Insurance & Banking Subcommittee

Tuesday, March 25, 2014
8:00 AM
Sumner Hall (404 HOB)

MEETING PACKET

Will Weatherford
Speaker

Bryan Nelson
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Insurance & Banking Subcommittee

Start Date and Time:	Tuesday, March 25, 2014 08:00 am
End Date and Time:	Tuesday, March 25, 2014 11:00 am
Location:	Sumner Hall (404 HOB)
Duration:	3.00 hrs

Consideration of the following bill(s):

CS/HB 31 Dentists by Health Innovation Subcommittee, Renuart
CS/HB 939 Bail Bond Premiums by Finance & Tax Subcommittee, Stewart
HB 783 Financing of Motor Vehicles by Albritton
HB 1395 Bail Bonds by Nelson

Consideration of the following proposed committee substitute(s):

PCS for HB 423 -- Cemeteries
PCS for HB 1001 -- Health Care
PCS for HB 1089 -- Property Insurance
PCS for HB 1109 -- Property Insurance

Consideration of the following proposed committee bill(s):

PCB IBS 14-02 -- Public Records and Meetings/Insurance Flood Loss Model

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 24, 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 24, 2014.

NOTICE FINALIZED on 03/21/2014 16:17 by McCloskey.Michele

The Florida House of Representatives

Regulatory Affairs Committee

Insurance & Banking Subcommittee

Will Weatherford
Speaker

Bryan Nelson
Chair

AGENDA

Tuesday, March 25, 2014
404 HOB
8:00 am – 11:00 am

I. Call to Order

II. Roll Call

III. Consideration of the following bill(s):

a. CS/HB 31 Dentists by Health Innovation Subcommittee, Renuart
b. PCS for HB 423 Cemeteries by Insurance & Banking Subcommittee
c. HB 783 Financing of Motor Vehicles by Albritton
d. CS/HB 939 Bail Bond Premiums by Finance & Tax Subcommittee, Stewart
e. PCS for HB 1001 Health Care by Insurance & Banking Subcommittee
f. PCS for HB 1089 Property Insurance by Insurance & Banking Subcommittee
g. PCS for HB 1109 Property Insurance by Insurance & Banking Subcommittee
h. HB 1395 Bail Bonds by Nelson
i. PCB IBS 14-02 Public Records and Meetings/Insurance Flood Loss Model 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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 31 Dentists
SPONSOR(S): Health Innovation Subcommittee; Renuart and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 86

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 0 N, As CS	Poche	Shaw
2) Insurance & Banking Subcommittee		Cooper	Cooper
3) Health & Human Services Committee			

SUMMARY ANALYSIS

House Bill 31 prohibits health insurance provider contracts from containing provisions requiring dentists to provide services at a fee set by the health insurer, prepaid limited health service organization or health maintenance organization unless the services are covered under the contract or subscriber agreement. The bill defines "covered services" as those services for which reimbursement is available under a plan or contract or those services for which reimbursement would be available but for contractual limitations such as deductibles, yearly or lifetime maximums, alternative payment benefits, or any other limitation in the plan or contract. Lastly, the bill prohibits an insurer or an organization from requiring, as a term of its contract with a dentist, that the dentist participate in a discount medical plan.

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

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

The bill provides an effective date of July 1, 2014, and applies to contracts entered into or renewed on or after that date.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Health Insurers and Health Maintenance Organizations (HMOs)

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

Health Care Practitioners

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

Health Insurer Provider Arrangements

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

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

Discount Medical Plan Organizations

Discount medical plan organizations (DMPOs) offer members access to health care products and services at a discounted fee. Products and services may include, but are not limited to, dental, emergency, mental health, vision care, chiropractic, and hearing care. Generally, a DMPO has a contract with a provider network under which the individual providers render the medical services at a discount. DMPOs are not health insurers.

The DMPOs are regulated by the OIR under part II of ch. 636, F.S. Part II establishes licensure requirements, minimum capital requirements, marketing restrictions, prohibited activities, and criminal penalties, and other regulations. Before offering access to its products and services, a DMPO must be incorporated and possess a DMPO license.[1] As a condition of licensure, each DMPO must maintain a net worth requirement of $150,000.[2] All charges to members of such plans must be filed with the OIR and any charge to a member greater than $30 per month or $360 per year must be approved by the

[1] S. 636.204(1), F.S.
[2] S. 636.220, F.S.

OIR before the charges can be used by the plan.[3] All forms used by the organization must be filed with and approved by the OIR.[4]

Prepaid Limited Health Service Organization (PLHSO) Provider Arrangements

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

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

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

HMO Provider Contracts

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

Effect of Proposed Changes

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

The bill also amends ss. 627.6474, 636.035, and 641.315, F.S., to prohibit a contract between a health insurer, a PLHSO, or an HMO and a dentist from containing provisions that require the dentist to provide a service to the insured or subscriber at a fee set by the insurer, PLHSO, or HMO, unless the service is a covered service under the applicable policy or subscriber agreement. The bill defines a "covered service" as a service for which reimbursement is available under a plan or contract or a service for which reimbursement would be available but for contractual limitations such as deductibles, yearly or lifetime maximums, alternative payment benefits, or any other limitation in the plan or contract. Services that are not listed in an individual's health insurance plan or policy as a benefit to which the individual is entitled under the plan or agreement are not considered covered services.

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

The bill applies to all contracts entered into or renewed on or after July 1, 2014.

[3] S. 636.216(1), F.S.
[4] S. 636.216(3), F.S.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6474, F.S., relating to provider contracts.
Section 2: Amends s. 636.035, F.S., relating to provider arrangements.
Section 3: Amends s. 641.315, F.S., relating to provider contracts.
Section 4: Provides for application to contracts entered into or renewed on or after July 1, 2014.
Section 5: 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.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

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

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 5, 2014, the Health Innovation Subcommittee adopted a strike-all amendment to House Bill 31. The amendment made the following changes to the bill:

- Removed the requirement that fees for covered services be set in good faith.
- Removed the prohibition against insurers, PLHSOs, and HMOs setting nominal or de minimis fees for covered services as a way of avoiding the provisions of the bill.
- Defined "covered services" to mean those services for which reimbursement is available under a plan or contract or those services for which reimbursement would be available but for contractual limitations such as deductibles, yearly or lifetime maximums, alternative payment benefits, or any other limitation in the plan or contract.

