Insurance & Banking Subcommittee

Tuesday, March 11, 2014
9:30 AM
Sumner Hall (404 HOB)

MEETING PACKET

Will Weatherford
Speaker

Bryan Nelson
Chair

The Florida House of Representatives

Regulatory Affairs Committee

Insurance & Banking Subcommittee

Will Weatherford
Speaker

Bryan Nelson
Chair

AGENDA

Tuesday, March 11, 2014
404 HOB
9:30 am – 11:30 am

I. Call to Order

II. Roll Call

III. Consideration of the following bill(s):

a. HB 785 Workers' Compensation by Albritton
b. HB 1007 Workers' Compensation by Hood
c. HB 7045 OGSR/Florida Guaranty Association by Government Operations Subcommittee, Cummings
d. PCS for HB 743 Property Insurance by Insurance & Banking Subcommittee

IV. Adjournment

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

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Insurance & Banking Subcommittee

Start Date and Time:	Tuesday, March 11, 2014 09:30 am
End Date and Time:	Tuesday, March 11, 2014 11:30 am
Location:	Sumner Hall (404 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 785 Workers' Compensation by Albritton

HB 1007 Workers' Compensation by Hood

HB 7045 OGSR/Florida Insurance Guaranty Association by Government Operations Subcommittee, Cummings

Consideration of the following proposed committee substitute(s):

PCS for HB 743 -- Property Insurance

Pursuant to rule 7.12, the filing deadline for amendments to bills on the agenda by a member who is not a member of the committee or subcommittee considering the bill is 6:00 p.m., Monday, March 10, 2014.

By request of the Chair, all Insurance & Banking Subcommittee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Monday, March 10, 2014.

NOTICE FINALIZED on 03/07/2014 16:26 by McCloskey.Michele

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 785 Workers' Compensation
SPONSOR(S): Albritton
TIED BILLS: **IDEN./SIM. BILLS:** SB 952

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

SUMMARY ANALYSIS

Workers' compensation premiums are based on the employer's payroll, the type of work performed by its employees (roofers, clerical, etc., each with a classification code to which a specific premium rate applies), and the employer's loss experience (as reflected in an experience modification factor). Generally, premiums are paid up-front to provide coverage for the policy period. At the end of the policy, the insurer conducts an audit to ensure that the appropriate premium has been paid. If the actual payroll is less than that initially estimated, the employer will receive a refund. If the actual payroll exceeds the initial estimation, the employer must pay an additional amount to the insurer.

Retrospective rating plans are utilized by large, sophisticated employers to decrease workers' compensation premiums. Briefly, the final premium paid by the employer is based on the employer's actual loss experience during the policy period, plus insurer expenses and an insurance charge. If the employer controls the amount of claims during the policy period, it will pay a lower premium. Retrospective rating plans allow for negotiations between an insurer and employer on various factors, e.g., negotiations on what maximum and minimum premium factors to use. These plans provide for a minimum premium and a maximum premium.

The bill permits a retrospective rating plan to contain a provision for negotiation of a workers' compensation premium between an employer and insurer if the employer has: (1) exposure in more than one state; (2) an estimated annual standard workers' compensation premium in Florida of at least $175,000; and (3) an estimated annual countrywide standard workers' compensation premium of at least $1 million.

To the extent that the bill decreases workers' compensation premiums for large employers, it will decrease the amount of insurer assessments paid to the Workers' Compensation Administration Trust Fund and Workers' Compensation Special Disability Trust Fund. The bill has no fiscal impact on local government.

The bill is effective July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Workers' Compensation Premiums
Workers' compensation premiums are based on the employer's payroll, the type of work performed by its employees (roofers, clerical, etc., each with a classification code to which a specific premium rate applies), and the employer's loss experience (as reflected in an experience modification factor). Generally, premiums are paid up-front to provide coverage for the policy period. At the end of the policy, the insurer conducts an audit to ensure that the appropriate premium has been paid. If the actual payroll is less than that initially estimated, the employer will receive a refund. If the actual payroll exceeds the initial estimation, the employer must pay an additional amount to the insurer.

Retrospective Rating Plans
Retrospective rating plans are utilized by large, sophisticated employers to decrease workers' compensation premiums. Briefly, the final premium paid by the employer is based on actual loss experience during the policy period, plus insurer expenses and an insurance charge. If the employer controls the amount of claims during the policy period, it will pay a lower premium. Before there were large deductible programs in workers' compensation, retrospective rating plans were the dominant rating plan for large employers.[1]

The Office of Insurance Regulation (OIR) relates that retrospective rating has been a component of workers' compensation for over 50 years in Florida and nationwide. Retrospective rating plans allow for negotiations between an insurer and employer on various factors, e.g., negotiations on what maximum and minimum premium factors to use. Limitations in the National Council on Compensation Insurance's (NCCI) "Retrospective Rating Plan Manual for Workers' Compensation and Employers Liability Insurance," which has been approved in Florida, are designed to ensure that the calculations always result in an actuarially sound premium.[2]

The bill permits retrospective rating plans to contain a provision for negotiation of a workers' compensation premium between an employer and insurer if the employer has: (1) exposure in more than one state; (2) an estimated annual standard workers' compensation premium in Florida of at least $175,000; and (3) an estimated annual countrywide standard workers' compensation premium of at least $1 million.

B. SECTION DIRECTORY:

Section 1. Amends s. 627.072, F.S., relating to the making and use of workers' compensation rates.
Section 2. Amends s. 627.281, F.S., relating to appeals from workers' compensation and employer's liability rate filings.
Section 3. Provides an effective date of July 1, 2014.

[1] See "2013 Workers' Compensation Annual Report" (December 31, 2013) by the Florida Office of Insurance Regulation. Available at: http://www.floir.com/Office/DataReports.aspx (Last accessed: March 8, 2014).
[2] Correspondence from OIR dated February 27, 2014, on file with the Insurance & Banking Subcommittee. OIR informs that in the early 1990s, NCCI filed the Large Risk Alternative Rating Option (LRARO) in Florida, which was disapproved by the Department of Insurance (the predecessor of the OIR). LRARO is a modification of the retrospective rating plan that removes the limitations on rating factors. The concern with such plans is that premiums may not be sufficient to cover expected losses and expenses. LRARO plans are available in many other states.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   To the extent that the bill decreases workers' compensation premiums for large employers, it will decrease insurer assessments paid to the Workers' Compensation Administration Trust Fund and Worker's Compensation Special Disability Trust Fund.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that the bill allows large employers and insurers to negotiate workers' compensation insurance premiums beyond the negotiations already allowed in current retrospective rating plans, the premiums paid by large employers under such plans may decrease. However, in certain circumstances, negotiations could lead to a premium that is not sufficient to cover expected losses and expenses.

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.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to workers' compensation; amending s. 627.072, F.S.; authorizing employers to negotiate the retrospectively rated premium with insurers under certain conditions; amending s. 627.281, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Subsections (2), (3), and (4) of section 627.072, Florida Statutes, are renumbered as subsections (3), (4), and (5), respectively, and subsection (2) is added to that section, to read:

627.072 Making and use of rates.—

(2) A retrospective rating plan may contain a provision that allows for negotiation of a premium between the employer and the insurer for employers having exposure in more than one state and an estimated annual standard premium in this state of $175,000 and an estimated annual countrywide standard premium of $1 million or more for workers' compensation.

Section 2. Subsection (2) of section 627.281, Florida Statutes, is amended to read:

627.281 Appeal from rating organization; workers' compensation and employer's liability insurance filings.—

(2) If such appeal is based upon the failure of the rating

organization to make a filing on behalf of such member or subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in s. 627.072(3) ~~627.072(2)~~, from the system of expense provisions included in a filing made by the rating organization, the office shall, if it grants the appeal, order the rating organization to make the requested filing for use by the appellant. In deciding such appeal, the office shall apply the applicable standards set forth in ss. 627.062 and 627.072.

Section 3. This act shall take effect July 1, 2014.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1007 Workers' Compensation
SPONSOR(S): Hood, Jr.
TIED BILLS: **IDEN./SIM. BILLS:** SB 1214

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

SUMMARY ANALYSIS

The bill makes various changes to Florida's workers' compensation law, including the following:

- Clarifies that all pre-existing conditions, both work-related and non-work-related, are to be considered in determining whether the workplace injury is the "major contributing cause" (more than 50 percent responsible) for the treatment or benefits being sought. Similarly, as employers or insurers are responsible only for medical treatment associated with a workplace injury, all pre-existing conditions are to be considered and the percentage of medical care attributable to those conditions apportioned out from the liability of the employer or insurer.
- Requires insurers to respond to an employee's written request to change to a new physician within 5 *business* days. At present, insurers are required to respond within 5 days.
- Authorizes permanent total disability (PTD) benefits to be paid at either 66 2/3 or 66.67 percent of the employee's average weekly week. Currently, PTD benefits are payable at 66 2/3 percent. The amendment addresses a court decision regarding the calculation of PTD benefits.
- Specifies that PTD benefits cannot be awarded if the authorized physician believes the employee can perform light-duty work.
- Limits circumstances under which the advance payment of compensation may be ordered or approved by a Judge of Compensation Claims to cases in which the injury is compensable (covered by workers' compensation). Prohibits an advance when the employer or insurer denies compensability. Provides a repayment formula when advance payments are made by self-insured employers.
- Authorizes the employer or insurer, when certain controlled substances are prescribed, to require the prescribing physician to meet with and evaluate the injured employee at medically reasonable intervals to determine levels of each controlled substance in the employee's system.
- Requires employers with a drug-free workplace program to conduct post-accident drug testing, which employees must submit to immediately after receiving initial treatment for their injury. Creates rebuttable presumption that the injury was primarily occasioned by drug use if the employee refuses to submit to testing.
- Provides that employers who are in compliance with material provisions of drug-free workplace program requirements, but are not in compliance with every non-material provision, cannot be precluded from using positive test results to deny benefits, unless the non-compliance affects the validity of the test results.
- Requires health care providers and medical entities, at the request of an employer who does not have a drug-free workplace program or its insurer, to collect bodily samples for drug or alcohol testing. Requires the employer or insurer to pay all associated costs, regardless of the test results.

