casualty Joint Underwriting Association and renewed by the corporation, which provides ~~that provide~~ coverage for basic property perils on risks that are not located in areas eligible for coverage by ~~in~~ the Florida Windstorm Underwriting Association as those areas were defined on January 1, 2002, and for ~~such~~ policies that do not provide coverage for the peril of wind on risks that are located in such areas; and

(III) A high-risk account for personal residential policies and commercial residential and commercial nonresidential property policies issued by the corporation, or transferred to the corporation, which provides ~~that provide~~ coverage for the peril of wind on risks that are located in

areas eligible for coverage by ~~in~~ the Florida Windstorm Underwriting Association as those areas were defined on January 1, 2002. The corporation may offer policies that provide multiperil coverage and the corporation shall continue to offer policies that provide coverage only for the peril of wind for risks located in areas eligible for coverage in the high-risk account. In issuing multiperil coverage, the corporation may use its approved policy forms and rates for the personal lines account. An applicant or insured who is eligible to purchase a multiperil policy from the corporation may purchase a multiperil policy from an authorized insurer without prejudice to the applicant's or insured's eligibility to prospectively purchase a policy that provides coverage only for the peril of wind from the corporation. An applicant or insured who is eligible for a corporation policy that provides coverage only for the peril of wind may elect to purchase or retain such policy and also purchase or retain coverage excluding wind from an authorized insurer without prejudice to the applicant's or insured's eligibility to prospectively purchase a policy that provides multiperil coverage from the corporation. ~~It is the goal of the Legislature that there would be an overall average savings of 10 percent or more for a policyholder who currently has a wind-only policy with the corporation, and an ex-wind policy with a voluntary insurer or the corporation, and who then obtains a multiperil policy from the corporation.~~ It is the intent of the Legislature that the offer of multiperil coverage in the high-risk account be made and implemented in a manner that does not adversely affect the tax-exempt status of the corporation or

creditworthiness of or security for currently outstanding financing obligations or credit facilities of the high-risk account, the personal lines account, or the commercial lines account. ~~The high-risk account must also include quota share primary insurance under subparagraph (c)2.~~ The area eligible for coverage under the high-risk account also includes the area within Port Canaveral, which is bordered on the south by the City of Cape Canaveral, bordered on the west by the Banana River, and bordered on the north by Federal Government property.

b. The three separate accounts must be maintained as long as financing obligations entered into by the Florida Windstorm Underwriting Association or Residential Property and Casualty Joint Underwriting Association are outstanding, in accordance with the terms of the corresponding financing documents. If ~~When~~ the financing obligations are no longer outstanding, ~~in accordance with the terms of the corresponding financing documents,~~ the corporation may use a single account for all revenues, assets, liabilities, losses, and expenses of the corporation. Consistent with ~~the requirement of~~ this subparagraph and prudent investment policies that minimize the cost of carrying debt, the board shall exercise its best efforts to retire existing debt or ~~to~~ obtain the approval of necessary parties to amend the terms of existing debt, so as to structure the most efficient plan to consolidate the three separate accounts into a single account.

c. Creditors of the Residential Property and Casualty Joint Underwriting Association and of the accounts specified in sub-sub-subparagraphs a.(I) and (II) may have a claim against,

and recourse to, those ~~the~~ accounts ~~referred to in sub-sub-subparagraphs a.(I) and (II)~~ and ~~shall have~~ no claim against, or recourse to, the account referred to in sub-sub-subparagraph a.(III). Creditors of the Florida Windstorm Underwriting Association ~~shall~~ have a claim against, and recourse to, the account referred to in sub-sub-subparagraph a.(III) and ~~shall have~~ no claim against, or recourse to, the accounts referred to in sub-sub-subparagraphs a.(I) and (II).

d. Revenues, assets, liabilities, losses, and expenses not attributable to particular accounts shall be prorated among the accounts.

e. The Legislature finds that the revenues of the corporation are revenues that are necessary to meet the requirements set forth in documents authorizing the issuance of bonds under this subsection.

f. No part of the income of the corporation may inure to the benefit of any private person.

3. With respect to a deficit in an account:

a. After accounting for the Citizens policyholder surcharge imposed under sub-subparagraph i., if ~~when~~ the remaining projected deficit incurred in a particular calendar year is not greater than 6 percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year, the entire deficit shall be recovered through regular assessments of assessable insurers under paragraph (q) and assessable insureds.

b. After accounting for the Citizens policyholder surcharge imposed under sub-subparagraph i., when the remaining

projected deficit incurred in a particular calendar year exceeds 6 percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year, the corporation shall levy regular assessments on assessable insurers under paragraph (q) and on assessable insureds in an amount equal to the greater of 6 percent of the deficit or 6 percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year. Any remaining deficit shall be recovered through emergency assessments under sub-subparagraph d.

c. Each assessable insurer's share of the amount being assessed under sub-subparagraph a. or sub-subparagraph b. must ~~shall~~ be in the proportion that the assessable insurer's direct written premium for the subject lines of business for the year preceding the assessment bears to the aggregate statewide direct written premium for the subject lines of business for that year. The applicable assessment percentage ~~applicable to each assessable insured~~ is the ratio of the amount being assessed under sub-subparagraph a. or sub-subparagraph b. to the aggregate statewide direct written premium for the subject lines of business for the prior year. Assessments levied by the corporation on assessable insurers under sub-subparagraphs a. and b. must ~~shall~~ be paid as required by the corporation's plan of operation and paragraph (q). Assessments levied by the corporation on assessable insureds under sub-subparagraphs a. and b. shall be collected by the surplus lines agent at the time the surplus lines agent collects the surplus lines tax required by s. 626.932 and ~~shall be~~ paid to the Florida Surplus Lines

Service Office at the time the surplus lines agent pays the surplus lines tax to that ~~the Florida Surplus Lines Service~~ office. Upon receipt of regular assessments from surplus lines agents, the Florida Surplus Lines Service Office shall transfer the assessments directly to the corporation as determined by the corporation.

d. Upon a determination by the board of governors that a deficit in an account exceeds the amount that will be recovered through regular assessments under sub-subparagraph a. or sub-subparagraph b., plus the amount that is expected to be recovered through surcharges under sub-subparagraph i., ~~as to the remaining projected deficit~~ the board ~~shall levy~~, after verification by the office, shall levy emergency assessments~~,~~ for as many years as necessary to cover the deficits, to be collected by assessable insurers and the corporation and collected from assessable insureds upon issuance or renewal of policies for subject lines of business, excluding National Flood Insurance policies. The amount of the emergency assessment collected in a particular year must ~~shall~~ be a uniform percentage of that year's direct written premium for subject lines of business ~~and all accounts of the corporation~~, excluding National Flood Insurance Program policy premiums, as annually determined by the board and verified by the office. For all accounts of the corporation, the amount of the emergency assessment levied in a particular year must be a uniform percentage equal to 1 1/2 times the uniform percentage emergency assessment levied on subject lines of business. The office shall verify the arithmetic calculations involved in the board's

determination within 30 days after receipt of the information on which the determination was based. Notwithstanding any other provision of law, the corporation and each assessable insurer that writes subject lines of business shall collect emergency assessments from its policyholders without such obligation being affected by any credit, limitation, exemption, or deferment. Emergency assessments levied by the corporation on assessable insureds shall be collected by the surplus lines agent at the time the surplus lines agent collects the surplus lines tax required by s. 626.932 and ~~shall be~~ paid to the Florida Surplus Lines Service Office at the time the surplus lines agent pays the surplus lines tax to that ~~the Florida Surplus Lines Service~~ office. The emergency assessments ~~so~~ collected shall be transferred directly to the corporation on a periodic basis as determined by the corporation and ~~shall be~~ held by the corporation solely in the applicable account. The aggregate amount of emergency assessments levied for an account under this sub-subparagraph in any calendar year may~~, at the discretion of the board of governors,~~ be less than but ~~may~~ not exceed the greater of 10 percent of the amount needed to cover the deficit, plus interest, fees, commissions, required reserves, and other costs associated with financing ~~of~~ the original deficit, or 10 percent of the aggregate statewide direct written premium for subject lines of business and 15 percent for all accounts of the corporation for the prior year, plus interest, fees, commissions, required reserves, and other costs associated with financing the deficit.