The bill was reported favorably as a committee substitute. The analysis reflects the committee substitute.

A bill to be entitled

An act relating to dentists; amending s. 627.6474, F.S.; prohibiting a contract between a health insurer and a dentist from requiring the dentist to provide services at a fee set by the insurer under certain circumstances; defining the term "covered services" as it relates to contracts between a health insurer and a dentist; prohibiting a health insurer from requiring as a condition of a contract that a dentist participate in a discount medical plan; amending s. 636.035, F.S.; prohibiting a contract between a prepaid limited health service organization and a dentist from requiring the dentist to provide services at a fee set by the organization under certain circumstances; defining the term "covered services" as it relates to contracts between a prepaid limited health service organization and a dentist; prohibiting the prepaid limited health service organization from requiring as a condition of a contract that a dentist participate in a discount medical plan; amending s. 641.315, F.S.; prohibiting a contract between a health maintenance organization and a dentist from requiring the dentist to provide services at a fee set by the organization under certain circumstances; defining the term "covered services" as it relates to contracts between a health maintenance organization and a

dentist; prohibiting the health maintenance organization from requiring as a condition of a contract that a dentist participate in a discount medical plan; providing applicability; providing an effective date.

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

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

627.6474 Provider contracts.—

(1) A health insurer may ~~shall~~ not require a contracted health care practitioner as defined in s. 456.001(4) to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or health maintenance organization, under common management and control with the insurer, including Medicare and Medicaid practitioner contracts and those authorized by s. 627.6471, s. 627.6472, s. 636.035, or s. 641.315, except for a practitioner in a group practice as defined in s. 456.053 who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this section is void. A violation of this subsection ~~section~~ is not subject to the criminal penalty specified in s. 624.15.

(2)(a) A contract between a health insurer and a dentist

licensed under chapter 466 for the provision of services to an insured may not contain a provision that requires the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract. As used in this paragraph, the term "covered services" means dental care services for which a reimbursement is available under the insured's contract or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

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

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

636.035 Provider arrangements.—

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

used in this paragraph, the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

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

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

641.315 Provider contracts.—

(11)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not contain a provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract. As used in this paragraph, the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract or for which a reimbursement would be available but for the application of contractual limitations such as deductibles,

coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

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

Section 4. This act applies to contracts entered into or renewed on or after July 1, 2014.

Section 5. This act shall take effect July 1, 2014.

Insurance & Banking Subcommittee

CS/HB 31 by Rep. Renuart
Dentists

AMENDMENT SUMMARY
March 25, 2014

Amendment 1 by Rep. Renuart (Lines 65-67): Removes the provision that a health insurer may not require as a condition of the contract that the dentist participate in a discount medical plan.

Amendment 2 by Rep. Renuart (Lines 86-89): Removes the provision that a prepaid limited health service organization may not require as a condition of the contract that the dentist participate in a discount medical plan.

Amendment 3 by Rep. Renuart (Lines 108-110): Removes the provision that a health maintenance organization may not require as a condition of the contract that the dentist participate in a discount medical plan.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 31 (2014)

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 bill: Insurance & Banking Subcommittee

Representative Renuart offered the following:

Amendment (with title amendment)

Remove lines 65-67

T I T L E A M E N D M E N T

Remove lines 8-10 and insert:

dentist; amending s.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 31 (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 bill: Insurance & Banking Subcommittee

Representative Renuart offered the following:

Amendment (with title amendment)

Remove lines 86-89

T I T L E A M E N D M E N T

Remove lines 17-20 and insert:

health service organization and a dentist; amending s.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 31 (2014)

Amendment No. 3

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 bill: Insurance & Banking Subcommittee

Representative Renuart offered the following:

Amendment (with title amendment)

Remove lines 108-110

T I T L E A M E N D M E N T

Remove lines 27-30 and insert:

dentist; providing applicability; providing an

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 423 Cemeteries
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

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

SUMMARY ANALYSIS

Chapter 497, F.S., regulates cemeteries, human burials, human cremation, and funeral directors through the Division of Funeral, Cemetery and Consumer Services, within the Department of Financial Services. In order to be licensed, new private cemeteries must be formed as a corporation, partnership, or limited liability company, have at least 30 acres, establish a care and maintenance trust with a starting amount of $50,000, and make certain financial disclosures. The care and maintenance trust is then funded through a set portion of all future costs and thereafter increases directly proportional to use.

Some cemeteries are specifically exempted by statute from these requirements, although certain provisions apply regardless of whether or not a cemetery is exempt. Currently, all religious institutions founded prior to 1971 as well as those that are less than 5 acres are exempted. The statute defines religious institutions as those that qualify for 501(c)(3) status from the IRS.

This Proposed Committee Substitute (PCS) creates an exemption from many of the provisions of ch. 497 for religious institutions to build a cemetery over 5 and up to 60 acres provided the institution establishes a care and maintenance trust fund of $2,000,000 and limits the burial rights to members of the institution and their families.

The PCS should not have any fiscal impact on local governments. Regarding any fiscal impact to the state, the Department of Financial Services has indicated that the PCS will have some unspecified administrative costs. To the extent that this PCS allows the creation of new cemeteries, there will be more competition in the marketplace.

The PCS provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Statutory Background

Chapter 497, F.S., otherwise known as "The Florida Funeral, Cemetery, and Consumer Services Act" provides for the regulation of cemeteries, columbaria, mausoleums, human burials, human cremation, and funeral directors.[1]

Currently, the Division of Funeral, Cemetery and Consumer Services (FCCS) is tasked with the administration of the overall licensing process of the industry.[2] In that regard, FCCS conducts investigations, financial examinations, and inspections of all licensed cemeteries.

FCCS is partially governed by an appointed board. The Board of Funeral, Cemetery, and Consumers Services is comprised of 10 members, 9 of whom are appointed by the Governor from nominations made by the CFO.[3] Unless the cemetery falls under an exemption, the Board has ultimate authority to approve or deny applications for cemeteries.[4]

Requirements to Build a New Licensed Cemetery

Currently, cemeteries fall into two categories; those cemeteries, typically for-profit, that are licensed through FCCS and those that are exempted from most regulation through a specific statutory exception. For those seeking to open a licensed cemetery, the entity must meet certain requirements, including corporate structure, trust, and financial disclosure requirements.