The bill has no fiscal impact on state or local government. The National Council on Compensation Insurance (NCCI) has indicated that the bill will likely result in some cost savings, partially offset by increased frictional costs. However, NCCI is unable to explicitly quantify the impact on overall workers' compensation costs that may result from the bill.

The bill is effective July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Chapter 440, F.S., is Florida's workers' compensation law, Whether an employer is required to have workers' compensation insurance depends upon the employer's industry (construction, non-construction, or agricultural) and the number of employees. Construction industry employers with 1 or more employees are required to have workers' compensation insurance.[1] Non-construction industry employers with 4 or more employees are required to have workers' compensation insurance. Agricultural employers with more than 5 regular employees and 12 or more employees at one time for seasonal agricultural labor who work more than 30 days are required to have workers' compensation insurance.[2]

Workers' Compensation Rates and Statistical Information

The National Council on Compensation Insurance (NCCI) is the designated statistical agent and rating organization for workers' compensation insurance in Florida. NCCI's responsibilities include collecting and analyzing data from workers' compensation insurers conducting business in Florida and submitting rate filings to the Office of Insurance Regulation. NCCI is often asked by the Florida Legislature to provide cost impacts of pending legislation to the Florida's workers' compensation system.

Workers' Compensation Benefits

For work-related injuries sustained by employees, workers' compensation provides:

- Medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, including medicines, medical supplies, durable medical equipment and prosthetics.[3]
- Compensation (indemnity benefits) for disability when the injury causes the employee to miss more than 7 days of work.[4] Indemnity benefits are discussed in more detail below.

To be eligible for workers' compensation benefits, the workplace injury must arise out of the course and scope of employment and be, and remain, the "major contributing cause" of any resulting injuries for which treatment or benefits are sought. Major contributing cause is defined as the cause which is more than 50 percent responsible for the injury as compared to all other causes combined for which treatment or benefits are sought.[5] The bill clarifies that all pre-existing diseases or conditions, both work-related and non-work-related, are to be considered in determining major contributing cause. NCCI is unable to quantify the savings associated with this provision.[6]

When an employee with a preexisting condition or disease suffers a compensable injury, the employer or insurer is responsible only for medical treatment associated with the compensable injury, excluding any preexisting conditions. In other words, the need for any medical care attributable to pre-existing conditions is "apportioned" out from that attributable to the workplace injury. The bill clarifies that all pre-existing diseases or conditions, both work-related and non-work-related, are to be considered in determining the percentage of medical treatment attributable to the compensable injury, and for which the employer or insurer is responsible. NCCI is unable to quantify the savings associated with this provision.[7]

Under the workers' compensation law, health care providers must be authorized by the insurer before providing treatment, except for emergency services. However, injured employees are entitled to one

[1] Section 440.02(17)(b)2, F.S.
[2] Section 440.02(17)(c)2, F.S.
[3] Section 440.13(2)(a), F.S.
[4] Section 440.12(1), F.S.
[5] Section 440.09(1), F.S.
[6] Correspondence from NCCI dated March 4, 2014, on file with the Insurance and Banking Subcommittee.
[7] *Id.*

change of physician. If the insurer does not authorize a new physician within 5 days after receiving the employee's written request, the employee is authorized to select the treating physician. The bill amends current law by providing that insurers have 5 *business* days to respond to an employee's written request to change physicians. NCCI estimates that this change would have a negligible impact on overall workers' compensation system costs.[8]

Workers' compensation indemnity benefits are payable to employees who miss at least 8 days of work due to a covered (compensable) injury. However, the benefits are payable retroactively from the first day of disability (to include compensation for the first 7 days missed) to employees who miss more than 21 days of work due to a compensable injury.[9] In most cases, indemnity benefits are payable at 66 2/3 percent of the employee's average weekly wage (AWW) up to the maximum weekly benefit for the year of injury. For example, s. 440.15(1)(a), F.S., provides for permanent total disability benefits to be paid at 66 2/3 percent of the employee's AWW up to the maximum weekly benefit established by the workers' compensation law.[10]

In *Escambia County School District v. Vickery-Orso*,[11] the employer calculated the compensation rate for an employee with a permanent total disability by multiplying the AWW by .66667. This resulted in the employer paying more than 66 2/3 percent of the AWW (a weekly benefit of $529.48 rather than $529.47, when rounded to cents). The Judge of Compensation Claims (JCC), however, determined that the appropriate multiplier was .6667 (AWW x .6667), which resulted in a weekly benefit of $529.50. The JCC ordered the employer to pay this benefit amount and awarded associated penalties, interest, costs, and fees to the employee. On appeal, the First District Court of Appeal held that the JCC erred in requiring the employer to pay a greater benefit because the employer had not paid less than the compensation rate (66 2/3 percent of the AWW) required by statute.

With respect to permanent total disability benefits, the bill addresses the *Escambia* decision by authorizing employers to pay compensation at either 66 2/3 percent or 66.67 percent of the AWW. The latter calculation produces a slightly higher compensation rate for injured employees and removes the need for employers/carriers that have been paying permanent total disability benefits at 66.67 percent to incur reprogramming costs.

Permanent Total Disability

As noted earlier, medically necessary treatment, care, and attendance is provided under the workers' compensation law for such period as the nature of the injury or the process of recovery may require. In cases in which the workplace injury results in permanent total disability (PTD), [12] monetary benefits are payable during the continuance of the total disability.[13] Section 440.15(1)(a), F.S., bars the payment of PTD benefits to employees engaged in, or physically capable of engaging in, at least sedentary employment.

The bill clarifies eligibility for PTD benefits by specifying that such benefits cannot be awarded if, in the opinion of the authorized physician, the employee is able to perform light-duty work. Employees, however, may contest their release to light-duty work. NCCI is unable to quantify the potential savings that might result from this change.[14]

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[8] *Id.*

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

[10] The maximum weekly compensation rate for work-related injuries and illnesses occurring on or after January 1, 2014 is $827.00. See Informational Bulletin DFS-03-2013 (December 19, 2013). Available at: http:www.myfloridacfo.com/division/wc/pdf/DFS-03-2013.pdf (Last accessed: March 7, 2014).

[11] 109 So.3d 1242 (2013).

[12] The employee can be adjudged to be permanently and totally disabled or presumed to be permanently and totally disabled. Section 440.15(1)(b), F.S., lists injuries that are presumed to result in PTD. The list includes a spinal cord injury involving severe paralysis of an arm, leg, or the trunk; amputation of an arm, hand, foot, or leg involving the effective loss of use of that appendage; and severe brain or closed-head injury under certain conditions. In all other cases, to obtain PTD benefits, the employee must establish that she/he is not able to engage in sedentary employment, within 50 miles of the employee's residence, due to her/his physical limitation.

[13] Entitlement to PTD benefits cease when an employee reaches age 75, unless the compensable injury has prevented the employee from working sufficient quarters to qualify for social security benefits. Additionally, employees who are injured on or after the age of 70 will receive PTD benefits during the continuance of the permanent total disability for up to 5 years.

[14] NCCI correspondence, *supra* note 6.

Advance Payment of Benefits

Section 440.20(12), F.S., permits JCCs to approve (informally by letter, without a hearing) or order (after a hearing) an advance payment of compensation of up to $2,000 to an injured employee.[15] The bill provides that advance payments of compensation may be approved or ordered only when the employee has suffered a compensable injury, and precludes an advance when the employer or insurer denies compensability. The bill also provides a formula for repaying any advance payments made by self-insured employers. Specifically, the self-insured employer is authorized to deduct 20 percent of the injured employee's wages until the advance is repaid in full. NCCI informs that it does not collect the data to objectively quantify the cost impact of this change, but estimates that the overall impact on system costs would be negligible.[16]

The Controlled Substances Act[17]

Under federal law, drugs, substances and certain chemicals (collectively referred to as "drugs" in the following) are classified into five distinct schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential:

- Schedule I drugs currently have no accepted medical use in the United States.
- Schedule II drugs have a high potential for abuse, but less abuse potential than Schedule I drugs, and may lead to severe psychological or physical dependence. These drugs include oxycodone, cocaine, and methamphetamine.
- Schedule III drugs have less potential for abuse than drugs in Schedules I or II and have a moderate to low potential for physical and psychological dependence. Schedule III narcotics include combination products containing less than 15 milligrams of hydrocodone per dosage unit and products containing less than 90 milligrams of codeine per dosage unit.
- Schedule IV drugs have low potential for abuse and low risk of dependence.
- Schedule V drugs have a lower potential for abuse than Schedule IV drugs and consist of preparations containing limited quantities of certain narcotics.

To ensure that Schedule II, Schedule III, or Schedule IV drugs are being taken by injured employees as prescribed, the bill authorizes the employer or insurer to require the prescribing physician to meet with and evaluate the injured employee at medically reasonable intervals to determine the level of each controlled substance in the employee's system. Such evaluation may include testing of blood or urine. NCCI is unable to quantify the potential savings resulting from this provision due to the uncertainty regarding the number of claims that would be affected and the reduction to claim costs.[18]

Drug-Free Workplace Program

Employers that implement a drug-free workplace (DFW) program in accordance with the criteria set forth in s. 440.102, F.S., may be eligible for a 5 percent discount on their workers' compensation insurance premium.

Employers with a DFW program must conduct the following types of drug tests:[19]

- Job application drug testing.
- Reasonable-suspicion drug testing.
- Routine fitness-for-duty drug testing.
- Followup drug testing.