e. The corporation may pledge the proceeds of assessments,

projected recoveries from the Florida Hurricane Catastrophe Fund, other insurance and reinsurance recoverables, policyholder surcharges and other surcharges, and other funds available to the corporation as the source of revenue for and to secure bonds issued under paragraph (q), bonds or other indebtedness issued under subparagraph (c)2.~~3.~~, or lines of credit or other financing mechanisms issued or created under this subsection, or to retire any other debt incurred as a result of deficits or events giving rise to deficits, or in any other way that the board determines will efficiently recover such deficits. The purpose of the lines of credit or other financing mechanisms is to provide additional resources to assist the corporation in covering claims and expenses attributable to a catastrophe. As used in this subsection, the term "assessments" includes regular assessments under sub-subparagraph a., sub-subparagraph b., or subparagraph (q)1. and emergency assessments under sub-subparagraph d. Emergency assessments collected under sub-subparagraph d. are not part of an insurer's rates, are not premium, and are not subject to premium tax, fees, or commissions; however, failure to pay the emergency assessment shall be treated as failure to pay premium. The emergency assessments under sub-subparagraph d. shall continue as long as any bonds issued or other indebtedness incurred with respect to a deficit for which the assessment was imposed remain outstanding, unless adequate provision has been made for the payment of such bonds or other indebtedness pursuant to the documents governing such bonds or ~~other~~ indebtedness.

f. As used in this subsection for purposes of any deficit

incurred on or after January 25, 2007, the term "subject lines of business" means insurance written by assessable insurers or procured by assessable insureds for all property and casualty lines of business in this state, but not including workers' compensation or medical malpractice. As used in this ~~the~~ sub-subparagraph, the term "property and casualty lines of business" includes all lines of business identified on Form 2, Exhibit of Premiums and Losses, in the annual statement required of authorized insurers under ~~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 or the Federal Crop Insurance Program. For purposes of this sub-subparagraph, the term "workers' compensation" includes both workers' compensation insurance and excess workers' compensation insurance.

g. The Florida Surplus Lines Service Office shall determine annually the aggregate statewide written premium in subject lines of business procured by assessable insureds and ~~shall~~ report that information to the corporation in a form and at a time the corporation specifies to ensure that the corporation can meet the requirements of this subsection and the corporation's financing obligations.

h. The Florida Surplus Lines Service Office shall verify the proper application by surplus lines agents of assessment percentages for regular assessments and emergency assessments levied under this subparagraph on assessable insureds and ~~shall~~ assist the corporation in ensuring the accurate, timely collection and payment of assessments by surplus lines agents as

required by the corporation.

i. If a deficit is incurred in any account in 2011 ~~2008~~ or thereafter, the board of governors shall levy a Citizens policyholder surcharge against all policyholders of the corporation.

(I) The surcharge ~~for a 12-month period, which~~ shall be levied ~~collected at the time of issuance or renewal of a policy,~~ as a uniform percentage of the premium for the policy of up to 15 percent of such premium, which funds shall be used to offset the deficit.

(II) It is the intent of the Legislature that the policyholder's liability for the surcharge attach on the date of the order levying the surcharge. The surcharge is payable upon cancellation or termination of the policy, upon renewal of the policy, or upon issuance of a new policy by the corporation within the first 12 months after the date of the levy or the period of time necessary to fully collect the surcharge amount.

(III) The corporation may not levy any regular assessments under paragraph (q) pursuant to sub-subparagraph a. or sub-subparagraph b. with respect to a particular year's deficit until the corporation has first levied a surcharge under this sub-subparagraph in the full amount authorized by this sub-subparagraph.

(IV) The Citizens policyholder surcharge is ~~surcharges under this sub-subparagraph are~~ not considered premium and is ~~are~~ not subject to commissions, fees, or premium taxes. However, failure to pay the surcharge ~~such surcharges~~ shall be treated as failure to pay premium.

j. If the amount of any assessments or surcharges collected from corporation policyholders, assessable insurers or their policyholders, or assessable insureds exceeds the amount of the deficits, such excess amounts shall be remitted to and retained by the corporation in a reserve to be used by the corporation, as determined by the board of governors and approved by the office, to pay claims or reduce any past, present, or future plan-year deficits or to reduce outstanding debt.

(c) The ~~plan of operation of the~~ corporation:

1. Must provide ~~for adoption of~~ residential property and casualty insurance policy forms and commercial residential and nonresidential property insurance forms, which ~~forms~~ must be approved by the office before ~~prior to~~ use. The corporation shall adopt the following policy forms:

a. Standard personal lines policy forms that are comprehensive multiperil policies providing full coverage of a residential property equivalent to the coverage provided in the private insurance market under an HO-3, HO-4, or HO-6 policy.

b. Basic personal lines policy forms that are policies similar to an HO-8 policy or a dwelling fire policy that provide coverage meeting the requirements of the secondary mortgage market, but which ~~coverage~~ is more limited than the coverage under a standard policy.

c. Commercial lines residential and nonresidential policy forms that are generally similar to the basic perils of full coverage obtainable for commercial residential structures and commercial nonresidential structures in the admitted voluntary

market.

d. Personal lines and commercial lines residential property insurance forms that cover the peril of wind only. The forms are applicable only to residential properties located in areas eligible for coverage under the high-risk account referred to in sub-subparagraph (b)2.a.

e. Commercial lines nonresidential property insurance forms that cover the peril of wind only. The forms are applicable only to nonresidential properties located in areas eligible for coverage under the high-risk account referred to in sub-subparagraph (b)2.a.

f. The corporation may adopt variations of the policy forms listed in sub-subparagraphs a.-e. which ~~that~~ contain more restrictive coverage.

~~2.a. Must provide that the corporation adopt a program in which the corporation and authorized insurers enter into quota share primary insurance agreements for hurricane coverage, as defined in s. 627.4025(2)(a), for eligible risks, and adopt property insurance forms for eligible risks which cover the peril of wind only. As used in this subsection, the term:~~

~~(I) "Quota share primary insurance" means an arrangement in which the primary hurricane coverage of an eligible risk is provided in specified percentages by the corporation and an authorized insurer. The corporation and authorized insurer are each solely responsible for a specified percentage of hurricane coverage of an eligible risk as set forth in a quota share primary insurance agreement between the corporation and an authorized insurer and the insurance contract. The~~

~~responsibility of the corporation or authorized insurer to pay its specified percentage of hurricane losses of an eligible risk, as set forth in the quota share primary insurance agreement, may not be altered by the inability of the other party to the agreement to pay its specified percentage of hurricane losses. Eligible risks that are provided hurricane coverage through a quota share primary insurance arrangement must be provided policy forms that set forth the obligations of the corporation and authorized insurer under the arrangement, clearly specify the percentages of quota share primary insurance provided by the corporation and authorized insurer, and conspicuously and clearly state that neither the authorized insurer nor the corporation may be held responsible beyond its specified percentage of coverage of hurricane losses.~~