The law requires that a "cemetery license may only be applied for and issued to a corporation, partnership, or limited liability company".[5] For religious institutions, not all faiths organize as one of these legal entities. For example, the Catholic Church organizes itself in Florida as a corporation sole,[6] which is embodied in the Bishop of each diocese.[7] Currently, the Catholic Church, as presently organized, believes that it is unable to establish a new licensed cemetery without creating a new legal entity.[8]

In addition to being a corporation, partnership, or limited liability company, all newly licensed cemeteries must create a care and maintenance trust fund with an initial capital of $50,000.[9] After the initial investment, the trust fund funded by a portion of every burial performed (the greater of 10% of the arrangement or $25) or prearrangement sold (calculated as 75%).[10] Because of this provision, the care

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[1] s. 497.001, F.S.
[2] s. 497.151(11), F.S.
[3] s. 497.101(1), F.S.
[4] s. 497.103(j), F.S.
[5] s. 497.141(12)(c), F.S.
[6] 18 C.J.S. Corporations § 15, p. 393 says that corporation sole is composed of a single member and his successors in the office.
[7] *See* Hurley v. Werly, 203 So. 2d 530 (Fla. 2d DCA 1967), *summarizing* Reid v. Barry, 112 So. 846 (Fla. 1927) (defining a corporate sole as a "single person, who is made a body corporate and politic, in order to give him some legal capacities and advantages, and especially that of perpetuity, which, as a natural person, he cannot have. A bishop, dean, parson, and vicar are given in the English books as instances of Sole Corporation; and they and their successors in perpetuity take the corporate property and privileges.") In Barry, the Florida Supreme Court held that "[b]oth our Constitution and our statues provide for the means for the formation of corporations aggregate, but we find nothing in either Constitution or statutes which either expressly or impliedly repeals the ancient common-law institution of the 'corporation sole.'"
[8] Email exchange with Florida Catholic Conference of Bishops, 2/20/2014. On file with the Insurance & Banking Subcommittee staff.
[9] s. 497.263(3)(a), F.S.
[10] s. 497.268(1)(a), F.S.

and maintenance trust funds are directly proportional to the use of the cemetery rather than geographic size. According the FCCS, the average licensed cemetery has a trust balance of around $1.6 million.[11] Some cemeteries in larger metropolitan areas have trust funds in excess of $6 million.[12]

Once created, a care and maintenance trust fund may only be used for care and maintenance of the cemetery.[13] Financial reports are required to be turned into FCCS biannually for the first two years of the cemetery's existence and then annually thereafter.[14] FCCS is authorized to seek more records if they deem it necessary.

In addition to the trust funds, licensed cemeteries are required to pay into a statewide emergency fund. This fund acts as an insurance policy of last resort for the whole community.[15]

After obtaining a license, DFS is tasked with collecting an annual license fee as determined by statute. The fee structure is based on gross sales, which ranges from a $250 fee for those cemeteries of less than $25,000 in gross sales to a statutory maximum of $4900 for cemeteries that exceed $5,000,000 in gross revenue.[16]

Existing Exemptions

Currently, there are several categorical exemptions for certain cemeteries from many, but not all, of the provisions of Chapter 497. Some of the provisions of Chapter 497 apply to all cemeteries, regardless of designation. The excepted cemeteries can be divided into two general categories: non-religious and religious cemeteries. Section 497.100(63), F.S., defines a religious institution as "an organization formed primarily for religious purposes that has qualified for exemption from federal income tax as an exempt organization under the provisions of s. 501(c)(3) of the Internal Revenue Code of 1986, as amended". Of the religious institutions, exempted cemeteries can be further divided into those exempted due to age and those exempted due to size.

1. Non-religious institutions: The nonreligious cemeteries that are excluded under these exemptions are as follows: all county and city cemeteries[17], all single level community and nonprofit cemeteries that sell burial spaces or merchandise[18], all family cemeteries of less than 2 acres that do not sell burial spaces or merchandise[19], and any columbaria located on the main campus of a university[20].

2. Religious institutions existing prior to 1971: All religious cemeteries dedicated prior to June 23, 1971 are exempt from the statutory requirements.[21] This includes several large cemeteries in South Florida. The statute allows for any religious cemetery operating under this exemption that in a county that had a population of 1.3 million in 1996 to open one additional cemetery under this exemption in 2020.[22] In practice, this exemption only applies to Miami-Date County.[23]

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[11] Email exchange with DFS, 3/4/2014. On file with the Insurance & Banking Subcommittee staff.
[12] Id.
[13] s. 497.267, F.S.
[14] s. 497.269, F.S.
[15] Conversation with Elder Care Services, 3/12/2014. Notes on file with the Insurance & Banking Subcommittee staff.
[16] s. 497.265, F.S.
[17] s. 497.260(1)(b), F.S.
[18] s. 497.260(1)(c), F.S.
[19] s. 497.260(1)(g), F.S.
[20] s. 497.260(1)(i), F.S.
[21] s. 497.260(1)(d), F.S.
[22] s. 497.260(4), F.S.
[23] *See Countywide, Unincorporated, and Incorporated Total: 1972-2013,* Office of Economic & Demographic Research, the Florida Legislature at http://edr.state.fl.us/Content/population-demographics/data/ (Last visited January 1, 2014).

3. Religious institutions exempted based on size: For those religious cemeteries that were not grandfathered in, exceptions exist for cemeteries that are less than 5 acres that are single-level ground burials[24], sufficiently funded mausoleums[25] up to 2 acres that are immediately contiguous to the religious institution[26], and a columbarium[27] of less than one-half acre which is immediately contiguous to the religious institution[28]. With careful planning, a religious institution would be able to utilize all three of these exceptions, for a grand total of 7.5 acres of memorial space. Even though the term "cemetery" is defined by statute to include related mausoleums and columbaria,[29] this section of exceptions expand the area in practice by drafting around the definition.