The bill adds post-accident drug testing to the list of required drug tests. Employees must submit to post-accident testing immediately after receiving initial treatment for their injury. The refusal to submit to such testing, absent clear and convincing evidence to the contrary. creates a presumption that the injury was occasioned primarily by the employee's drug use. The presumption may be rebutted by evidence that there is no reasonable hypothesis that the drug influence contributed to the injury. NCCI

[15] The parties may also stipulate to an advance payment of compensation.
[16] NCCI correspondence, *supra* note 6.
[17] For information on the Federal Controlled Substances Act, see the United States Drug Enforcement website, http://www.justice.gov/dea/druginfo/ds.shtml (Last accessed: March 7, 2014).
[18] NCCI correspondence, *supra* note 6.
[19] Section 440.102(4), F.S.

notes that to the extent that DFW employers already regularly conduct post-accident drug testing immediately after the initial treatment, no change in system costs would be expected. It also states that for DFW employers that do not currently regularly require such testing, the bill could potentially decrease the number of claims that are eligible for workers' compensation benefits. Accordingly, NCCI states that the potential impact of this provision on system costs is unknown.[20]

Under current law, one time only and prior to testing, an employer with a DFW program must give each employee and job applicant a written policy statement with specific information, including a general statement of the employer's policy on employee drug use; a general statement concerning confidentiality; the consequences of refusing to submit to a drug test; and a list of all drugs for which the employer will test, described by brand name or common name, as well as by chemical name.[21]

Section 440.102(5), F.S., lists procedures governing specimen collection and testing for drugs, including:

- Samples must be collected with due regard to an individual's privacy and in a manner reasonably calculated to prevent sample substitution or contamination.
- Specimen collection must be documented.
- Specimen collection, storage, and transportation to the testing site must be performed to reasonably preclude contamination or adulteration.
- Confirmation tests must be conducted by a licensed or certified laboratory.
- Persons collecting or taking a specimen for a drug test must collect enough for two drug tests.
- Every specimen producing a positive, confirmed test result must be preserved for at least 210 days.

Employers must deny workers' compensation benefits to employees with a confirmed, positive test result. However, all medical care provided before the denial must be paid by the insurer or self-insured employer.[22]

The bill provides that employers who are in compliance with material[23] provisions of the DFW statute, but who are not in compliance with every non-material requirement, cannot be prevented from using positive test results to deny benefits, unless the non-compliance affects the validity of the test results.

Pursuant to s. 440.09(7), F.S., employers that do not have a DFW program, but have a reasonable suspicion that a workplace injury was primarily occasioned by an employee's intoxication (by drugs or alcohol), may require the employee to submit to testing for any drugs or alcohol. In such circumstances, the bill requires medical providers and entities, at the request of the employer or insurer, to collect bodily samples, including blood or urine, for drug and alcohol testing. Medical providers are required to retain all samples, follow chain-of-custody requirements, and release the samples to a licensed laboratory for testing. The bill requires the employer or insurer to pay all associated costs, regardless of the test results. NCCI anticipates that this provision would result in a negligible impact on overall workers' compensation system costs.[24]

B. SECTION DIRECTORY:

Section. 1. Amends s. 440.09, F.S., relating to workers' compensation coverage.
Section 2. Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
Section 3. Amends s. 440.13, F.S., relating to medical services and supplies.
Section 4. Amends s. 440.15, F.S., relating to compensation for disability.
Section 5. Amends s. 440.20 F.S., relating to time for payment of compensation and medical bills.
Section 6. Provides an effective date of July 1, 2014.

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[20] NCCI correspondence, *supra* note 6.
[21] Section 440.102(3), F.S.
[22] Section 440.102(5) (p), F.S.
[23] Although the term "material" is not defined in the bill, *Black's Law Dictionary* (9th ed., 2009) defines the term in part to mean "Having some logical connection with the consequential facts. Of such a nature that knowledge of the item would affect a person's decision-making; significant; essential."
[24] NCCI correspondence, *supra* note 6.

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.

D. FISCAL COMMENTS:

NCCI states that the bill will likely result in some cost savings, which would be partially offset by increased frictional costs. However, it is unable to explicitly quantify the impact of overall workers' compensation system costs that may result from the bill.[25] NCCI pricings as to specific provisions of the bill are contained throughout the bill analysis.

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:

The DFS informs that payment for some of the "related medical costs" for reasonable suspicion drug testing provided by the bill may not be contained in the Workers' Compensation Health Care Provider Reimbursement Manual.

[25] NCCI correspondence, *supra* note 6.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to workers' compensation; amending s. 440.09, F.S.; clarifying factors to be considered in determining major contributing cause; authorizing the collection and testing of blood and urine samples upon employer or carrier request; providing for payment of resulting medical bills regardless of test results; amending s. 440.102, F.S.; providing for post-accident drug testing; authorizing use of drug test results by an employer who complies with material provisions of drug-free workplace requirements; amending s. 440.13, F.S.; revising the period within which a carrier must authorize an alternative physician; revising requirements related to treatment reassessment when certain controlled substances are prescribed; amending s. 440.15, F.S.; providing that permanent total disability benefits shall not be awarded if an employee is capable of performing light-duty work; providing that all preexisting conditions and injuries are subject to apportionment; amending s. 440.20, F.S.; authorizing the advance payment of compensation only for compensable injuries; providing a methodology for the repayment of advances made by self-insured employers; providing an effective date.

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

Section 1. Paragraph (b) of subsection (1) and paragraph (a) of subsection (7) of section 440.09, Florida Statutes, are amended to read:

440.09 Coverage.—

(1) The employer must pay compensation or furnish benefits required by this chapter if the employee suffers an accidental compensable injury or death arising out of work performed in the course and the scope of employment. The injury, its occupational cause, and any resulting manifestations or disability must be established to a reasonable degree of medical certainty, based on objective relevant medical findings, and the accidental compensable injury must be the major contributing cause of any resulting injuries. For purposes of this section, "major contributing cause" means the cause which is more than 50 percent responsible for the injury as compared to all other causes combined for which treatment or benefits are sought. In cases involving occupational disease or repetitive exposure, both causation and sufficient exposure to support causation must be proven by clear and convincing evidence. Pain or other subjective complaints alone, in the absence of objective relevant medical findings, are not compensable. For purposes of this section, "objective relevant medical findings" are those objective findings that correlate to the subjective complaints of the injured employee and are confirmed by physical examination findings or diagnostic testing. Establishment of the

causal relationship between a compensable accident and injuries for conditions that are not readily observable must be by medical evidence only, as demonstrated by physical examination findings or diagnostic testing. Major contributing cause must be demonstrated by medical evidence only.

(b) If an injury arising out of and in the course of employment combines with a preexisting disease or condition to cause or prolong disability or need for treatment, the employer must pay compensation or benefits required by this chapter only to the extent that the injury arising out of and in the course of employment is and remains more than 50 percent responsible for the injury as compared to all other causes combined and thereafter remains the major contributing cause of the disability or need for treatment. Major contributing cause must be demonstrated by medical evidence only. A preexisting disease or condition is not limited to work-related injuries and conditions, and all preexisting diseases and conditions may be considered in the determination of major contributing cause.

(7)(a) To ensure that the workplace is a drug-free environment and to deter the use of drugs and alcohol at the workplace, if the employer has reason to suspect that the injury was occasioned primarily by the intoxication of the employee or by the use of any drug, as defined in this chapter, which affected the employee to the extent that the employee's normal faculties were impaired, and the employer has not implemented a drug-free workplace pursuant to ss. 440.101 and 440.102, the

employer may require the employee to submit to a test for the presence of any or all drugs or alcohol in his or her system. Upon request of the employer or carrier, a hospital, medical clinic, physician, or other medical provider licensed and authorized to collect bodily samples, including blood or urine, shall collect blood or urine samples, retain all samples, follow chain-of-custody requirements, retain laboratory reports, and release the samples to a licensed laboratory for subsequent testing following all work-related injuries. The cost of collecting and testing the samples and related medical costs must be paid by the employer or carrier, regardless of the test results, in accordance with the provisions of this chapter governing the payment of medical bills.

Section 2. Paragraph (a) of subsection (4) of section 440.102, Florida Statutes, is amended, subsections (13), (14), and (15) of that section are renumbered as subsections (14), (15), and (16), respectively, and a new subsection (13) is added to that section, to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(4) TYPES OF TESTING.—

(a) An employer is required to conduct the following types of drug tests:

1. Job applicant drug testing.—An employer must require

job applicants to submit to a drug test and may use a refusal to submit to a drug test or a positive confirmed drug test as a basis for refusing to hire a job applicant.

2. Reasonable-suspicion drug testing.—An employer must require an employee to submit to reasonable-suspicion drug testing.

3. Routine fitness-for-duty drug testing.—An employer must require an employee to submit to a drug test if the test is conducted as part of a routinely scheduled employee fitness-for-duty medical examination that is part of the employer's established policy or that is scheduled routinely for all members of an employment classification or group.

4. Followup drug testing.—If the employee in the course of employment enters an employee assistance program for drug-related problems, or a drug rehabilitation program, the employer must require the employee to submit to a drug test as a followup to such program, unless the employee voluntarily entered the program. In those cases, the employer has the option to not require followup testing. If followup testing is required, it must be conducted at least once a year for a 2-year period after completion of the program. Advance notice of a followup testing date must not be given to the employee to be tested.

5. Post-accident drug testing.—An employee who sustains or reports a work-related injury shall submit to drug testing immediately after receiving initial treatment for the injury. If the injured employee refuses to submit to testing, it shall be

presumed, in the absence of clear and convincing evidence to the contrary, that the injury was occasioned primarily by the influence of drugs. This presumption may be rebutted only by evidence that there is no reasonable hypothesis that the drug influence contributed to the injury.

(13) COMPLIANCE WITH MATERIAL PROVISIONS.—An employer who is in compliance with the material provisions of this section but is not in compliance with every nonmaterial provision may not be precluded from using positive test results to deny benefits unless the noncompliance affects the validity of the test results obtained.