~~(II) "Eligible risks" means personal lines residential and commercial lines residential risks that meet the underwriting criteria of the corporation and are located in areas that were eligible for coverage by the Florida Windstorm Underwriting Association on January 1, 2002.~~

~~b. The corporation may enter into quota share primary insurance agreements with authorized insurers at corporation coverage levels of 90 percent and 50 percent.~~

~~c. If the corporation determines that additional coverage levels are necessary to maximize participation in quota share primary insurance agreements by authorized insurers, the corporation may establish additional coverage levels. However, the corporation's quota share primary insurance coverage level may not exceed 90 percent.~~

~~d. Any quota share primary insurance agreement entered into between an authorized insurer and the corporation must provide for a uniform specified percentage of coverage of hurricane losses, by county or territory as set forth by the corporation board, for all eligible risks of the authorized insurer covered under the quota share primary insurance agreement.~~

~~e. Any quota share primary insurance agreement entered into between an authorized insurer and the corporation is subject to review and approval by the office. However, such agreement shall be authorized only as to insurance contracts entered into between an authorized insurer and an insured who is already insured by the corporation for wind coverage.~~

~~f. For all eligible risks covered under quota share primary insurance agreements, the exposure and coverage levels for both the corporation and authorized insurers shall be reported by the corporation to the Florida Hurricane Catastrophe Fund. For all policies of eligible risks covered under quota share primary insurance agreements, the corporation and the authorized insurer shall maintain complete and accurate records for the purpose of exposure and loss reimbursement audits as required by Florida Hurricane Catastrophe Fund rules. The corporation and the authorized insurer shall each maintain duplicate copies of policy declaration pages and supporting claims documents.~~

~~g. The corporation board shall establish in its plan of operation standards for quota share agreements which ensure that there is no discriminatory application among insurers as to the~~

~~terms of quota share agreements, pricing of quota share agreements, incentive provisions if any, and consideration paid for servicing policies or adjusting claims.~~

~~h. The quota share primary insurance agreement between the corporation and an authorized insurer must set forth the specific terms under which coverage is provided, including, but not limited to, the sale and servicing of policies issued under the agreement by the insurance agent of the authorized insurer producing the business, the reporting of information concerning eligible risks, the payment of premium to the corporation, and arrangements for the adjustment and payment of hurricane claims incurred on eligible risks by the claims adjuster and personnel of the authorized insurer. Entering into a quota sharing insurance agreement between the corporation and an authorized insurer shall be voluntary and at the discretion of the authorized insurer.~~

2.~~3.~~ May ~~provide that the corporation may~~ employ or otherwise contract with individuals or other entities to provide administrative or professional services ~~that may be appropriate to effectuate the plan~~.

a. The corporation may ~~shall have the power to~~ borrow funds~~,~~ by issuing bonds or by incurring other indebtedness~~,~~ and shall have other powers reasonably necessary to effectuate the requirements of this subsection, including, without limitation, the power to issue bonds and incur other indebtedness in order to refinance outstanding bonds or other indebtedness. The corporation may~~, but is not required to,~~ seek judicial validation of its bonds or other indebtedness under chapter 75.

The corporation may issue bonds or incur other indebtedness, or have bonds issued on its behalf by a unit of local government pursuant to subparagraph (q)2., in the absence of a hurricane or other weather-related event, upon a determination by the corporation, subject to approval by the office, that such action would enable it to efficiently meet the financial obligations of the corporation and that such financings are reasonably necessary to effectuate the requirements of this subsection. The corporation may ~~is authorized to~~ take all actions needed to facilitate tax-free status for ~~any~~ such bonds or indebtedness, including formation of trusts or other affiliated entities. The corporation may ~~shall have the authority to~~ pledge assessments, projected recoveries from the Florida Hurricane Catastrophe Fund, other reinsurance recoverables, market equalization and other surcharges, and other funds available to the corporation as security for bonds or other indebtedness. In recognition of s. 10, Art. I of the State Constitution, prohibiting the impairment of obligations of contracts, it is the intent of the Legislature that no action be taken whose purpose is to impair any bond indenture or financing agreement or any revenue source committed by contract to such bond or other indebtedness.

b. To ensure that the corporation is operating in an efficient and economic manner while providing quality service to policyholders, applicants, and agents, the board shall commission an independent third-party consultant having expertise in insurance company management or insurance company management consulting to prepare a report and make recommendations on the relative costs and benefits of

outsourcing various policy issuance and service functions to private servicing carriers or entities performing similar functions in the private market for a fee, rather than performing such functions in house. In making such recommendations, the consultant shall consider how other residual markets, both in this state and around the country, outsource appropriate functions or use servicing carriers to better match expenses with revenues that fluctuate based on a widely varying policy count. The report must be completed by July 1, 2012. Upon receiving the report, the board shall develop a plan to implement the report and submit the plan for review, modification, and approval to the Financial Services Commission. Upon the commission's approval of the plan, the board shall begin implementing the plan by January 1, 2013.

3.~~4.a.~~ Must ~~require that the corporation~~ operate subject to the supervision and approval of a board of governors consisting of eight individuals who are residents of this state, from different geographical areas of this state.

a. The Governor, the Chief Financial Officer, the President of the Senate, and the Speaker of the House of Representatives shall each appoint two members of the board. At least one of the two members appointed by each appointing officer must have demonstrated expertise in insurance and be within the scope of the exemption provided in s. 112.313(7)(b). The Chief Financial Officer shall designate one of the appointees as chair. All board members serve at the pleasure of the appointing officer. All members of the board ~~of governors~~ are subject to removal at will by the officers who appointed

them. All board members, including the chair, must be appointed to serve for 3-year terms beginning annually on a date designated by the plan. However, for the first term beginning on or after July 1, 2009, each appointing officer shall appoint one member of the board for a 2-year term and one member for a 3-year term. A ~~Any~~ board vacancy shall be filled for the unexpired term by the appointing officer. The Chief Financial Officer shall appoint a technical advisory group to provide information and advice to the board ~~of governors~~ in connection with the board's duties under this subsection. The executive director and senior managers of the corporation shall be engaged by the board and serve at the pleasure of the board. Any executive director appointed on or after July 1, 2006, is subject to confirmation by the Senate. The executive director is responsible for employing other staff as the corporation may require, subject to review and concurrence by the board.

b. The board shall create a Market Accountability Advisory Committee to assist the corporation in developing awareness of its rates and its customer and agent service levels in relationship to the voluntary market insurers writing similar coverage and to provide advice on issues regarding agent appointments and compensation.

(I) The members of the advisory committee shall consist of the following 11 persons, one of whom must be elected chair by the members of the committee: four representatives, one appointed by the Florida Association of Insurance Agents, one by the National ~~Florida~~ Association of Insurance and Financial Advisors-Florida ~~Advisors~~, one by the Professional Insurance

Agents of Florida, and one by the Latin American Association of Insurance Agencies; three representatives appointed by the insurers with the three highest voluntary market share of residential property insurance business in the state; one representative from the Office of Insurance Regulation; one consumer appointed by the board who is insured by the corporation at the time of appointment to the committee; one representative appointed by the Florida Association of Realtors; and one representative appointed by the Florida Bankers Association. All members shall be appointed to ~~must serve for~~ 3-year terms and may serve for consecutive terms.

(II) The committee shall report to the corporation at each board meeting on insurance market issues which may include rates and rate competition with the voluntary market; service, including policy issuance, claims processing, and general responsiveness to policyholders, applicants, and agents; and matters relating to depopulation, producer compensation, or agency agreements.