Section 497.260(2), F.S., specifies that all cemeteries in this state, regardless of exemption status, are subject to the following requirements:

- Prohibits discrimination by race, color, creed, marital status, sex or national origin;[30]
- Requires the cemetery to keep records regarding burials; [31]
- Regulates solicitation of sales of burial rights, merchandise or services by licensees;[32]
- Provides a mechanism to record human remains in the county of records;[33]
- Forbids a cemetery company from charging a fee for the installation of a monument or marker not purchased from it;[34]
- Prohibits sellers of a grave space from tying that purchase to the purchase of a monument; [35] and
- Outlines provisions for counties and municipalities in dealing with an abandoned cemetery. [36]

Preneed Services

According to statute, a preneed contract is any arrangement or method, of which the provider of funeral merchandise or service has actual knowledge, whereby any person agrees to furnish funeral merchandise or service in the future.[37] Generally, those wishing to sell preneed contracts must be licensed through FCCS.[38] An individual does not need a funeral director's license in order to sell pre-need policies.

Pre-need arrangements are prepaid transactions for future promises that take place once the beneficiary is deceased. Many of those seeking these arrangements may be elderly or infirm. In many

[24] s. 497.260(a), F.S.
[25] Section 497.005 (42), F.S., defines a "mausoleum" as "a structure or building that is substantially exposed above the ground and that is intended for human remains."
[26] s. 497.260 (h), F.S.
[27] Section 497.005 (16), F.S., defines a "columbarium" as "a structure or building that is substantially exposed above the ground and that is intended to be used for the interment of cremated remains."
[28] s. 497.260 (f), F.S.
[29] Section 497.005 (11), F.S., defines a "cemetery" as "a place dedicated to and used or intended to be used for the permanent interment of human remains or cremated remains. A cemetery may contain land or earth interment; mausoleum, vault, or crypt interment; a columbarium, ossuary, scattering garden, or other structure or place used or intended to be used for the interment or disposition of cremated remains; or any combination of one or more of such structures or places."
[30] s. 497.152(1)(d), F.S.
[31] s. 497.276(1), F.S.
[32] s. 497.164, F.S.
[33] s. 497.2765, F.S.
[34] s. 497.278, F.S.
[35] s. 497.280, F.S.
[36] s. 497.284, F.S.
[37] s. 497.005 (56), F.S.
[38] See s. 497.466, F.S.

cases, the market value of a funeral home is determined by physical assets plus existing preneed contracts with the business. Those seeking pre-need arrangements can be a target for unscrupulous individuals.

Effect of the Proposed Committee Substitute (PCS)

The PCS amends Chapter 497 to allow religious institutions to construct an exempted cemetery of between 5 and 60 acres, provided that the cemetery has $2,000,000 set aside in a financial institution and limits burial rights to members of the institution and their families. The PCS also allows these exempt cemeteries to sell a limited amount of preneed products.

The minimum of $2,000,000 set aside in reserves must be submitted to FCCS under oath and must identify the financial institution and the account number where the funds are maintained.

This PCS does not apply to those religious cemeteries who are also less than 5 acres.

The PCS also limits burial rights to "members of the religious institution and their families". The term "families" is not defined in the PCS. One of the PCS proponents considers family members to be those "in the direct lineal chain, including parents and children and also includ[ing] siblings and spouse".[39] According to FCCS, the term "families" is not defined by Chapter 497 or by DFS rule.[40]

The Florida Statutes currently provide at least two definitions for families, found in Chapter 732 regarding estate definitions and in Chapter 63 regarding the adoption definitions. Chapter 732 defines familial relationships for the purposes of intestate succession and includes provisions for mixed families, adoptions, and those children born out of wedlock. For the purposes of adoption, the Florida Statutes has defined a "close relative" as a "brother, sister, grandparent, aunt, or uncle".[41] The adoption statute assumes the deaths of both parents, which is why spouses, fathers, and mothers are not included.

B. SECTION DIRECTORY:

Section 1. Amends s. 497.260, F.S., relating to cemeteries.

Section 2. Amends s. 497.452, F.S., relating to preneed license requirements.

Section 3. Provides an effective date July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Department of Financial Services has indicated that the PCS will have some unspecified administrative costs.

[39] Email exchange with Florida Catholic Conference of Bishops, 2/20/2014. On file with the Insurance & Banking Subcommittee staff.
[40] Conversation with FCCS, 2/24/14. Notes on file with the Insurance & Banking Subcommittee staff.
[41] s. 63.172(2), F.S.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The demand for burials in Florida private cemeteries has decreased as a percentage over the past few years.[42] This has been attributed to the rise of cremation rates and federal cemeteries. The increase of cremation paired with the expansion of three new federal veterans' cemeteries in Florida has led FCCS to express concern regarding the financial solvency of any new cemeteries.[43]

To the extent that a religious cemetery with a lower regulatory burden will compete for business with private cemeteries, there may be an impact on competition in the private sector. With more cemeteries comes the risk of having more cemeteries going out of business, leaving administrative costs in perpetuity.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Currently, there are no provisions in the law to limit the ability of any exempted cemetery operating under any provision to contract with third parties for services relating to the industry. There are instances of large religious cemeteries in other states contracting out cemetery functions and maintenance to third party funeral companies.[44] A similarly contracted entity would have a competitive advantage in the current regulatory environment.

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[42] See FCCS's Bill Analysis, SB 512. On file with the Insurance & Banking Subcommittee staff.

[43] Id.

[44] Archdiocese of Philadelphia Announces Outsourced Management Agreement and Long-term Lease with Stonemor L.P. Regarding Catholic Cemeteries" Press Release, Archdiocese of Philadelphia (Sept 26, 2013) *available at* http://archphila.org/press%20releases/pr002245.php

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to cemeteries; amending s. 497.260, F.S.; exempting certain religious-institution-owned cemeteries from provisions of the Florida Funeral, Cemetery, and Consumer Services Act relating to cemeteries; amending s. 497.452, F.S.; deleting obsolete provisions; conforming a provision to changes made by the act; providing an effective date.