Section 3. Paragraph (f) of subsection (2) and paragraph (c) of subsection (15) of section 440.13, Florida Statutes, are amended to read:

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

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—

(f) Upon the written request of the employee, the carrier shall give the employee the opportunity for one change of physician during the course of treatment for any one accident. Upon the granting of a change of physician, the originally authorized physician in the same specialty as the changed physician shall become deauthorized upon written notification by the employer or carrier. The carrier shall authorize an alternative physician who shall not be professionally affiliated with the previous physician within 5 business days after receipt

of the request. If the carrier fails to provide a change of physician as requested by the employee, the employee may select the physician and such physician shall be considered authorized if the treatment being provided is compensable and medically necessary.

Failure of the carrier to timely comply with this subsection shall be a violation of this chapter and the carrier shall be subject to penalties as provided for in s. 440.525.

(15) STANDARDS OF CARE.—The following standards of care shall be followed in providing medical care under this chapter:

(c) Reasonable necessary medical care of injured employees shall in all situations:

1. Utilize a high intensity, short duration treatment approach that focuses on early activation and restoration of function whenever possible.

2. Include reassessment of the treatment plans, regimes, therapies, prescriptions, and functional limitations or restrictions prescribed by the provider every 30 days. <u>If a controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03 is prescribed, the employer or carrier may require the prescribing physician to meet with and evaluate the injured worker at medically reasonable intervals to determine the level of each controlled substance in the injured worker's system. Such evaluation may include testing of blood or urine.</u>

3. Be focused on treatment of the individual employee's specific clinical dysfunction or status and shall not be based upon nondescript diagnostic labels.

All treatment shall be inherently scientifically logical, and the evaluation or treatment procedure must match the documented physiologic and clinical problem. Treatment shall match the type, intensity, and duration of service required by the problem identified.

Section 4. Paragraphs (a) and (b) of subsection (1) and paragraph (b) of subsection (5) of section 440.15, Florida Statutes, are amended to read:

440.15 Compensation for disability.—Compensation for disability shall be paid to the employee, subject to the limits provided in s. 440.12(2), as follows:

(1) PERMANENT TOTAL DISABILITY.—

(a) In case of total disability adjudged to be permanent, 66 2/3 or 66.67 percent of the average weekly wages shall be paid to the employee during the continuance of such total disability. ~~No~~ Compensation is not ~~shall be~~ payable under this section if the employee is engaged in, or is physically capable of engaging in, at least sedentary employment. Permanent total disability benefits shall not be awarded if, in the opinion of the authorized physicians, the employee is able to perform light-duty work. However, an employee is not precluded from contesting her or his release to light-duty work.

(b) In the following cases, an injured employee is presumed to be permanently and totally disabled unless the employer or carrier establishes that the employee is physically capable of engaging in at least sedentary employment within a 50-mile radius of the employee's residence:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;

2. Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;

3. Severe brain or closed-head injury as evidenced by:

a. Severe sensory or motor disturbances;

b. Severe communication disturbances;

c. Severe complex integrated disturbances of cerebral function;

d. Severe episodic neurological disorders; or

e. Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in sub-subparagraphs a.-d.;

4. Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands; or

5. Total or industrial blindness.

In all other cases, in order to obtain permanent total disability benefits, the employee must establish that he or she is not able to engage in at least sedentary employment, within a

50-mile radius of the employee's residence, due to his or her physical limitation. Permanent total disability benefits shall not be awarded if, in the opinion of the authorized physicians, the employee is able to perform light-duty work. However, an employee is not precluded from contesting her or his release to light-duty work. Entitlement to such benefits shall cease when the employee reaches age 75, unless the employee is not eligible for social security benefits under 42 U.S.C. s. 402 or s. 423 because the employee's compensable injury has prevented the employee from working sufficient quarters to be eligible for such benefits, notwithstanding any age limits. If the accident occurred on or after the employee reaches age 70, benefits shall be payable during the continuance of permanent total disability, not to exceed 5 years following the determination of permanent total disability. Only claimants with catastrophic injuries or claimants who are incapable of engaging in employment, as described in this paragraph, are eligible for permanent total benefits. In no other case may permanent total disability be awarded.

(5) SUBSEQUENT INJURY.—

(b) If a compensable injury, disability, or need for medical care, or any portion thereof, is a result of aggravation or acceleration of a preexisting condition, or is the result of merger with a preexisting condition, only the disabilities and medical treatment associated with such compensable injury shall be payable under this chapter, excluding the degree of

disability or medical conditions existing at the time of the impairment rating or at the time of the accident, regardless of whether the preexisting condition was disabling at the time of the accident or at the time of the impairment rating and without considering whether the preexisting condition would be disabling without the compensable accident. All preexisting conditions and injuries, whether work related or not work related, are subject to apportionment. The degree of permanent impairment or disability attributable to the accident or injury shall be compensated in accordance with this section, apportioning out the preexisting condition based on the anatomical impairment rating attributable to the preexisting condition. Medical benefits shall be paid apportioning out the percentage of the need for such care attributable to the preexisting condition. As used in this paragraph, "merger" means the combining of a preexisting permanent impairment or disability with a subsequent compensable permanent impairment or disability which, when the effects of both are considered together, result in a permanent impairment or disability rating which is greater than the sum of the two permanent impairment or disability ratings when each impairment or disability is considered individually.

Section 5. Paragraph (c) of subsection (12) and subsection (13) of section 440.20, Florida Statutes, are amended to read:

440.20 Time for payment of compensation and medical bills; penalties for late payment.—

(12)

(c) If ~~In the event~~ the claimant has sustained a compensable injury and has not returned to the same or equivalent employment with no substantial reduction in wages or has suffered a substantial loss of earning capacity or a physical impairment, actual or apparent:

1. An advance payment of compensation not in excess of $2,000 may be approved informally by letter, without hearing, by any judge of compensation claims or the Chief Judge.

2. An advance payment of compensation not in excess of $2,000 may be ordered by any judge of compensation claims after giving the interested parties an opportunity for a hearing thereon pursuant to not less than 10 days' notice by mail, unless such notice is waived, and after giving due consideration to the interests of the person entitled thereto. When the parties have stipulated to an advance payment of compensation not in excess of $2,000, such advance may be approved by an order of a judge of compensation claims, with or without hearing, or informally by letter by any such judge of compensation claims, if such advance is found to be for the best interests of the person entitled thereto.

3. When the parties have stipulated to an advance payment in excess of $2,000, such payment may be approved by a judge of compensation claims by order if the judge finds that such advance payment is for the best interests of the person entitled thereto and is reasonable under the circumstances of the particular case. The judge of compensation claims shall make or

cause to be made such investigations as she or he considers necessary concerning the stipulation and, in her or his discretion, may have an investigation of the matter made. The stipulation and the report of any investigation shall be deemed a part of the record of the proceedings.

4. An advance payment of compensation shall not be issued or ordered if compensability has been denied by the employer or carrier.

(13) If the employer has made advance payments of compensation, she or he shall be entitled to be reimbursed out of any unpaid installment or installments of compensation due. If an advance payment of compensation is made by a self-insured employer, the employer may deduct 20 percent of the claimant's wages until the entire amount of the advance is repaid.

Section 6. This act shall take effect July 1, 2014.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7045 OGSR/Florida Insurance Guaranty Association
SPONSOR(S): Government Operations Subcommittee, Cummings
TIED BILLS: **IDEN./SIM. BILLS:** SB 506

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Government Operations Subcommittee	11 Y, 0 N	Williamson	Williamson
1) Insurance & Banking Subcommittee		Cooper	Cooper
2) State Affairs Committee			

SUMMARY ANALYSIS

The Open Government Sunset Review Act requires the Legislature to review each public record and each public meeting exemption five years after enactment. If the Legislature does not reenact the exemption, it automatically repeals on October 2nd of the fifth year after enactment.

The Florida Insurance Guaranty Association (FIGA) is a nonprofit corporation that was created in 1970 to provide a mechanism for the payment of claims of insolvent property and casualty insurance companies in Florida. It operates under a board of directors with members appointed and approved by the Department of Financial Services based upon recommendations by the member insurers.

When a property and casualty insurance company becomes insolvent, FIGA is required to take over the claims of the insurer and pay the claims of the company's policyholders. This ensures that policyholders having paid premiums for insurance are not left without valid claims being paid.

Current law provides a public record exemption for certain FIGA records. Specifically, claims files, medical records, and records pertaining to matters reasonably encompassed in privileged attorney-client communications are confidential and exempt from public record requirements. FIGA may release the confidential and exempt records to a state agency, upon written request, and the state agency must maintain the confidential and exempt status of the records received.

The bill reenacts this public record exemption, which will repeal on October 2, 2014, if this bill does not become law.

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

The bill takes effect on October 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Open Government Sunset Review Act

The Open Government Sunset Review Act[1] sets forth a legislative review process for newly created or substantially amended public record or public meeting exemptions. It requires an automatic repeal of the exemption on October 2nd of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.

The Act 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.

If, and only if, in reenacting an exemption that will repeal, the exemption is expanded (essentially creating a new exemption), then a public necessity statement and a two-thirds vote for passage are required.[2] If the exemption is reenacted with grammatical or stylistic changes that do not expand the exemption, if the exemption is narrowed, or if an exception to the exemption is created[3] then a public necessity statement and a two-thirds vote for passage are not required.

Florida Insurance Guaranty Association

The Florida Insurance Guaranty Association (FIGA) is a nonprofit corporation that was created in 1970 to provide a mechanism for the payment of claims of insolvent property and casualty insurance companies in Florida.[4] It operates under a board of directors[5] with members appointed and approved by the Department of Financial Services based upon recommendations by the member insurers.[6] FIGA's membership is composed of all Florida licensed direct writers of property or casualty insurance.[7]

When a property and casualty insurance company becomes insolvent, FIGA is required to take over the claims of the insurer and pay the claims of the company's policyholders. This ensures that policyholders having paid premiums for insurance are not left without valid claims being paid.