4.~~5.~~ Must provide a procedure for determining the eligibility of a risk for coverage, as follows:

a. Subject to ~~the provisions of~~ s. 627.3517, with respect to personal lines residential risks, if the risk is offered coverage from an authorized insurer at the insurer's approved rate under ~~either~~ a standard policy including wind coverage or, if consistent with the insurer's underwriting rules as filed with the office, a basic policy including wind coverage, for a new application to the corporation for coverage, the risk is not eligible for any policy issued by the corporation ~~unless the~~

~~premium for coverage from the authorized insurer is more than 15 percent greater than the premium for comparable coverage from the corporation~~. If the risk is not able to obtain ~~any~~ such offer, the risk is eligible for ~~either~~ a standard policy including wind coverage or a basic policy including wind coverage issued by the corporation; however, if the risk could not be insured under a standard policy including wind coverage regardless of market conditions, the risk is ~~shall be~~ eligible for a basic policy including wind coverage unless rejected under subparagraph 7. ~~8.~~ Notwithstanding these limitations, an application for coverage having an effective date before January 1, 2015, is eligible for coverage by the corporation if the premium for coverage from an authorized insurer exceeds the premium for comparable coverage from the corporation by more than 25 percent. ~~However, with regard to a policyholder of the corporation or a policyholder removed from the corporation through an assumption agreement until the end of the assumption period, the policyholder remains eligible for coverage from the corporation regardless of any offer of coverage from an authorized insurer or surplus lines insurer.~~ The corporation shall determine the type of policy to be provided on the basis of objective standards specified in the underwriting manual and based on generally accepted underwriting practices.

(I) If the risk accepts an offer of coverage through the market assistance plan or ~~an offer of coverage~~ through a mechanism established by the corporation before a policy is issued to the risk by the corporation or during the first 30 days of coverage by the corporation, and the producing agent who

submitted the application to the plan or to the corporation is not currently appointed by the insurer, the insurer shall:

(A) Pay to the producing agent of record of the policy, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(B) Offer to allow the producing agent of record of the policy to continue servicing the policy for at least ~~a period of not less than~~ 1 year and offer to pay the agent the greater of the insurer's or the corporation's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

(II) If ~~When~~ the corporation enters into a contractual agreement for a take-out plan, the producing agent of record of the corporation policy is entitled to retain any unearned commission on the policy, and the insurer shall:

(A) Pay to the producing agent ~~of record of the corporation policy~~, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(B) Offer to allow the producing agent ~~of record of the corporation policy~~ to continue servicing the policy for at least ~~a period of not less than~~ 1 year and offer to pay the agent the

greater of the insurer's or the corporation's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

b. Subject to s. 627.3517, with respect to commercial lines residential risks, ~~for a new application to the corporation for coverage,~~ if the risk is offered coverage under a policy including wind coverage from an authorized insurer at its approved rate, the risk is not eligible for a ~~any~~ policy issued by the corporation ~~unless the premium for coverage from the authorized insurer is more than 15 percent greater than the premium for comparable coverage from the corporation~~. If the risk is not able to obtain any such offer, the risk is eligible for a policy including wind coverage issued by the corporation. Notwithstanding these limitations, an application for coverage having an effective date before January 1, 2015, is eligible for coverage by the corporation if the premium for coverage from an authorized insurer exceeds the premium for comparable coverage from the corporation by more than 25 percent. ~~However, with regard to a policyholder of the corporation or a policyholder removed from the corporation through an assumption agreement until the end of the assumption period, the policyholder remains eligible for coverage from the corporation regardless of any offer of coverage from an authorized insurer or surplus lines insurer.~~

(I) If the risk accepts an offer of coverage through the

market assistance plan or ~~an offer of coverage~~ through a mechanism established by the corporation before a policy is issued to the risk by the corporation or during the first 30 days of coverage by the corporation, and the producing agent who submitted the application to the plan or the corporation is not currently appointed by the insurer, the insurer shall:

(A) Pay to the producing agent ~~of record of the policy~~, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(B) Offer to allow the producing agent ~~of record of the policy~~ to continue servicing the policy for at least ~~a period of not less than~~ 1 year and offer to pay the agent the greater of the insurer's or the corporation's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

(II) If ~~When~~ the corporation enters into a contractual agreement for a take-out plan, the producing agent of record of the corporation policy is entitled to retain any unearned commission on the policy, and the insurer shall:

(A) Pay to the producing agent ~~of record of the corporation policy~~, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary

commission of the corporation; or

(B) Offer to allow the producing agent ~~of record of the corporation policy~~ to continue servicing the policy for at least ~~a period of not less than~~ 1 year and offer to pay the agent the greater of the insurer's or the corporation's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

c. For purposes of determining comparable coverage under sub-subparagraphs a. and b., the comparison shall be based on those forms and coverages that are reasonably comparable. The corporation may rely on a determination of comparable coverage and premium made by the producing agent who submits the application to the corporation, made in the agent's capacity as the corporation's agent. A comparison may be made solely of the premium with respect to the main building or structure only on the following basis: the same coverage A or other building limits; the same percentage hurricane deductible that applies on an annual basis or that applies to each hurricane for commercial residential property; the same percentage of ordinance and law coverage, if the same limit is offered by both the corporation and the authorized insurer; the same mitigation credits, to the extent the same types of credits are offered both by the corporation and the authorized insurer; the same method for loss payment, such as replacement cost or actual cash value, if the same method is offered both by the corporation and the

authorized insurer in accordance with underwriting rules; and any other form or coverage that is reasonably comparable as determined by the board. If an application is submitted to the corporation for wind-only coverage in the high-risk account, the premium for the corporation's wind-only policy plus the premium for the ex-wind policy that is offered by an authorized insurer to the applicant shall be compared to the premium for multiperil coverage offered by an authorized insurer, subject to the standards for comparison specified in this subparagraph. If the corporation or the applicant requests from the authorized insurer a breakdown of the premium of the offer by types of coverage so that a comparison may be made by the corporation or its agent and the authorized insurer refuses or is unable to provide such information, the corporation may treat the offer as not being an offer of coverage from an authorized insurer at the insurer's approved rate.

5.~~6.~~ Must include rules for classifications of risks and rates ~~therefor~~.

6.~~7.~~ Must provide that if premium and investment income for an account attributable to a particular calendar year are in excess of projected losses and expenses for the account attributable to that year, such excess shall be held in surplus in the account. Such surplus must ~~shall~~ be available to defray deficits in that account as to future years and ~~shall be~~ used for that purpose before ~~prior to~~ assessing assessable insurers and assessable insureds as to any calendar year.

7.~~8.~~ Must provide objective criteria and procedures to be uniformly applied to ~~for~~ all applicants in determining whether

an individual risk is so hazardous as to be uninsurable. In making this determination and in establishing the criteria and procedures, the following must ~~shall~~ be considered:

a. Whether the likelihood of a loss for the individual risk is substantially higher than for other risks of the same class; and

b. Whether the uncertainty associated with the individual risk is such that an appropriate premium cannot be determined.

The acceptance or rejection of a risk by the corporation shall be construed as the private placement of insurance, and the provisions of chapter 120 do ~~shall~~ not apply.

8.~~9.~~ ~~Must provide that the corporation~~ Shall make its best efforts to procure catastrophe reinsurance at reasonable rates, to cover its projected 100-year probable maximum loss as determined by the board of governors.

9.~~10.~~ Must issue ~~The~~ policies that ~~issued by the corporation must~~ provide that, if the corporation or the market assistance plan obtains an offer from an authorized insurer to cover the risk at its approved rates, the risk is no longer eligible for renewal through the corporation, except as otherwise provided in this subsection.