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

Section 1. Paragraph (j) is added to subsection (1) of section 497.260, Florida Statutes, to read:

497.260 Cemeteries; exemption; investigation and mediation.—

(1) The provisions of this chapter relating to cemeteries and all rules adopted pursuant thereto shall apply to all cemeteries except for:

(j) A religious-institution-owned cemetery larger than 5 acres and a maximum of 60 acres if the religious institution:

1. Limits burial rights in the cemetery to members of the religious institution and their families.

2. Provides an annual certification to the department that it maintains funds sufficient to cover maintenance costs and pre-need arrangements in a separate account designed solely for such purposes. The funds must be held in a designated account

with a financial institution as defined in s. 280.02(13) and the account must maintain a minimum balance of $2,000,000. The annual certification must be made under oath and must identify the financial institution and the account number where the funds are maintained.

Section 2. Subsection (4) of section 497.452, Florida Statutes, is amended to read:

497.452 Preneed license required.—

(4) ~~The provisions of~~ This section does ~~do~~ not apply to religious-institution-owned cemeteries exempt under s. 497.260(1)(d) or (j)~~, in counties with a population of at least 960,000 persons on July 1, 1996,~~ with respect to the sale to the religious institution's members and their families of interment rights, mausoleums, crypts, cremation niches, cremation interment containers, vaults, liners, urns, memorials, vases, foundations, memorial bases, floral arrangements, monuments, markers, engraving, and the opening and closing of interment rights, mausoleums, crypts, cremation niches, and cremation interment containers, if such cemeteries ~~have engaged in the sale of preneed contracts prior to October 1, 1993, and~~ maintain a positive net worth at the end of each fiscal year of the cemetery.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 783 Financing of Motor Vehicles
SPONSOR(S): Albritton and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 832

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

SUMMARY ANALYSIS

Currently, when an individual buys a motor vehicle, the dealer may offer additional automotive products such as an extended warranty, guaranteed asset protection, a maintenance package, dent repair, or tire protection. These arrangements are generally financed through third parties or the manufacturer's captive financial entity. Typically, the manufacturer's captive automotive finance company is also the institution that is financing the vehicle and the warranty. Because of this arrangement, the captive automotive financial institution might have more leverage than third parties in offering their aftermarket automotive product on the consumer.

The bill amends s. 545.045, F.S., to prohibit an automotive manufacturer's finance company from denying, charging a fee, or unfavorably adjusting the terms of a financing agreement on an automotive contract solely because the contract contains a similar "automotive-related" product from a competitor.

The bill also defines "automotive related product" and "vehicle contract" for the statute.

The bill has no fiscal impact on the state or on local governments.

The bill provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Many automotive manufacturers have captive finance companies.[1] For example, Ford Motor Company has Ford Credit[2] and Toyota has Toyota Financial.[3] Other automotive manufactures may have preferred arrangements with a single bank, like Fiat has with Ally Bank.[4] These captive finance companies work directly with the manufacturers to finance the purchase of motor vehicles and manufacturer's warranties. The ultimate terms of the finance agreement can have a significant impact on the ultimate price paid by the consumer. In Florida, each new car dealership is a franchised outlet for a particular automotive manufacturer. Under the current statutory scheme, automotive manufacturers are not able to sell vehicles directly to consumers in Florida.

Currently, Chapter 545, F.S., regulates some combinations in regards to restricting the financing of motor vehicles, and is enforced by the Attorney General.[5] The chapter prohibits manufacturers and whole distributors of motor vehicles from requiring motor vehicle dealers to use only designated finance companies, such that the restriction would create a monopoly by the designated finance company.[6] The chapter also prohibits manufacturers and distributors from using threats or giving anything of value to any particular finance company that would lessen or eliminate competition. In addition to the Attorney General's enforcement authority, a violation of this chapter is a second-degree misdemeanor and may also result in civil damages for an injured business.[7]

Many vehicles come with a manufacturer's warranty, which is the manufacturer's legal responsibility to stand behind its product, and is included in the price of the product.[8] In addition to the car itself, the consumer typically has the option to purchase a myriad of motor vehicle service agreements and other automotive related products from the manufacturer's affiliates as well as from third-party companies. These decisions are made completely independently of any additional features or customization of the car, and do not include any physical asset. Recently, it has been discovered that some exclusionary financing practices have occurred with the purchase of these additional automotive-related products. At least one car manufacturer has gone on record stating that they have placed some requirements for the purchase of automotive related products on their dealerships:

> '[Volkswagen of America] does not require VW or Audi dealers to exclusively sell or finance its ancillary products, with one exception . . . The one exception is the Lease Excess Wear Protection product, because it represents a waiver of certain lease contract terms, and we are the only party authorized to make such waivers. This practice is customary amongst captive lenders for this type of product and has been part of VCI's product since introduction approximately 21/2 years ago."[9]

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[1] "Most Car Companies Want Their Own Finance Company So They Have A Place To Go Home To." Jim Henry. *Forbes*, October 31, 2012. (accessed Mar 21, 2013) *available at* http://www.forbes.com/sites/jimhenry/2012/10/31/most-car-companies-want-their-own-finance-company-so-they-have-a-place-to-go-home-to/

[2] http://credit.ford.com/

[3] http://www.toyotafinancial.com/

[4] See "Our History" Ally Bank. *available at* http://www.ally.com/about/company-structure/history/

[5] s. 545.08, F.S.

[6] s. 545.02, F.S.

[7] ss. 545.08-545.12, F.S.

[8] "Extended Warranties and Service Contracts" Consumer Information, Federal Trade Commission. Accessed Mar 3, 2014. *available at* http://www.consumer.ftc.gov/articles/0240-extended-warranties-and-service-contracts

[9] "Dealers, captive battle in statehouses" Jim Henery, Automotive News. Mar 19, 2014, accessed Mar 21, 2014. *available at* http://www.autonews.com/article/20140319/FINANCE_AND_INSURANCE/303199986/dealers-captives-battle-in-statehouses

This practice is viewed by some as enabling manufacturers to bundle the purchase of the car and manufacturer's warranty with the automotive related products. In doing so, such a manufacturer would be able to incentivize consumers to pick their automotive-related product by changing the ultimate finance terms of the entire purchase.

The Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR) may, within their respective regulatory jurisdictions, examine and investigate every person involved in the business of motor vehicle service agreements (which provide vehicle owners with protection when the manufacturer's warranty expires) in this state to determine whether such person is engaged in any unfair method of competition or in any unfair or deceptive acts or practices that are prohibited by s. 634.282, F.S.[10] The OIR conducts financial examinations of motor vehicle service agreement companies as required under part II of ch. 634, F.S. The OIR may examine the companies as often as may be warranted for the protection of policyholders and the public interest, but must examine each company once every 5 years.[11]

Additionally, the Office of Financial Regulation administers and enforces ch. 520, F.S., the Motor Vehicle Retail Sales Finance Act, which includes licensing and enforcement authority over motor vehicle retail installment sellers and sales finance companies. This act prohibits any motor vehicle retail installment seller, sales finance company, retail lessor, or assignee from requiring the purchase of a guaranteed asset protection (GAP) product as a condition for making a loan, and requires certain conditions and disclosures prior to the offer of any GAP product.[12]

There is nothing in current law that prohibits the manufactures from incentivizing their automotive related products over those of a third party through interest rate changes, fees, or penalties on the dealership.

Effect of the Bill

The bill creates a definition in s. 545.01, F.S., to define "automotive related products" as a service agreement as defined in s. 634.011, F.S., or a guaranteed asset protection product, as defined in s. 520.02, F.S., or other ancillary product that is purchased or otherwise provided at the point of sale or lease of the motor vehicle. These products include:

Motor vehicle service agreements – These agreements are currently defined in s. 634.011, F.S., as "any contract or agreement indemnifying the service agreement holder for the motor vehicle listed on the service agreement and arising out of the ownership, operation, and use of the motor vehicle against loss caused by failure of any mechanical or other component part, or any mechanical or other component part that does not function as it was originally intended." Section 634.011, F.S., is within the motor vehicle service agreement act, described above, that the Department of Financial Services and the Office of Insurance Regulation administer and enforce.[13]

Extended warranty agreements – These contracts provide for specified repair and maintenance on a product for a set amount of time or use.[14] Extended warranties are purchased in conjunction with the purchase of the product and are priced separately. Other maintenance packages including dent repair and tire protection.

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[10] s. 634.283, F.S.
[11] s. 634.141, F.S.
[12] ss. 520.07(11) and 520.994, F.S., relating to requirements and prohibitions as to retail installment contracts and powers of the OFR.
[13] Part I of ch. 634, F.S., relates to motor vehicle service agreement companies. Section 634.021, F.S., empowers the OIR to administer this part, and the DFS is empowered to enforce it as it relates to sales representatives.
[14] "Extended Warranties and Service Contracts" Consumer Information, Federal Trade Commission. Accessed Mar 3, 2014. *available at* http://www.consumer.ftc.gov/articles/0240-extended-warranties-and-service-contracts

GAP protection – Guaranteed Asset Protection Product (GAP) is an optional product that pays the difference between the amount owed on a vehicle and the amount the insurance company would pay if the vehicle is stolen or destroyed before the credit obligation is completed.[15] Section 520.02, F.S., defines GAP as a "guaranteed asset as a loan, lease, or retail installment contract term, or modification or addendum to a loan, lease, or retail installment contract, under which a creditor agrees to waive a customer's liability for payment of some or all of the amount by which the debt exceeds the value of the collateral. Such a product is not insurance for purposes of the Florida Insurance Code."[16] This insurance-like product ensures that a consumer would not have to pay car payments on a destroyed or stolen car. Section 520.02, F.S., is within the Motor Vehicle Retail Sales Finance Act, described above, which is administered and enforced by the Office of Financial Regulation.

In the instances when a consumer purchases a "substantially similar" automotive related product from a third party, this bill would prohibit a manufacturer-affiliated financial institution from adjusting policy rates of that consumer, charging the dealer of additional fee or surcharge, or denying the financing of that vehicle.

The bill applies to finance companies that are "affiliated with or controlled by a manufacturer or wholesale distributor through common ownership, officers, directors, or management, or that has a contractual agreement to represent a manufacturer or wholesale distributor with respect to financing the sale or 60 lease of motor vehicles."

This bill would only apply if the third party automotive related product contained in the vehicle contract is of "substantially similar or superior kind and quality to an automotive related product" offered by the finance company or the manufacturer.

B. SECTION DIRECTORY:

Section 1. Amends s. 545.01, F.S., relating to definitions.

Section 2. Creates s. 545.045, F.S., relating to the purchase or assignment of automotive financing.

Section 3. 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.

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[15] "Understanding Vehicle Financing" Consumer Information, Federal Trade Commission. Accessed Mar 3, 2014. *available at* http://www.consumer.ftc.gov/articles/0056-understanding-vehicle-financing

[16] s. 520.02(7), F.S.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill prohibits finance companies from making their product more favorable to consumers by bundling options, penalizing the dealer, or denying financing on a new car purchase. To the extent that this bill changes the current regulatory environment, there may be an indeterminable change in prices for these automotive related products.

The proponents claim that this change will increase competition and consumer choice. The automotive manufactures have gone on record in opposition to this bill, believing that it unfairly ties the hands of their financial institutions to incentivize their own product.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill targets those policies that are substantially similar or of superior kind and quality as those offered by the manufacture. This standard is not defined in the statute, and could result in litigation.

The bill amends Chapter 545, which is enforced by the Attorney General. The bill cross-cites to definitions from Chapter 634, which is regulated by the Office of Insurance Regulation and the Department Financial Services, and Chapter 520, which is regulated by the Office of Financial Regulation. The DFS and the OFR have indicated that this bill has no impact on their agencies.[17] However, because the bill creates a new definition of "automotive related product" that includes terms that are already defined in the Florida Statutes and regulated by other agencies, the bill could lead to some confusion as to who is ultimately responsible for determining what products are considered "automotive related products".