In assuming the obligation of certain existing covered claims,[8] FIGA covers only the amount of each covered claim that is greater than $100 and less than $300,000, with certain exceptions. For damages

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[1] Section 119.15, F.S.

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

[3] An example of an exception to a public record exemption would be allowing another agency access to confidential and exempt records.

[4] Chapter 70-20, L.O.F.; codified as part II of chapter 631, F.S.

[5] Section 631.55(1), F.S.

[6] Section 631.56(1), F.S.

[7] Section 631.55(1), F.S.

[8] Section 631.54(3), F.S., defines the term "covered claim" to mean an unpaid claim, including one of unearned premiums, which arises out of, and is within the coverage, and not in excess of, the applicable limits of an insurance policy to which part II of chapter

to structure and contents on homeowners' claims, the FIGA cap is an additional $200,000, for a total of $500,000.[9] For condominium and homeowners' association claims, the cap is the lesser of policy limits or $100,000 multiplied by the number of units in the association.[10] All claims are subject to a $100 FIGA deductible in addition to any deductible identified in the insurance policy.[11]

FIGA obtains funds to pay claims of insolvent insurance companies, in part, from the liquidation of assets of these companies by the Division of Rehabilitation and Liquidation in the Department of Financial Services. FIGA also obtains funds from the liquidation of assets of insolvent insurers domiciled in other states but having claims in Florida. In addition, after insolvency occurs, FIGA can issue two types of assessments against property and casualty insurance companies to raise funds to pay claims – regular and emergency[12] assessments.

FIGA assesses solvent insurance companies directly for both assessments, and the insurance company is allowed to pass the assessment on to its policyholders. The maximum assessment in any one year is 2 percent of each affected insurer's net direct written premiums on property and casualty insurance policies in the state for the prior year.[13]

Public Record Exemption under Review

In 2009, the Legislature created a public record exemption for certain FIGA records.[14] The following records are confidential and exempt[15] from public record requirements:

- Claims files, until termination of all litigation, settlement, and final closing of all claims arising out of the same incident.[16]
- Medical records that are part of a claims file and information relating to the medical condition or medical status of a claimant.[17]
- Records pertaining to matters reasonably encompassed in privileged attorney-client communications.[18]

631, F.S., applies, issued by an insurer, if such insurer becomes an insolvent insurer and the claimant or insured is a resident of this state at the time of the insured event or the property from which the claim arises is permanently located in this state. For entities other than individuals, the residence of a claimant, insured, or policyholder is the state in which the entity's principal place of business is located at the time of the insured event. The term does not include:

(a) Any amount due any reinsurer, insurer, insurance pool, or underwriting association, sought directly or indirectly through a third party, as subrogation, contribution, indemnification, or otherwise;

(b) Any claim that would otherwise be a covered claim that has been rejected or denied by any other state guaranty fund based upon that state's statutory exclusions, including, but not limited to, those based on coverage, policy type, or an insured's net worth. Member insurers have no right of subrogation, contribution, indemnification, or otherwise, sought directly or indirectly through a third party, against the insured of any insolvent member; or

(c) Any amount payable for a sinkhole loss other than testing deemed appropriate by FIGA or payable for the actual repair of the loss, except that FIGA may not pay for attorney's fees or public adjuster's fees in connection with a sinkhole loss or pay the policyholder. FIGA may pay for actual repairs to the property but is not liable for amounts in excess of policy limits.

[9] Section 631.57(1)(a)2., F.S.

[10] Section 631.57(1)(a)3., F.S.

[11] Section 631.57(1)(a), F.S.

[12] Emergency assessments may only be issued to pay claims of insurers rendered insolvent due to a hurricane. *See* s. 631.57(3)(e), F.S.

[13] *See* s. 631.57(3), F.S. The maximum regular assessment is 2% per FIGA account. Because FIGA has two accounts, the aggregate maximum regular assessment is 4% per year.

[14] Chapter 2009-186, L.O.F.; codified as s. 631.582, F.S.

[15] 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).

[16] Section 631.582(1)(a), F.S.

[17] Section 631.582(1)(b), F.S.

[18] Section 631.582(1)(c), F.S.

Upon written request, such records may be released to any state agency in the furtherance of its official duties and responsibilities. The state agency must maintain the confidential and exempt status of the records received.[19]

Pursuant to the Open Government Sunset Review Act, the public record exemption will repeal on October 2, 2014, unless reenacted by the Legislature.[20]

During the 2013 interim, subcommittee staff sent a questionnaire to FIGA as part of the Open Government Sunset Review process. As part of its questionnaire response, FIGA recommended reenactment of the public record exemption under review. According to FIGA:

> ...failure to reenact the current public record exemption would expose the personal, private financial and medical information of the insureds of insolvent insurance companies and claimants of such companies to persons who have adverse interests to those individuals. The public dissemination of such personal, private information might be detrimental to the financial and personal affairs of these insureds and claimants.[21]

Effect of the Bill

The bill removes the repeal date, thereby reenacting the public record exemption for FIGA's claims files, medical records that are part of a claims file and information relating to the medical condition or medical status of a claimant, and records pertaining to matters reasonably encompassed in privileged attorney-client communications.

B. SECTION DIRECTORY:

Section 1 amends s. 631.582, F.S., to save from repeal the public record exemption for certain records of the Florida Insurance Guaranty Association.

Section 2 provides an effective date of October 1, 2014.

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:

[19] Section 631.582(2), F.S.
[20] Section 631.582(3), F.S.
[21] Open Government Sunset Review questionnaire for the Florida Insurance Guaranty Association, received August 28, 2013, at question 5 (on file with the Government Operations Subcommittee).

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:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to a review under the Open Government Sunset Review Act; amending s. 631.582, F.S., relating to an exemption from public records requirements for certain records of the Florida Insurance Guaranty Association; removing the scheduled repeal of the exemption; providing an effective date.

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

Section 1. Subsection (3) of section 631.582, Florida Statutes, is amended to read:

631.582 Public records exemption.—

~~(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2014, unless reviewed and saved from repeal through reenactment by the Legislature.~~

Section 2. This act shall take effect October 1, 2014.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 743 Property Insurance
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Callaway	Cooper

SUMMARY ANALYSIS

The Department of Financial Services (DFS) administers alternative dispute resolution programs for various types of insurance. The PCS gives DFS increased power relating to the approval, suspension, and revocation of approval of mediators in the DFS property mediation program and for neutral evaluators in the DFS sinkhole neutral evaluation program.

Post-claim underwriting is a practice where the underwriting of a policy application is actually done for the first time when a claim is filed. If an insurer discovers a misrepresentation or omission after issuing the policy, it may deny coverage after a claim is made or cancel the policy. The PCS should curtail claim denials and cancellation of residential property insurance due to misrepresentations about the policyholder's credit contained on the insurance application that are found during post-claim underwriting. The PCS provides that if a residential property insurance policy or contract has been in effect for more than 90 days, a claim filed by the insured cannot be denied and the insurer may not cancel or terminate the policy or contract based on credit information available in public records.

An appraisal clause is commonly found in insurance policies. The purpose of the appraisal clause is to establish a procedure to allow disputed amounts to be resolved by disinterested parties, called appraisers. If the appraiser hired by the policyholder and the one hired by the insurer cannot agree on the amount of damages, they together choose a mutually acceptable umpire that decides the disputed amount. Current law does not address disqualification of an umpire due to impartiality. The PCS adds grounds to current law which the insurer or policyholder in a residential property dispute can use to challenge the impartiality of the umpire in order to disqualify the umpire.

The PCS creates a "Homeowner Claim Bill of Rights," describing some of the rights held by personal lines residential property insurance policyholders and requires the insurer to provide a copy to the policyholder within 14 days of a claim. It does not create a new civil cause of action.

The PCS creates new requirements for agreements between insureds and providers of services needed to mitigate the damage caused by fire, water, or catastrophic events. It provides conditions upon which an agreement for emergency mitigation services will be valid, including requiring that emergency mitigation services be provided by a licensed contractor or by someone or a company certified in water damage restoration in order to be paid by the insurance.

The PCS has no fiscal impact on state or local government. Under specified circumstances, residential property insurance policyholders may no longer get a claim denied or their property insurance policy canceled or terminated based on credit information available in public records. Insurers will incur costs associated with providing policyholders with the "Homeowner Claim Bill of Rights" created by the PCS. Persons or companies currently providing emergency mitigation services that are not licensed contractors or certified in water damage restoration will incur costs associated with obtaining a contractor license or water damage restoration certification in order to be paid by insurance for emergency mitigation work performed on residential property.

The PCS is effective July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Department of Financial Services Alternative Dispute Resolution Programs

The Department of Financial Services (DFS) administers alternative dispute resolution programs for various types of insurance. The DFS has mediation programs for property insurance[1] and automobile insurance[2] claims. The DFS has a neutral evaluation program, similar to mediation, for sinkhole insurance claims.[3] The DFS approves mediators used in the two mediation programs and certifies the neutral evaluators used in neutral evaluations for sinkhole insurance claims.[4]

To qualify as a mediator for the property or automobile mediation programs, a person must possess graduate level degrees in specified areas, be a member of the Florida Bar, be a licensed certified public accountant, or be a mediator for 4 years.[5] In addition, an applicant must complete a training program approved by DFS.[6]

To qualify as a neutral evaluator for sinkhole insurance claims, a neutral evaluator must be a professional engineer or a professional geologist who has completed a course of study in alternative dispute resolution approved by DFS and who is determined by DFS to be fair and impartial.[7]

According to an analysis provided by DFS,[8] the number of reported mediations and neutral evaluations is:

Mediations:	FY 2012-13 – 3,966
	FY 2011-12 – 3,323
	FY 2010-11 – 3,489
Neutral Evaluations:	FY 2012-13 – 1,867
	FY 2011-12 – 2,681
	FY 2010-11 – 2,245

The PCS requires DFS to adopt rules for the denial of application, suspension, revocation of approval and other penalties for mediators in the DFS mediation program for disputed property insurance claims. Current law requires the DFS rules relating to the program to include qualifications for mediators and gives DFS discretion to determine appropriate education, training, or experience qualifications for those mediators who are not court certified and appointed or do not meet the mediator qualifications set forth in s. 627.745, F.S. The PCS removes DFS' discretionary authority to set mediator qualifications. Thus, only court certified and appointed mediators or mediators who meet the qualifications in s. 627.745, F.S., can be mediators for the DFS property mediation program.