10.~~11.~~ Must ~~Corporation Policies and applications must~~ include a notice in the corporation policies and applications that the corporation policy could, under this section, be replaced with a policy issued by an authorized insurer which ~~that~~ does not provide coverage identical to the coverage provided by the corporation. The notice must ~~shall~~ also specify

that acceptance of corporation coverage creates a conclusive presumption that the applicant or policyholder is aware of this potential.

11.~~12.~~ May establish, subject to approval by the office, different eligibility requirements and operational procedures for any line or type of coverage for any specified county or area if the board determines that such changes ~~to the eligibility requirements and operational procedures~~ are justified due to the voluntary market being sufficiently stable and competitive in such area or for such line or type of coverage and that consumers who, in good faith, are unable to obtain insurance through the voluntary market through ordinary methods ~~would~~ continue to have access to coverage from the corporation. If ~~When~~ coverage is sought in connection with a real property transfer, the ~~such~~ requirements and procedures may ~~shall~~ not provide ~~for~~ an effective date of coverage later than the date of the closing of the transfer as established by the transferor, the transferee, and, if applicable, the lender.

12.~~13.~~ Must provide that, with respect to the high-risk account, any assessable insurer with a surplus as to policyholders of $25 million or less writing 25 percent or more of its total countrywide property insurance premiums in this state may petition the office, within the first 90 days of each calendar year, to qualify as a limited apportionment company. A regular assessment levied by the corporation on a limited apportionment company for a deficit incurred by the corporation for the high-risk account ~~in 2006 or thereafter~~ may be paid to the corporation on a monthly basis as the assessments are

collected by the limited apportionment company from its insureds pursuant to s. 627.3512, but the regular assessment must be paid in full within 12 months after being levied by the corporation. A limited apportionment company shall collect from its policyholders any emergency assessment imposed under sub-subparagraph (b)3.d. ~~The plan shall provide that,~~ If the office determines that any regular assessment will result in an impairment of the surplus of a limited apportionment company, the office may direct that all or part of such assessment be deferred as provided in subparagraph (q)4. However, ~~there shall be no limitation or deferment of~~ an emergency assessment to be collected from policyholders under sub-subparagraph (b)3.d. may not be limited or deferred.

13.~~14.~~ Effective January 1, 2012, must ~~provide that the corporation~~ appoint as its licensed agents only those agents who also hold an appointment as defined in s. 626.015(3) with an insurer who ~~at the time of the agent's initial appointment by the corporation~~ is authorized to write and is actually writing personal lines residential property coverage, commercial residential property coverage, or commercial nonresidential property coverage within the state.

14.~~15.~~ Must provide~~, by July 1, 2007,~~ a premium payment plan option to its policyholders which, ~~allows~~ at a minimum, allows for quarterly and semiannual payment of premiums. A monthly payment plan may~~, but is not required to,~~ be offered.

15.~~16.~~ Must limit coverage on mobile homes or manufactured homes built before ~~prior to~~ 1994 to actual cash value of the dwelling rather than replacement costs of the dwelling.

16.~~17.~~ May provide such limits of coverage as the board determines, consistent with the requirements of this subsection.

17.~~18.~~ May require commercial property to meet specified hurricane mitigation construction features as a condition of eligibility for coverage.

18. As of January 1, 2012, must require that the agent obtain from an applicant for coverage from the corporation an acknowledgement signed by the applicant, which includes, at a minimum, the following statement:

ACKNOWLEDGEMENT OF POTENTIAL SURCHARGE AND ASSESSMENT LIABILITY:

1. AS A POLICYHOLDER OF CITIZENS PROPERTY INSURANCE CORPORATION, I UNDERSTAND THAT IF THE CORPORATION SUSTAINS A DEFICIT AS A RESULT OF HURRICANE LOSSES OR FOR ANY OTHER REASON, MY POLICY COULD BE SUBJECT TO SURCHARGES, WHICH WILL BE DUE AND PAYABLE UPON RENEWAL, CANCELLATION, OR TERMINATION OF THE POLICY, AND THAT THE SURCHARGES COULD BE AS HIGH AS 45 PERCENT OF MY PREMIUM, OR A DIFFERENT AMOUNT AS IMPOSED BY THE FLORIDA LEGISLATURE.

2. I ALSO UNDERSTAND THAT I MAY BE SUBJECT TO EMERGENCY ASSESSMENTS TO THE SAME EXTENT AS POLICYHOLDERS OF OTHER INSURANCE COMPANIES, OR A DIFFERENT AMOUNT AS IMPOSED BY THE FLORIDA LEGISLATURE.

3. I ALSO UNDERSTAND THAT CITIZENS PROPERTY INSURANCE CORPORATION IS NOT SUPPORTED BY THE FULL FAITH AND CREDIT OF THE STATE OF FLORIDA.

a. The corporation shall maintain, in electronic format or otherwise, a copy of the applicant's signed acknowledgement and provide a copy of the statement to the policyholder as part of the first renewal after the effective date of this subparagraph.

b. The signed acknowledgement form creates a conclusive presumption that the policyholder understood and accepted his or her potential surcharge and assessment liability as a policyholder of the corporation.

19. Upon notice and determination by the department that an agent appointed by the corporation has violated s. 626.9541(1)(h), must immediately terminate the agent's appointment to represent the corporation.

20. Must provide that new or renewal policies issued by the corporation on or after January 1, 2012, do not include coverage for attached or detached screen enclosures. The corporation is not required to issue a notice of nonrenewal to exclude this coverage upon the renewal of current policies, but shall exclude such coverage using a notice of coverage change.

21. Must provide that new or renewal policies issued by the corporation on or after January 1, 2012, which cover sinkhole loss do not include coverage for any loss to appurtenant structures, driveways, sidewalks, decks, or patios which is caused directly or indirectly by sinkhole activity. The corporation is not required to issue a notice of nonrenewal to exclude this coverage upon the renewal of current policies, but shall exclude such coverage using a notice of coverage change which may be included with the policy renewal.

(d)1. All prospective employees for senior management

positions, as defined by the plan of operation, are subject to background checks as a prerequisite for employment. The office shall conduct the background checks ~~on such prospective employees~~ pursuant to ss. 624.34, 624.404(3), and 628.261.

2. On or before July 1 of each year, employees of the corporation must ~~are required to~~ sign and submit a statement attesting that they do not have a conflict of interest, as defined in part III of chapter 112. As a condition of employment, all prospective employees must ~~are required to~~ sign and submit to the corporation a conflict-of-interest statement.

3. Senior managers and members of the board of governors are subject to ~~the provisions of~~ part III of chapter 112, including, but not limited to, the code of ethics and public disclosure and reporting of financial interests, pursuant to s. 112.3145.

a. Senior managers and board members are also required to file such disclosures with the Commission on Ethics and the Office of Insurance Regulation. The executive director of the corporation or his or her designee shall notify each existing and newly appointed ~~and existing appointed~~ member of the board of governors and senior managers of their duty to comply with the reporting requirements of part III of chapter 112. At least quarterly, the executive director or his or her designee shall submit to the Commission on Ethics a list of names of the senior managers and members of the board of governors who are subject to the public disclosure requirements under s. 112.3145.

b. Notwithstanding s. 112.3143(2), a board member may not vote on any measure that would inure to his or her special

private gain or loss; that he or she knows would inure to the special private gain or loss of any principal by whom he or she is retained or to the parent organization or subsidiary of a corporate principal by which he or she is retained, other than an agency as defined in s. 112.312; or that he or she knows would inure to the special private gain or loss of a relative or business associate of the public officer. Before the vote is taken, such member must publicly state to the assembly the nature of his or her interest in the matter from which he or she is abstaining and, within 15 days after the vote occurs, disclose the nature of his or her interest as a public record in a memorandum filed with the person responsible for recording the minutes of the meeting, who shall incorporate the memorandum in the minutes.