[17] OFR and DFS analyses of SB 832, on file with the Insurance & Banking Subcommittee staff. During the 2013 legislative session, the OIR provided an analysis of HB 1307, which was substantially similar to this bill. The OIR indicated that the bill has no fiscal or regulatory impact on OIR, and that its regulatory authority was over the manufacturer or wholesale distributor that offers a financed product, which may not necessarily encompass the motor vehicle service agreement company. Email from the OIR (dated March 18, 2013), on file with the Insurance & Banking Subcommittee staff.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the financing of motor vehicles; amending s. 545.01, F.S.; revising definitions; defining terms; creating s. 545.045, F.S.; prohibiting a finance company that is affiliated with or controlled by, or that has a contractual relationship to represent, a manufacturer or wholesale distributor from adopting or implementing a policy or business practice that results in specified actions relating to certain finance obligations arising from the retail sale or lease of a motor vehicle that includes a specified third party automotive related product; providing an effective date.

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

Section 1. Section 545.01, Florida Statutes, is reordered and amended to read:

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

(1) "Automotive related product" means a motor vehicle service agreement, as defined in s. 634.011, or a guaranteed asset protection product, as defined in s. 520.02, or other ancillary product that is purchased or otherwise provided as part of the sale or lease of a motor vehicle by a dealer.

(2)~~(5) The term~~ "Dealer" means a franchised motor vehicle dealer, as defined in s. 320.27(1)(c)1. ~~any person who is~~

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

~~engaged in, or who intends to engage in the business of selling motor vehicles at retail in this state. The term "dealer" shall also include "retail agent."~~

(3) ~~(6) The term~~ "Finance company" means a ~~any~~ person engaged in the business of financing the sale or lease of motor vehicles, or engaged in the business of purchasing or acquiring vehicle contracts ~~conditional bills of sale, or promissory notes, either secured by vendor's lien or chattel mortgages, or arising from the sale of motor vehicles~~ in this state.

(4) ~~(3) The term~~ "Manufacturer" means a ~~any~~ person engaged, directly or indirectly, in the manufacture of motor vehicles.

(5) ~~(1) The term~~ "Person" ~~as used in this chapter~~ means an ~~any~~ individual, firm, corporation, partnership, limited liability company, association, trustee, receiver, or assignee for the benefit of creditors.

(6) ~~(2) The terms~~ "Sell," "sold," "buy," or ~~and~~ "purchase~~,~~" includes ~~as used in this chapter, include~~ an exchange, barter, gift, or ~~and~~ offer to contract to sell or buy.

(7) "Vehicle contract" means a conditional sales contract, retail installment sales contract, chattel mortgage, lease agreement, promissory note, or any other financial obligation arising from the retail sale or lease of a motor vehicle.

(8) ~~(4) The term~~ "Wholesale distributor" means a ~~any~~ person engaged, directly or indirectly, in the sale or distribution of motor vehicles to agents or to dealers.

Section 2. Section 545.045, Florida Statutes, is created to read:

545.045 Purchase or assignment of third-party financing.—

(1) A finance company that is affiliated with or controlled by a manufacturer or wholesale distributor through common ownership, officers, directors, or management, or that has a contractual agreement to represent a manufacturer or wholesale distributor with respect to financing the sale or lease of motor vehicles, may not adopt or implement a policy or business practice that results in:

(a) A refusal to purchase or accept the assignment of a vehicle contract from a dealer because the vehicle contract includes a third party automotive related product;

(b) A charge to a dealer of an additional fee or surcharge for the purchase, or acceptance of the assignment, of a vehicle contract from a dealer because the vehicle contract includes a third party automotive related product; or

(c) An offer to purchase or accept assignment of a vehicle contract from a dealer on less favorable terms than a vehicle contract that contains otherwise substantially similar credit risk, duration, and other terms, because the vehicle contract includes a third party automotive related product.

(2) This section applies only if the third party automotive related product contained in the vehicle contract is of substantially similar or superior kind and quality to an automotive related product offered by the finance company or the

manufacturer or wholesale distributor that is affiliated with or controls the finance company or with which the finance company has a contractual agreement.

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

INSURANCE & BANKING SUBCOMMITTEE

HB 783 by Rep. Albritton
Financing of Motor Vehicles

AMENDMENT SUMMARY
March 25, 2014

Amendment 1 by Rep. Albritton (Strike All): In addition to conforming changes, the strike all does the following:

- Removes the provision which prohibited a manufacturer's financial institution from adjusting the rates of an automotive loan based on whether or not the consumer purchased an "automotive related product" from a third party;
- Prohibits the financial institution from charging from anyone, and not just the dealer, a fee for purchasing an "automotive related product" from a third party;
- Changes the applicability of the statute to those products that are of "similar nature, scope, and quality";
- Adds factors to determine whether an automotive related product is of similar nature, scope, and quality; and
- Adds definitions for an "affiliated finance company" and a "third party provider".

Amendment No.

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 bill: Insurance & Banking Subcommittee

Representative Albritton offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 545.01, Florida Statutes, is reordered and amended to read:

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

(1) "Affiliated finance company" means a finance company which:

(a) Is affiliated with or controlled by a manufacturer or wholesale distributor through common ownership, officers, directors, or management; or

(b) Has a contractual agreement with a manufacturer or wholesale distributor to finance, via sale or lease, motor

vehicles produced or distributed by such manufacturer or wholesale distributor.

(2) "Automotive related product" means a motor vehicle service agreement, as defined in s. 634.011, or a guaranteed asset protection product, as defined in s. 520.02, or other non-tangible ancillary product that is purchased or otherwise provided as part of the sale or lease of a motor vehicle by a dealer.

(6) ~~(1)~~ ~~The term~~ "Person" ~~as used in this chapter~~ means an ~~any~~ individual, firm, corporation, partnership, limited liability company, association, trustee, receiver, or assignee for the benefit of creditors.

(7) ~~(2)~~ ~~The terms~~ "Sell," "sold," "buy," or ~~and~~ "purchase," includes ~~as used in this chapter, include~~ an exchange, barter, gift, or ~~and~~ offer to contract to sell or buy.

(5) ~~(3)~~ ~~The term~~ "Manufacturer" means a ~~any~~ person engaged, directly or indirectly, in the manufacture of motor vehicles.

(10) ~~(4)~~ ~~The term~~ "Wholesale distributor" means a ~~any~~ person engaged, directly or indirectly, in the sale or distribution of motor vehicles to agents or to dealers.