The PCS specifies circumstances that require DFS to deny an application for a neutral evaluator or suspend or revoke the certification of a neutral evaluator. If the evaluator does not meet the statutory qualifications to be a neutral evaluator; has a material misstatement, misrepresentation, or fraud in the attempt to obtain certification as a neutral evaluator; has a demonstrated lack of fitness and

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[1] *See* s. 627.7015, F.S.
[2] *See* s. 626.745, F.S.
[3] *See* s. 627.7074, F.S.
[4] *See* ss. 627.7015, 627.7074, and 627.745, F.S.
[5] *See* ss. 627.7015, 627.745(3), F.S.
[6] *See* ss. 627.7015, 627.745(3), F.S.
[7] *See* s. 627.706, F.S.
[8] *See* Department of Financial Services, *House Bill 759 Analysis* dated February 21, 2014 (on file with the Insurance & Banking Subcommitee).

trustworthiness to act as a neutral evaluator; has fraudulent or dishonest practices in the conduct of a neutral evaluation or in the conduct of business relating to financial services; or violates statutes, DFS rules, or DFS orders, then DFS must deny the application or suspend or revoke certification of the evaluator. The DFS has similar authority over the licenses of insurance agents and other regulated persons or entities.[9]

Post-Claim Underwriting

Post-claim underwriting is a practice where the underwriting of a policy application is actually done for the first time when a claim is filed. Post-claim underwriting can result in a denial of the claim or cancelation of the policy and is a way insurers implement s. 627.409, F.S., which provides recovery under an insurance policy may be prevented if a misrepresentation, omission, concealment of fact, or incorrect statement on an application for insurance:

1. is fraudulent or is material either to the acceptance of the risk or to the hazard assumed by the insurer or
2. if the true facts had been known to the insurer, the insurer would not have issued the policy, would not have issued it at the same premium rate, would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss.

If an insurer discovers a misrepresentation or omission after issuing the policy, it may deny coverage after a claim is made. In *Nationwide Mutual Fire Insurance Company v. Kramer,*[10] an insurer refused to pay a claim for a stolen automobile because the insureds did not disclose a previous bankruptcy filing. In *Kieser v. Old Line Insurance Company of America,*[11] an insurance company refused to pay a life insurance policy because the insured failed to disclose certain health conditions and failed to disclose that he was shopping for other life insurance policies. In *Universal Property and Casualty Insurance Company v. Johnson,*[12] an insurance company refused to pay a property insurance claim because the insureds failed to disclose prior criminal history. A misrepresentation from or an omission in an insurance application does not have to be intentional in order for the insurance company to deny recovery.[13]

Section 627.4133(2), F.S., requires notice to the insured before an insurer can cancel, nonrenew, or terminate any personal lines or commercial residential property insurance policy. The timing of the notice ranges from 10 days for nonpayment of premium to 120 days for certain policyholders.[14] After the policy has been in effect for 90 days, such a policy cannot be canceled unless that has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements with 90 days after the date of effectuation of coverage, or a substantial change in the risk covered by the policy.[15]

The PCS should curtail cancellation of residential property insurance due to misrepresentations about the policyholder's credit contained on the insurance application that are found during post-claim underwriting. The PCS provides that if a residential property insurance policy or contract has been in effect for more than 90 days, a claim filed by the insured cannot be denied and the insurer may not cancel or terminate the policy or contract based on credit information available in public records. The PCS does not change the law relating to other types of insurance or other types of misrepresentations (such as a misrepresentation regarding health or criminal history).

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[9] *See* s. 626.611, F.S., which sets forth DFS' power relating to refusal, suspension, or revocation of agent's, title agency's, adjuster's, customer representative's, service representative's, or managing general agent's license or appointment.
[10] 725 So.2d 1141 (Fla. 2d DCA 1998).
[11] 712 So.2d 1261 (Fla. 1st DCA 1998).
[12] 114 So.3d 1031 (Fla. 1st DCA 2013).
[13] *Universal Property and Casualty Insurance Company*, 114 So.3d at 1035.
[14] *See* s. 627.4133(2), F.S.
[15] *Id.*

Disqualification of Appraisal Umpire In Residential Property Claims

An appraisal clause is commonly found in insurance policies. The purpose of the appraisal clause is to establish a procedure to allow disputed amounts to be resolved by disinterested parties. The appraisal clause is used only to determining disputed values. An appraisal cannot be used to determine what is covered under an insurance policy. Coverage issues are litigated and determined by the courts.

The appraisal process generally works as follows:

- The insurance company and the policyholder each appoint an independent, disinterested appraiser.
- Each appraiser evaluates the loss independently.
- The appraisers negotiate and reach an agreed amount of the damages.
- If the appraisers cannot agree on the amount of damages, they together choose a mutually acceptable umpire.
- Once the umpire has been chosen, the appraisers each present their loss assessment to the umpire.
- The umpire will subsequently provide a written decision to both parties.

Because current law does not address disqualification of an umpire due to impartiality, a party wanting to disqualify an umpire must go to Circuit Court and have a judge rule on the umpire's impartiality. In making the ruling, the judge uses his or her judgment about the umpire's impartiality. There are no parameters in current law for a judge's ruling on an umpire's impartiality. The PCS provides parameters for the judge's impartiality ruling by adding grounds to current law which the insurer or policyholder in a residential property dispute can use to challenge the impartiality of the umpire in order to disqualify the umpire. The disqualification grounds provided in the PCS are the substantially the same as those used to disqualify a neutral evaluator in sinkhole claims under s. 627.7074(7)(a), F.S.

Homeowner Rights in Property Insurance Claims

Property insurance policyholders have a number of rights pursuant to statute or rule. Section 627.70131, F.S., and rule 69O-166.24, Florida Administrative Code, require an insurer to review and acknowledge receipt of communication with respect to a claim within 14 days of receipt. Section 626.9541(1)(i), F.S., requires an insurer to affirm or deny full or partial coverage of claims or provide a written statement that the claim is being investigated upon the written request of the insured within 30 days after proof-of-loss statements have been completed. An insurer must pay or deny the claim within 90 days.[16]

The DFS provides services to insurers and consumers such as the mediation of property insurance claims[17] and neutral evaluation[18] of sinkhole claims. In addition, the DFS has a Division of Consumer Services that can assist consumers in the claims process.[19]

The PCS creates a "Homeowner Claims Bill of Rights." It requires an insurer issuing a personal lines residential property insurance policy to provide a copy of the Homeowner Claims Bill of Rights ("Bill of Rights") to a policyholder within 14 calendar days after receiving an initial communication with respect to a claim unless the claim follows an event that is the subject of a declaration of state of emergency by the Governor.

The PCS provides that the purpose of the Bill of Rights is to explain the rights of a personal lines residential property insurance policyholder who files a claim of loss. The PCS further provides that the

[16] *See* s. 627.70131, F.S.
[17] *See* s. 627.7015, F.S.
[18] *See* s. 627.7074, F.S.
[19] *See* http://www.myfloridacfo.com/division/consumers/#.UvTl9vldUeE (last viewed on March 7, 2014).

Bill of Rights does not create a civil cause of action by a policyholder or class of policyholders against an insurer.

The PCS provides the exact language of the Bill of Rights. In summary, the Bill of Rights informs policyholders that they have the right to:

- Receive acknowledgment of the reported claim and necessary claim forms within 14 days after the claim is communicated to the insurance company.
- Receive confirmation that a claim is covered in full, partially covered, or denied, or receive a written statement that a claim is being investigated within 30 days.
- Receive full settlement payment for the claim or payment of the undisputed portion of the claim or the insurance company's denial of the claim within 90 days.
- Receive free mediation of the claim by DFS under most circumstances and subject to certain restrictions.
- Receive a neutral evaluation of a disputed sinkhole claim covered by the policy.

The Bill of Rights informs consumers of services provided by DFS, such as the Division of Consumer Services helpline.

The Bill of Rights advises policyholders to contact the insurance company before entering into any contract for repairs, to make and document emergency repairs that are necessary to prevent further damage, to read any contract that requires a payment of out-of-pocket expenses or a fee that is based on a percentage of the insurance proceeds, and to confirm that the contractor is licensed to do business in Florida.

The Bill of Rights informs policyholders that it does not create a civil cause of action by an individual policyholder, or a class of policyholders, against an individual insurer.

Emergency Mitigation Services

Homeowners can experience significant damage to their homes in situations that require immediate action to prevent further damage. There are companies that provide services such as "drying" a structure after a loss caused by water. These companies are not regulated by the state. According to the DFS, consumers have no guarantee or protection in place to ensure their homes will be repaired by an accredited professional.[20]

The PCS provides conditions upon which an agreement for emergency mitigation services will be valid. The PCS defines "emergency mitigation services" as the delivery of goods or services[21] that are needed to mitigate damage caused by fire, water, or catastrophic events when delay may exacerbate the damage to the covered property. An agreement for emergency mitigation services to which insurance proceeds may be applied is valid only if:

- The agreement specifies in writing the estimated scope and price of the work before it is performed;
- Any change from the original estimated scope and price of the work is preapproved by the policyholder; and
- The work is performed by an individual or company possessing a valid certification consistent with the most recent Standard and Reference Guide for Professional Water Damage Restoration, as developed by the Institute of Inspection, Cleaning and Restoration Certification and approved by the American National Standards Institute, or by a company that possesses a

[20] *See* Department of Financial Services, *House Bill 759 Analysis* dated February 21, 2014 at p. 4 (on file with the Insurance & Banking Subcommittee). (HB 759 contains the same provision relating to emergency mitigation services as the PCS for HB 734).
[21] Services include the removal of contents, removal of water or other contaminants, cleaning, sanitizing, incidental demolition, or other treatment, including preventive activities.

valid Division I license under chapter 489, which is providing services within the scope of that license.[22]

B. SECTION DIRECTORY:

Section 1: Amends s. 627.3518, F.S., relating to Citizens Property Insurance Corporation policyholder eligibility clearinghouse program to conform a cross reference.