4. Notwithstanding s. 112.3148 or s. 112.3149, or any other provision of law, an employee or board member may not knowingly accept, directly or indirectly, any gift or expenditure from a person or entity, or an employee or representative of such person or entity, which ~~that~~ has a contractual relationship with the corporation or who is under consideration for a contract. An employee or board member who fails to comply with subparagraph 3. or this subparagraph is subject to penalties provided under ss. 112.317 and 112.3173.

5. Any senior manager of the corporation who is employed on or after January 1, 2007, regardless of the date of hire, who subsequently retires or terminates employment is prohibited from representing another person or entity before the corporation for 2 years after retirement or termination of employment from the

corporation.

6. Any senior manager of the corporation who is employed on or after January 1, 2007, regardless of the date of hire, who subsequently retires or terminates employment is prohibited from having any employment or contractual relationship for 2 years with an insurer that has entered into a take-out bonus agreement with the corporation.

(n)~~1.~~ It is the intent of the Legislature that the rates for coverage provided by the corporation be actuarially determined and not be competitive with rates charged in the admitted voluntary market such that the corporation functions as a residual market mechanism that provides insurance only if such insurance cannot be procured in the voluntary market. To achieve this goal, for any rate filing made by the corporation on or after July 1, 2011:

1. Rates for coverage provided by the corporation shall be actuarially sound and subject to the requirements of s. 627.062, except as otherwise provided in this paragraph. The corporation shall file its recommended rates with the office at least annually. The office shall consider the recommended rates and issue a final order establishing the rates within 45 days after the recommended rates are filed. ~~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 developing its rates, the corporation shall use an appropriate industry expense equalization factor to ensure that its rates include standard industry ratemaking expense provisions. The industry expense equalization factor must include a catastrophe risk load, a provision for taxes, a market provision for reinsurance costs, and an industry expense provision for general expenses, acquisition expenses, and commissions.

3. The corporation shall implement a rate increase each year, which may not exceed 20 percent by territory and 25 percent for any single policy, excluding coverage changes and surcharges. This subparagraph expires January 1, 2015, and does not apply to rates for sinkhole coverage or costs for the purchase of private reinsurance, if any.

4.~~2.~~ In addition to the rates otherwise determined pursuant to this paragraph, the corporation shall impose and collect an amount equal to the premium tax provided for in s. 624.509 to augment the financial resources of the corporation.

~~3. After the public hurricane loss-projection model under s. 627.06281 has been found to be accurate and reliable by the Florida Commission on Hurricane Loss Projection Methodology, that model 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 which 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 shall provide refunds to policyholders who have paid higher rates as a result of that rate filing. The rates in effect on December 31, 2006, shall 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 the requirements of this paragraph.~~

~~5. Beginning on July 15, 2009, and each year thereafter, the corporation 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 implement a rate increase each year which does not exceed 10 percent for any single policy issued by the corporation, excluding coverage changes and surcharges.~~

5.~~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.~~

(o) If coverage in an account is deactivated pursuant to paragraph (p), coverage through the corporation shall be reactivated by order of the office only under one of the following circumstances:

1. If the market assistance plan receives a minimum of 100 applications for coverage within a 3-month period, or 200 applications for coverage within a 1-year period or less for residential coverage, unless the market assistance plan provides a quotation from admitted carriers at their filed rates for at least 90 percent of such applicants. A ~~Any~~ market assistance plan application that is rejected because an individual risk is so hazardous as to be uninsurable using the criteria specified in subparagraph (c)7. may ~~(c)8. shall~~ not be included in the minimum percentage calculation ~~provided herein~~. If ~~In the event that~~ there is a legal or administrative challenge to a determination by the office that the conditions of this subparagraph have been met for eligibility for coverage by ~~in~~ the corporation, an ~~any~~ eligible risk may obtain coverage during the pendency of such challenge.

2. In response to a state of emergency declared by the Governor under s. 252.36, the office may activate coverage by order during ~~for the period of~~ the emergency upon a finding by the office that the emergency significantly affects the availability of residential property insurance.

(s)1. There is ~~shall be~~ no liability on the part of, and no cause of action ~~of any nature~~ shall arise against, any assessable insurer or its agents or employees, the corporation or its agents or employees, members of the board of governors or their respective designees at a board meeting, corporation committee members, or the office or its representatives, for any action taken by them in the performance of their duties or responsibilities under this subsection.

a. As part of the immunity, the corporation, as a governmental entity serving a public purpose, is not liable for any claim for bad faith whether or not brought pursuant to s. 624.155, and this subsection or any other provision of law does not create liability or a cause of action for bad faith or a claim for extracontractual damages.

b. Such immunity does not apply to:

(I) ~~a.~~ Any of the foregoing persons or entities for any willful tort;

(II) ~~b.~~ The corporation or its producing agents for breach of any contract or agreement pertaining to insurance coverage;

(III) ~~c.~~ The corporation with respect to issuance or payment of debt;

(IV) ~~d.~~ An ~~Any~~ assessable insurer with respect to any action to enforce an assessable insurer's obligations to the corporation under this subsection; or

(V) ~~e.~~ The corporation in any pending or future action for breach of contract or for benefits under a policy issued by the corporation. ~~;~~ In any such action, the corporation is ~~shall be~~ liable to the policyholders and beneficiaries for attorney's

fees under s. 627.428.

2. The corporation shall manage its claim employees, independent adjusters, and others who handle claims to ensure they carry out the corporation's duty to its policyholders to handle claims carefully, timely, diligently, and in good faith, balanced against the corporation's duty to the state to manage its assets responsibly in order to minimize its assessment potential.

(w) Notwithstanding any other provision of law:

1. The pledge or sale of, the lien upon, and the security interest in any rights, revenues, or other assets of the corporation created or purported to be created pursuant to any financing documents to secure any bonds or other indebtedness of the corporation shall be and remain valid and enforceable, notwithstanding the commencement of and during the continuation of, and after, any rehabilitation, insolvency, liquidation, bankruptcy, receivership, conservatorship, reorganization, or similar proceeding against the corporation under the laws of this state.

2. ~~No~~ Such proceeding does not ~~shall~~ relieve the corporation of its obligation, or otherwise affect its ability to perform its obligation, to continue to collect, or levy and collect, assessments, market equalization or other surcharges ~~under subparagraph (c)10.~~, or any other rights, revenues, or other assets of the corporation pledged pursuant to any financing documents.

3. Each such pledge or sale of, lien upon, and security interest in, including the priority of such pledge, lien, or

security interest, any such assessments, market equalization or other surcharges, or other rights, revenues, or other assets which are collected, or levied and collected, after the commencement of and during the pendency of, or after, any such proceeding continues ~~shall continue~~ unaffected by such proceeding. As used in this subsection, the term "financing documents" means any agreement or agreements, instrument or instruments, or other document or documents now existing or hereafter created evidencing any bonds or other indebtedness of the corporation or pursuant to which any such bonds or other indebtedness has been or may be issued and pursuant to which any rights, revenues, or other assets of the corporation are pledged or sold to secure the repayment of such bonds or indebtedness, together with the payment of interest on such bonds or such indebtedness, or the payment of any other obligation or financial product, as defined in the plan of operation of the corporation related to such bonds or indebtedness.

4. Any such pledge or sale of assessments, revenues, contract rights, or other rights or assets of the corporation constitutes ~~shall constitute~~ a lien and security interest, or sale, as the case may be, that is immediately effective and attaches to such assessments, revenues, or contract rights or other rights or assets, whether or not imposed or collected at the time the pledge or sale is made. ~~Any~~ Such pledge or sale is effective, valid, binding, and enforceable against the corporation or other entity making such pledge or sale, and valid and binding against and superior to any competing claims or obligations owed to any other person or entity, including

policyholders in this state, asserting rights in any such assessments, revenues, or contract rights or other rights or assets to the extent set forth in and in accordance with the terms of the pledge or sale contained in the applicable financing documents, whether or not any such person or entity has notice of such pledge or sale and without the need for any physical delivery, recordation, filing, or other action.

5. If ~~As long as~~ the corporation has any bonds outstanding, the corporation may not file a voluntary petition under chapter 9 of the federal Bankruptcy Code or such corresponding chapter or sections as may be in effect, ~~from time to time,~~ and a public officer or any organization, entity, or other person may not authorize the corporation to be or become a debtor under chapter 9 of the federal Bankruptcy Code or such corresponding chapter or sections as may be in effect~~, from time to time,~~ during any such period.

6. If ordered by a court ~~of competent jurisdiction~~, the corporation may assume policies or otherwise provide coverage for policyholders of an insurer placed in liquidation under chapter 631, under such forms, rates, terms, and conditions as the corporation deems appropriate, subject to approval by the office.

(y) It is the intent of the Legislature that the amendments to this subsection enacted in 2002 should, over time, reduce the probable maximum windstorm losses in the residual markets and ~~should~~ reduce the potential assessments to be levied on property insurers and policyholders statewide. ~~In furtherance of this intent:~~

~~1. The board shall, on or before February 1 of each year, provide a report to the President of the Senate and the Speaker of the House of Representatives showing the reduction or increase in the 100-year probable maximum loss attributable to wind-only coverages and the quota share program under this subsection combined, as compared to the benchmark 100-year probable maximum loss of the Florida Windstorm Underwriting Association. For purposes of this paragraph, the benchmark 100-year probable maximum loss of the Florida Windstorm Underwriting Association shall be the calculation dated February 2001 and based on November 30, 2000, exposures. In order to ensure comparability of data, the board shall use the same methods for calculating its probable maximum loss as were used to calculate the benchmark probable maximum loss.~~

~~2. Beginning December 1, 2010, if the report under subparagraph 1. for any year indicates that the 100-year probable maximum loss attributable to wind-only coverages and the quota share program combined does not reflect a reduction of at least 25 percent from the benchmark, the board shall reduce the boundaries of the high-risk area eligible for wind-only coverages under this subsection in a manner calculated to reduce such probable maximum loss to an amount at least 25 percent below the benchmark.~~

~~3. Beginning February 1, 2015, if the report under subparagraph 1. for any year indicates that the 100-year probable maximum loss attributable to wind-only coverages and the quota share program combined does not reflect a reduction of at least 50 percent from the benchmark, the boundaries of the~~

~~high-risk area eligible for wind-only coverages under this subsection shall be reduced by the elimination of any area that is not seaward of a line 1,000 feet inland from the Intracoastal Waterway.~~

(aa) . As a condition of eligibility for coverage by the corporation, an applicant or insured of a property located in a Special Flood Hazard Area, as defined by the National Flood Insurance Program, must maintain in effect a separate flood insurance policy having coverage limits for building and contents at least equal to those provided under the corporation's policy, subject to the maximum limits available under the National Flood Insurance Program policy. This requirement does not apply to an insured who is a tenant or a condominium unit owner above the ground floor; a policy issued by the corporation which excludes wind and hail coverage; a risk that is not eligible for flood coverage under the National Flood Insurance Program; or a mobile home that is located more than 2 miles from open water, including the ocean, the gulf, a bay, a river, or the intracoastal waterway. This paragraph applies to new policies issued by the corporation on or after January 1, 2012, and to policies renewed by the corporation on or after January 1, 2013. ~~The corporation shall not require the securing of flood insurance as a condition of coverage if the insured or applicant executes a form approved by the office affirming that flood insurance is not provided by the corporation and that if flood insurance is not secured by the applicant or insured in addition to coverage by the corporation, the risk will not be covered for flood damage. A corporation policyholder electing~~

~~not to secure flood insurance and executing a form as provided herein making a claim for water damage against the corporation shall have the burden of proving the damage was not caused by flooding. Notwithstanding other provisions of this subsection, the corporation may deny coverage to an applicant or insured who refuses to execute the form described herein.~~

~~(ee) The office may establish a pilot program to offer optional sinkhole coverage in one or more counties or other territories of the corporation for the purpose of implementing s. 627.706, as amended by s. 30, chapter 2007-1, Laws of Florida. Under the pilot program, the corporation is not required to issue a notice of nonrenewal to exclude sinkhole coverage upon the renewal of existing policies, but may exclude such coverage using a notice of coverage change.~~

Section 2. Subsection (1) of section 627.712, Florida Statutes, is amended to read:

627.712 Residential windstorm coverage required; availability of exclusions for windstorm or contents.—

(1) An insurer issuing a residential property insurance policy must provide windstorm coverage. Except as provided in paragraph (2)(c), this section does not apply ~~with respect~~ to risks that are eligible for wind-only coverage from Citizens Property Insurance Corporation under s. 627.351(6), and ~~with respect~~ to risks that are not eligible for coverage from Citizens Property Insurance Corporation under s. 627.351(6)(a)3. or 4. ~~5.~~ A risk ineligible for Citizens coverage under s. 627.351(6)(a)3. or 4. ~~5.~~ is exempt from the requirements of this section only if the risk is located within the boundaries of the

high-risk account of the corporation.

Section 3. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB INBS 11-02 The Uniform Home Grading Scale
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 215.55865, F.S., enacted in 2007, requires the Financial Services Commission to adopt a uniform home grading scale consistent with the rating system required by legislation enacted in 2006. The 2006 legislation required the Office of Insurance Regulation (OIR) to develop a program to provide an objective rating system allowing homeowners to evaluate the relative ability of Florida properties to withstand the wind load from a sustained severe tropical storm or hurricane. The OIR developed the home structure rating system on March 30, 2007. In November 2007, the Financial Services Commission adopted the home structure rating system developed by the OIR as the uniform home rating scale required by s. 215.55865, F.S.

The uniform home rating scale adopted scores a homes' ability to withstand wind load from a tropical storm or hurricane on a scale of 1 to 100.

In 2008, the Legislature required use of the home grading scale in sales of homes located in the state's wind borne debris region. The 2008 legislation required sellers of homes located in this region to disclose the home's windstorm mitigation rating based on the home grading scale to buyers. The legislation established a two-part phase in for this disclosure requirement. However, the entire disclosure requirement was subsequently repealed and current law does not require use of the home grading scale in real estate transactions.

The only use of the home grading scale in current law is in s. 627.0629(1)(b), F.S. This statute requires the OIR to develop, by February 1, 2011, a method for correlating the numerical rating of a home issued pursuant to the uniform home rating scale with mitigation discount amounts. This statute also requires the Financial Services Commission to adopt rules by October 1, 2011 requiring property insurers to make a rate filing to correlate mitigation discounts to the home grading scale. The repeal of current law requiring the correlation of mitigation discounts to the home grading scale is proposed in HB 7181 filed this Session.

The bill repeals the statutory authority for the home grading scale.

The bill has no fiscal impact on state or local governments or the private sector.