Section 2: Amends s. 627.409, F.S., relating to representations in applications; warranties.

Section 3: Amends s. 624.4133, F.S., relating to notice of cancellation, nonrenewal, or renewal premium.

Section 4: Amends s. 627.7015, F.S., relating to alternative procedure for resolution of disputed property insurance claims.

Section 5: Creates s. 627.70151, F.S., relating to appraisal; conflicts of interest.

Section 6: Amends s. 627.706, F.S., relating to sinkhole insurance; catastrophic ground cover collapse; definitions.

Section 7: Amends s. 627.7074, F.S., relating to alternative procedure for resolution of disputed sinkhole insurance claims.

Section 8: Creates s. 627.7142, F.S., relating to Homeowner Claims Bill of Rights.

Section 9: Creates s. 627.715, F.S., relating to emergency mitigation services; agreements.

Section 10: Provides an effective date of July 1, 2014.

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.

[22] A Division 1 license includes general contractors, building contractors, and residential contractors. *See* s. 489.105(3), F.S.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

After a residential property insurance policy or contract has been in effect for more than 90 days, policyholders may no longer get a claim denied or their property insurance policy canceled or terminated for credit history information in the insurance application.

Insurers will incur costs related to providing a Bill of Rights to policyholders when a personal lines residential property insurance claim is filed.

Persons or companies currently providing emergency mitigation services that are not licensed contractors or certified in water damage restoration will incur costs associated with obtaining a contractor license or water damage restoration certification in order to be paid by insurance for emergency mitigation work performed on residential property. Certification requires a three day course and an examination and is taught by various vendors throughout the country.[23] Once certified, continuing education is required.[24]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The PCS requires DFS to adopt rules relating to the certification of neutral evaluators.

The PCS also requires existing rules relating to the DFS property mediation program to include information relating to denial of an application for mediation, suspension of approval of a mediator, or revocation of approval of a mediator.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

[23] http://www.iicrc.org/
[24] http://www.iicrc.org/

A bill to be entitled

An act relating to property insurance; amending s. 627.3518, F.S.; conforming a cross-reference; amending s. 627.409, F.S.; providing that a claim for residential property insurance cannot be denied based on certain credit information; amending s. 627.4133, F.S.; providing that a policy or contract may not be cancelled based on certain credit information; amending s. 627.7015, F.S.; revising the rule requirements relating to the property insurance mediation program administered by the department; creating s. 627.70151, F.S.; providing grounds for challenging an umpire's impartiality in estimating the amount of a property loss; amending s. 627.706, F.S.; redefining the term "neutral evaluator"; amending s. 627.7074, F.S.; specifying grounds for denying, suspending, or revoking approval of a neutral evaluator; creating s. 627.7142, F.S.; establishing a Claims Bill of Rights for residential property insurance policyholders; providing that such bill of rights does not provide a cause of action; creating s. 627.715, F.S.; defining terms; providing requirements for emergency mitigation repair agreements; requiring an emergency mitigation contractor to be appropriately certified or to possess a contracting license; providing an effective date.

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

Section 1. Section 1. Subsection (9) of section 627.3518, Florida Statutes, is amended to read:

627.3518 Citizens Property Insurance Corporation policyholder eligibility clearinghouse program.—The purpose of this section is to provide a framework for the corporation to implement a clearinghouse program by January 1, 2014.

(9) The 45-day notice of nonrenewal requirement set forth in s. 627.4133(2)(b)5.b. ~~s. 627.4133(2)(b)4.b.~~ applies when a policy is nonrenewed by the corporation because the risk has received an offer of coverage pursuant to this section which renders the risk ineligible for coverage by the corporation.

Section 2. Section 627.409, Florida Statutes, is amended to read:

627.409 Representations in applications; warranties.—

(1) Any statement or description made by or on behalf of an insured or annuitant in an application for an insurance policy or annuity contract, or in negotiations for a policy or contract, is a representation and ~~is~~ not a warranty. Except as provided in subsection (3), a misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the contract or policy only if any of the following apply:

(a) The misrepresentation, omission, concealment, or statement is fraudulent or is material ~~either~~ to the acceptance

of the risk or to the hazard assumed by the insurer.

(b) If the true facts had been known to the insurer pursuant to a policy requirement or other requirement, the insurer in good faith would not have issued the policy or contract, would not have issued it at the same premium rate, would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss.

(2) A breach or violation by the insured of a ~~any~~ warranty, condition, or provision of a ~~any~~ wet marine or transportation insurance policy, contract of insurance, endorsement, or application ~~therefor~~ does not void the policy or contract, or constitute a defense to a loss thereon, unless such breach or violation increased the hazard by any means within the control of the insured.

(3) For residential property insurance, if a policy or contract is in effect for more than 90 days, a claim filed by the insured may not be denied based on credit information available in public records.

Section 3. Paragraph (b) of subsection (2) of section 627.4133, Florida Statutes, is amended to read:

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

(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:

(b) The insurer shall give the first-named insured written notice of nonrenewal, cancellation, or termination at least 100 days before 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 insured written notice of nonrenewal, cancellation, or termination at least 120 days before ~~prior to~~ the effective date of the nonrenewal, cancellation, or termination for a first-named insured whose residential structure has been insured by that insurer or an affiliated insurer for at least 5 years before ~~a 5-year period immediately prior to~~ the date of the written notice.

2. If cancellation is for nonpayment of premium, at least 10 days' written notice of cancellation accompanied by the reason therefor must be given. As used in this subparagraph, the term "nonpayment of premium" means failure of the named insured to discharge when due her or his obligations for paying the premium ~~in connection with the payment of premiums~~ on a policy or an ~~any~~ installment of such premium, whether the premium is

payable directly to the insurer or its agent or indirectly under a ~~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. The term 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 are 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 must be refunded to that party in full.

3. If ~~such~~ cancellation or termination occurs during the first 90 days 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 must be given unless there has been a material misstatement or misrepresentation or a failure to comply with the underwriting requirements established by the insurer.

4. After a policy or contract has been in effect for 90 days, the insurer may not cancel or terminate the policy or

contract based on credit information available in public records.

5.~~4.~~ The requirement for providing written notice 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 before 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.

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 coverage to the policyholder is exempt from the notice requirements of paragraph (a) and this paragraph. In such cases, the corporation must give the named insured written notice of nonrenewal at least 45 days before the effective date of the nonrenewal.

After the policy has been in effect for 90 days, the policy may not be canceled by the insurer unless there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days after the date of effectuation of coverage, ~~or~~ a substantial change in the risk covered by the policy, or ~~if~~ the

cancellation is for all insureds under such policies for a given class of insureds. This paragraph does not apply to individually rated risks that have ~~having~~ a policy term of less than 90 days.

6.~~5.~~ Notwithstanding any other provision of law, an insurer may cancel or nonrenew a property insurance policy after at least 45 days' notice if the office finds that the early cancellation of some or all of the insurer's policies is necessary to protect the best interests of the public or policyholders and the office approves the insurer's plan for early cancellation or nonrenewal of some or all of its policies. The office may base such finding upon the financial condition of the insurer, lack of adequate reinsurance coverage for hurricane risk, or other relevant factors. The office may condition its finding on the consent of the insurer to be placed under administrative supervision pursuant to s. 624.81 or to the appointment of a receiver under chapter 631.

7.~~6.~~ A policy covering both a home and a motor vehicle may be nonrenewed for any reason applicable to ~~either~~ the property or motor vehicle insurance after providing 90 days' notice.

Section 4. Paragraph (b) of subsection (4) of section 627.7015, Florida Statutes, is amended to read:

627.7015 Alternative procedure for resolution of disputed property insurance claims.—

(4) The department shall adopt by rule a property insurance mediation program to be administered by the department or its designee. The department may also adopt special rules

which are applicable in cases of an emergency within the state. The rules shall be modeled after practices and procedures set forth in mediation rules of procedure adopted by the Supreme Court. The rules shall provide for:

(b) Qualifications, denial of application, suspension, revocation of approval, and other penalties for ~~of~~ mediators as provided in s. 627.745 and in the Florida Rules of Certified and Court Appointed Mediators~~, and for such other individuals as are qualified by education, training, or experience as the department determines to be appropriate~~.

Section 5. Section 627.70151, Florida Statutes, is created to read:

627.70151 Appraisal; conflicts of interest.—An insurer that offers residential coverage, as defined in s. 627.4025, or a policyholder that uses an appraisal clause in a property insurance contract to establish a process of estimating or evaluating the amount of loss through the use of an impartial umpire may challenge an umpire's impartiality and disqualify the proposed umpire only if:

(1) A familial relationship within the third degree exists between the umpire and any party or a representative of any party;

(2) The umpire has previously represented any party or a representative of any party in a professional capacity in the same or a substantially related matter;

(3) The umpire has represented another person in a

professional capacity on the same or a substantially related matter, which includes the claim, same property, or an adjacent property and that other person's interests are materially adverse to the interests of any party; or

(4) The umpire has worked as an employer or employee of any party within the preceding 5 years.