The bill is effective July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Section 215.55865, F.S., enacted in 2007,[1] requires the Financial Services Commission to adopt a uniform home grading scale consistent with the rating system required by legislation enacted in 2006.[2] The 2006 legislation required the Office of Insurance Regulation (OIR) to develop a program to provide an objective rating system allowing homeowners to evaluate the relative ability of Florida properties to withstand the wind load from a sustained severe tropical storm or hurricane. In response to the 2006 legislation, the OIR created a Home Structure Rating System Advisory Board (advisory board) comprised of representatives from the:

- OIR
- Department of Community Affairs Building Codes and Standards Office;
- Department of Financial Services;
- Federal Alliance for Safe Homes;
- Florida Insurance Council;
- Florida Home Builders Association;
- Florida Manufactured Housing Association;
- Florida State University, Risk Management and Insurance, College of Business;
- Institute for Business and Homes Safety; and
- Mercedes Homes.

Faculty from the University of Florida in the following areas provided technical support to the advisory board:

- Rinker School of Building Construction, College of Design, Construction and Planning;
- Institute of Food and Agricultural Science; and
- Department of Civil Engineering, College of Engineering

The advisory board held numerous meetings in 2006 and 2007 and recommended a home structure rating system to the OIR on March 30, 2007.[3] In November 2007, the Financial Services Commission[4] adopted the home structure rating system developed by the OIR based upon recommendations by the advisory board as the uniform home rating scale required by s. 215.55865, F.S.[5]

The uniform home rating scale adopted scores a homes' ability to withstand wind load from a tropical storm or hurricane on a scale of 1 to 100. The primary factors used to calculate the home rating score include roof shape, secondary water resistance, roof cover, roof deck attachment, roof-to-wall connection, opening protection, number of stories, and roof covering type. General geographic features of wind zone location and local terrain are also used to calculate a home's score.

In 2008, the Legislature required use of the home grading scale in sales of homes located in the state's wind borne debris region.[6] The 2008 legislation required sellers of homes located in this region to disclose the home's windstorm mitigation rating based on the home grading scale to buyers.[7] The legislation established a two-part phase in for this disclosure requirement:[8]

---

[1] Section 40, Ch. 2007-1, L.O.F.
[2] Section 39, 2006-12, L.O.F.
[3] The report issued by the OIR on the home structure rating system can be found at http://www.floir.com/pdf/HSRS_Report_Package_March302007.pdf (last viewed March 21, 2011).
[4] The Financial Services Commission is comprised of the Governor and Cabinet (s. 20.121(3), F.S.).
[5] Rule 69O-167.015, F.A.C.
[6] The wind borne debris region applicable in is the one defined in s. 1609.2 of the 2006 International Building Code. A map is available of the region at http://www.dca.state.fl.us/fbc/maps/Wind_borne_MAP_081208.pdf (last viewed March 21, 2011).
[7] Section 13, Ch. 2008-66, L.O.F., created the first part of the phase-in of disclosure that was to begin January 2010, and section 15 created s. 689.262 F.S., the second part of the phase-in of disclosure that was to begin January 2011.
[8] s. 627.351(6)(a)5., F.S. (changes made by Ch. 2009-87, L.O.F. now repealed); s. 689.262, F.S. (complete statute now repealed)

- The first part of the phase-in was to begin in January 2010 and would have required sellers of homes insured by Citizens Property Insurance Corporation for $500,000 or more to disclose the home's windstorm mitigation rating. However, in 2009, before it took effect, this disclosure requirement was repealed.[9]

- The second part of the phase-in,[10] which was to begin on January 1, 2011, would have required sellers of any home in the windborne debris region to disclose the home's rating. However, in 2010, before it took effect, this disclosure requirement was repealed.[11]

Current law does not require use of the home grading scale in real estate transactions.

In 2008, legislation was also enacted[12] requiring the OIR to develop, by February 1, 2011, a method for correlating the numerical rating of a home issued pursuant to the uniform home rating scale with mitigation discount amounts. This legislation also required the Financial Services Commission to adopt rules by October 1, 2011 requiring property insurers to make a rate filing to correlate mitigation discounts to the home grading scale. The repeal of current law requiring the correlation of mitigation discounts to the home grading scale is proposed in HB 7181 filed this Session.

The bill repeals the statutory authority for the home grading scale.

B. SECTION DIRECTORY:

Section 1: Repeals s. 215.55865, F.S., relating to the uniform home grading scale.

Section 2: Provides an effective date of July 1, 2011.

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:

None.

[9] Ch. 2009-87, L.O.F., s.10 removed ("repealed") the first part of the phase-in of disclosure from s. 627.351(6)(a)5., F.S.
[10] s. 689.262, F.S.
[11] Ch. 2010-275, L.O.F.
[12] Section 12, Ch. 2008-66, L.O.F., creating s. 627.0629(1)(b), F.S.

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:

The statute repealed requires the Financial Services Commission to adopt the uniform home grading scale by rule.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the uniform home grading scale; repealing s. 215.55865, F.S., repealing the requirement to adopt a uniform home grading scale; repealing rulemaking requirements relating to the uniform home grading scale; providing an effective date.

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

Section 1. Section 215.55865, Florida Statutes, is repealed.

Section 2. This act shall take effect July 1, 2011.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB INBS 11-03 Repeal of a Workers' Compensation Reporting Requirement
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Reilly	Cooper

SUMMARY ANALYSIS

Section 440.59, F.S., requires the Division of Workers' Compensation (DWC) to prepare an annual report, which is to be distributed by the following September 15th to the Governor and the Legislature. The report must provide information on the Workers' Compensation Administration Trust Fund, the causes of accidents leading to workplace injuries covered by the Workers' Compensation Law, and recommendations of the DWC. The DWC also includes information that is not mandated by statute. An annual report that is published on September 15th contains data (on the previous calendar year) that are nearly nine months old.

The bill repeals s. 440.59, F.S., repealing the requirement for an annual report on worker's compensation. The DWC estimates that 2,223 work hours are spent preparing and producing each year's annual report, and advises that the information in the report would remain available upon request if the annual report were discontinued.

The bill is effective July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Workers' Compensation Annual Report

Section 440.59, F.S., requires the Division of Workers' Compensation (DWC) to prepare an annual report, which is to be distributed by the following September 15th to the Governor and the Legislature. The report is also made available online. The report provides information on the Workers' Compensation Administration Trust Fund, the causes of accidents leading to workplace injuries covered by the Workers' Compensation Law, chapter 440, F.S., and recommendations of the DWC. The DWC also includes information that is not mandated by statute. An annual report that is published on September 15th contains data (on the previous calendar year) that are nearly nine months old. The DWC estimates that 2,223 work hours are spent preparing and producing each year's annual report.[1]

Effect of the Bill

The bill repeals s. 440.59, F.S., which requires the DWC to publish an annual report. The DWC advises that if the bill were enacted into law, the information currently provided in the annual report would remain available to the Legislature upon request.

The bill is effective July 1, 2011.

B. SECTION DIRECTORY:

Section 1: Repeals s. 440.59, F.S., providing for an annual report on workers' compensation.

Section 2: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Enactment of the bill would result in annual savings of 2,223 work hours by DWC employees and over $1,400 in printing costs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[1] Correspondence from the Division of Workers' Compensation on file with staff of the Insurance & Banking Subcommittee.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

To the extent that the time DWC employees currently spend on the annual report could be used more productively and allow employees to assume additional responsibilities, it is likely that the bill will result in cost savings to the DWC.

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.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to repeal of a workers' compensation reporting requirement; repealing s.440.59, F.S.; repealing a provision requiring an annual report; providing an effective date.

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

Section 1. Section 440.59, Florida Statutes, is repealed.

Section 2. This act shall take effect July 1, 2011.