Section 6. Paragraph (c) of subsection (2) of section 627.706, Florida Statutes, is amended to read:

627.706 Sinkhole insurance; catastrophic ground cover collapse; definitions.—

(2) As used in ss. 627.706-627.7074, and as used in connection with any policy providing coverage for a catastrophic ground cover collapse or for sinkhole losses, the term:

(c) "Neutral evaluator" means a professional engineer or a professional geologist who has completed a course of study in alternative dispute resolution designed or approved by the department for use in the neutral evaluation process, ~~and~~ who is determined by the department to be fair and impartial, and who is not otherwise ineligible for certification as provided in s. 627.7074.

Section 7. Subsections (7) and (18) of section 627.7074, Florida Statutes, are amended to read:

627.7074 Alternative procedure for resolution of disputed sinkhole insurance claims.—

(7) Upon receipt of a request for neutral evaluation, the department shall provide the parties a list of certified neutral

evaluators. The department shall allow the parties to submit requests to disqualify evaluators on the list for cause.

(a) The department shall disqualify neutral evaluators for cause based only on any of the following grounds:

1. A familial relationship exists between the neutral evaluator and either party or a representative of either party within the third degree.

2. The proposed neutral evaluator has, in a professional capacity, previously represented either party or a representative of either party, in the same or a substantially related matter.

3. The proposed neutral evaluator has, in a professional capacity, represented another person in the same or a substantially related matter and that person's interests are materially adverse to the interests of the parties. The term "substantially related matter" means participation by the neutral evaluator on the same claim, property, or adjacent property.

4. The proposed neutral evaluator has, within the preceding 5 years, worked as an employer or employee of any party to the case.

(b) The department shall deny an application, or suspend or revoke its certification, of a neutral evaluator to serve in such capacity if the department finds that one or more of the following grounds exist:

1. Lack of one or more of the qualifications for

certification specified in this section.

2. Material misstatement, misrepresentation, or fraud in obtaining or attempting to obtain the certification.

3. Demonstrated lack of fitness or trustworthiness to act as a neutral evaluator.

4. Fraudulent or dishonest practices in the conduct of an evaluation or in the conduct of business in the financial services industry.

5. Violation of any provision of this code or of a lawful order or rule of the department or aiding, instructing, or encouraging another party to commit such a violation.

(c) ~~(b)~~ The parties shall appoint a neutral evaluator from the department list and promptly inform the department. If the parties cannot agree to a neutral evaluator within 14 business days, the department shall appoint a neutral evaluator from the list of certified neutral evaluators. The department shall allow each party to disqualify two neutral evaluators without cause. Upon selection or appointment, the department shall promptly refer the request to the neutral evaluator.

(d) ~~(c)~~ Within 14 business days after ~~the~~ referral, the neutral evaluator shall notify the policyholder and the insurer of the date, time, and place of the neutral evaluation conference. The conference may be held by telephone, if feasible and desirable. The neutral evaluator shall make reasonable efforts to hold the conference within 90 days after the receipt of the request by the department. Failure of the neutral

evaluator to hold the conference within 90 days does not invalidate either party's right to neutral evaluation or to a neutral evaluation conference held outside this timeframe.

(18) The department shall adopt rules of procedure for the neutral evaluation process and adopt rules for certifying, denying certification of, suspending certification of, and revoking the certification of a neutral evaluator.

Section 8. Section 627.7142, Florida Statutes, is created to read:

627.7142 Homeowner Claims Bill of Rights.—An insurer issuing a personal lines residential property insurance policy in this state must provide a Claims Bill of Rights to a policyholder within 14 calendar days after receiving an initial communication with respect to a claim, unless the claim follows an event that is the subject of a declaration of a state of emergency by the Governor. The purpose of the bill of rights is to explain, in simple, nontechnical terms, the rights of a personal lines residential property insurance policyholder who files a claim of loss. The Claims Bill of Rights is specific to the claims process and does not represent all of a policyholder's rights under Florida law regarding the insurance policy. The Claims Bill of Rights does not create a civil cause of action by any individual policyholder or class of policyholders against an individual insurer. The Claims Bill of Rights shall state:

HOMEOWNER CLAIMS

BILL OF RIGHTS

This Bill of Rights is specific to the claims process and does not represent all of your rights under Florida law regarding your policy. There are also exceptions to the stated timelines when conditions are beyond your insurance company's control. This document does not create a civil cause of action by an individual policyholder, or a class of policyholders, against an individual insurer.

YOU HAVE THE RIGHT TO:

1. Receive from your insurance company an acknowledgment of your reported claim within 14 days after the time you communicated the claim, along with necessary claim forms, including a proof-of-loss form, instructions, and appropriate, up-to-date contact information.

2. Upon written request, receive from your insurance company within 30 days after you have completed a proof-of-loss statement to your insurance company, confirmation that your claim is covered in full, partially covered, or denied, or receive a written statement that your claim is being investigated.

3. Within 90 days, receive full settlement payment for your claim or payment of the undisputed portion of

your claim, or your insurance company's denial of your claim.

4. Free mediation of your disputed claim by the Division of Consumer Services, under most circumstances and subject to certain restrictions.

5. Neutral evaluation of your disputed claim, if your claim is for damage caused by a sinkhole and is covered by your policy.

6. Contact the Florida Department of Financial Services Division of Consumer Services' toll-free helpline for assistance with any insurance claim or questions pertaining to the handling of your claim. You can reach the Helpline by phone at...toll free phone number..., or you can seek assistance online at the Florida Department of Financial Services Division of Consumer Services' website at...website address....

YOU ARE ADVISED TO:

1. Contact your insurance company before entering into any contract for repairs to confirm any managed repair policy provisions or optional preferred vendors.

2. Make and document emergency repairs that are necessary to prevent further damage. Keep the damaged property, if feasible, keep all receipts, and take photographs of damage before and after any repairs.

3. Carefully read any contract that requires you to pay out-of-pocket expenses or a fee that is based on a percentage of the insurance proceeds that you will receive for repairing or replacing your property.

4. Confirm that the contractor you choose is licensed to do business in Florida. You can verify a contractor's license and check to see if there are any complaints against him or her by calling the Florida Department of Business and Professional Regulation. You should also ask the contractor for references from previous work.

5. Require all contractors to provide proof of insurance before beginning repairs.

6. Take precautions if the damage requires you to leave your home, including securing your property and turning off your gas, water, and electricity, and contacting your insurance company and provide a phone number where you can be reached.

Section 9. Section 627.715, Florida Statutes, is created to read:

627.715 Emergency mitigation services; agreements.—

(1) As used in this section, the term "emergency mitigation services" means the delivery of goods or services that are needed to mitigate damage caused by fire, water, or catastrophic events when delay may exacerbate the damage to the

covered property. Services include the removal of contents, removal of water or other contaminants, cleaning, sanitizing, incidental demolition, or other treatment, including preventive activities.

(2) For residential property insurance, an agreement for emergency mitigation services to which insurance proceeds may be applied is valid only if:

(a) The agreement specifies in writing the estimated scope and price of the work before it is performed;

(b) Any change from the original estimated scope and price of the work is preapproved by the policyholder; and

(c) The work is performed by an individual or company possessing a valid certification consistent with the most recent Standard and Reference Guide for Professional Water Damage Restoration, as developed by the Institute of Inspection, Cleaning and Restoration Certification and approved by the American National Standards Institute, or by a company that possesses a valid Division I license under chapter 489, which is providing services within the scope of that license. A company is considered to be certified for the purposes of this paragraph if the company representative who possesses a valid certification personally supervises the emergency mitigation services performed.

Section 10. This act shall take effect July 1, 2014.

INSURANCE & BANKING SUBCOMMITTEE

PCS for HB 743 by Rep. Hood
Property Insurance

AMENDMENT SUMMARY
March 11, 2014

Amendment 1 by Rep. Broxson (Lines 303-330): Rewords the Homeowners Claims Bill of Rights. The amendment adds provisions relating to an insurer's right to repair damaged property, delineates statutes covered by the Bill of Rights, and removes language from the Bill of Rights informing homeowners of their right to receive claims forms, instructions, and contact information from their insurer with the insurer's acknowledgment of the claim.

Amendment 2 by Rep. Broxson (Between lines 397 and 398): Requires agreements for emergency mitigation services to comply with the insurance policy's managed repair or preferred vendor program in order for the insurer to pay for the emergency mitigation services.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing PCB: Insurance & Banking Subcommittee

Representative Broxson offered the following:

Amendment

Remove lines 303-330 and insert:

to summarize, in simple, nontechnical terms, existing Florida law regarding the rights of a personal lines residential property insurance policyholder who files a claim of loss. The Claims Bill of Rights is specific to the claims process and does not represent all of a policyholder's rights under Florida law regarding the insurance policy. The Claims Bill of Rights does not create a civil cause of action by any individual policyholder of class of policyholders against an insurer or insurers and does not enlarge, modify, or contravene statutory requirements, including but not limited to,

sections 626.854, 626.9541, 627.70131, 627.7015, and 627.7074. The Claims Bill of Rights shall not prohibit an insurer from exercising its right to repair damaged property in compliance with the terms of an applicable policy or ss. 627.7011(5)(e) and 627.702(7). The Claims Bill of Rights shall state:

HOMEOWNERS CLAIMS

BILL OF RIGHTS

This Bill of Rights is specific to the claims process and does not represent all of your rights under Florida law regarding your policy. There are also exceptions to the stated timelines when conditions are beyond your insurance company's control. This document does not create a civil cause of action by an individual policyholder or a class of policyholders against an insurer or insurers and does not prohibit an insurer from exercising its right to repair damaged property in compliance with the terms of an applicable policy.

YOU HAVE THE RIGHT TO:

1. Receive from your insurance company an acknowledgment of your reported claim within 14 days after the time you communicated the claim.

COMMITTEE/SUBCOMMITTEE AMENDMENT

PCB Name: PCS for HB 743 (2014)

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing PCB: Insurance & Banking Subcommittee

Representative Broxson offered the following:

Amendment

Between lines 397 and 398, insert:

(a) The agreement entered into by the policyholder is in compliance with any managed repair or preferred vendor policy provisions;