(3) ~~(5)~~ ~~The term~~ "Dealer" means a franchised motor vehicle dealer, as defined in s. 320.27(1)(c)1. ~~any person who is engaged in, or who intends to engage in the business of selling motor vehicles at retail in this state. The term "dealer" shall also include "retail agent."~~

(4) ~~(6) The term~~ "Finance company" means a ~~any~~ person engaged in the business of financing the sale or lease of motor vehicles, or engaged in the business of purchasing or acquiring vehicle contracts ~~conditional bills of sale, or promissory notes, either secured by vendor's lien or chattel mortgages, or arising from the sale of motor vehicles~~ in this state.

(8) "Third-party provider" means a provider of an automotive related product that is not an affiliated finance company, manufacturer, or wholesale distributor.

(9) "Vehicle contract" means a conditional sales contract, retail installment sales contract, chattel mortgage, lease agreement, promissory note, or any other financial obligation arising from the retail sale or lease of a motor vehicle.

Section 2. Section 545.045, Florida Statutes, is created to read:

545.045 Purchase or assignment of third-party financing.—

(1) When a vehicle contract contains a third-party provider's automotive related product that is of similar nature, scope, and quality to an automotive related product offered for sale by an affiliated finance company or its related manufacturer or wholesale distributor, that affiliated finance company may not, solely because the vehicle contract contains a third party's automotive related product:

(a) Refuse to purchase or accept the assignment of the vehicle contract from a dealer; or

(b) Charge an additional fee or surcharge for the purchase of, or acceptance of the assignment of, the vehicle contract.

(2) Factors in determining whether an automotive related product is similar in nature, scope, and quality include, but are not limited to, the financial capacity of the third-party provider to meet all of its obligations, inclusive of any contractual liability insurance policies, and the third-party provider's history of compliance with any applicable state and federal regulations.

(3) A violation of this section does not constitute a criminal offense pursuant to s. 545.12.

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

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to the financing of motor vehicles; amending s. 545.01, F.S.; revising and reordering definitions; defining terms; creating s. 545.045, F.S.; prohibiting an affiliated finance company from taking specified actions relating to certain finance obligations arising from a vehicle contract that contains a third-party provider's specifed automotive related product; providing factors to determine whether an automotive related product is similar in

nature, scope, and quality to an automotive related product offered for sale by an affiliated finance company or its related manufacturer or wholesale distributor; providing that a violation does not constitute a criminal offense; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 939 Bail Bond Premiums
SPONSOR(S): Finance & Tax Subcommittee; Stewart and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1390

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Tax Subcommittee	14 Y, 2 N, As CS	Pewitt	Langston
2) Insurance & Banking Subcommittee		Bauer GB	Cooper JC
3) Appropriations Committee			

SUMMARY ANALYSIS

Florida imposes an annual tax on premiums collected by insurance companies doing business in the state. This tax applies to life, health, property and casualty, title insurance, and most other types of policies at a rate of 1.75% on the gross amount of premium, with deductions allowed for reinsurance accepted, return premiums, assessments, and various credits. It applies to self-insurance funds at a rate of 1.6%. It applies to annuities at a rate of 1%. It applies to wet marine and transportation insurance at a rate of 0.75% of gross underwriting profit, defined as net premiums minus net losses paid.

The bill provides that insurance premiums tax on bail bond premiums shall be calculated as 1.75% of bail bond premiums excluding any portion of the premium retained by bail bond agents or managing general agents. Other credits and exemptions applicable to insurance premiums tax may still be applied as under current law.

The Revenue Estimating Conference met on March 7, 2014 and estimated this bill would have a cash and recurring impact of -$0.7 million to general revenue beginning in fiscal year 2014-2015.

The bill provides an effective date of January 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Insurance Premiums Tax

Florida imposes an annual tax on premiums collected by insurance companies doing business in the state.[1] This tax applies to life, health, property and casualty, surety, title insurance, and most other types of policies at a rate of 1.75% on the gross amount of premium, with deductions allowed for reinsurance accepted, return premiums and assessments.[2] It applies to self-insurance funds at a rate of 1.6%.[3] It applies to annuities at a rate of 1%.[4] It applies to wet marine and transportation insurance at a rate of 0.75% of gross underwriting profit, defined as net premiums minus net losses paid.[5]

There are a number of credits allowed against insurance premiums tax liability. These include:

- 100% of corporate income tax paid pursuant to chapter 220, F.S.[6]
- 15% of salaries paid by the company to its Florida-based employees.[7]
- 50% of a community contribution made pursuant to the Community Contribution Tax Credit Program for enterprise zones.[8]
- 100% of donations made to eligible scholarship funding organizations pursuant to s. 1002.395.[9]

The sum of the credits granted for corporate income tax and employee salaries may not exceed 65% of the insurer's premium tax liability.[10]

Retaliatory Tax

When another state or foreign country levies certain taxes or fees, including insurance premiums tax, on Florida insurers in excess of the taxes and fees levied by Florida on insurers from such other state or foreign country, a retaliatory tax is charged.[11] Companies from the other state or foreign country are taxed using the same tax and fee structure that a similar Florida insurer operating in such state or foreign country would be charged.

Bail Bonds

When a person is charged with a crime in this state, they may seek pre-trial release. One method of seeking release is by applying for bail.[12] After a bail determination hearing, the court may grant the defendant monetary bail. Such bail can be satisfied by a surety bond presented by a qualified individual, group of individuals, or a bail bond agent licensed under chapter 648, F.S.[13] Such surety bonds serve as a guarantee by the surety that the defendant will appear at all necessary hearings.[14]

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[1] Section 624.509, F.S.
[2] Section 624.509(1)(a), F.S.
[3] Section 624.4625(4), F.S.
[4] Section 624.509(1)(b), F.S.
[5] Section 624.510, F.S.
[6] Section 624.509(4), F.S.
[7] Section 624.509(5), F.S.
[8] Section 624.5105, F.S.
[9] Section 624.51055, F.S.
[10] Section 624.509(6)(a), F.S.
[11] Section 624.5091, F.S.
[12] Section 903.035, F.S.
[13] Section 903,045, F.S.
[14] Section 624.606, F.S.

Licensed bail bond agents are required to charge a premium in exchange for granting the surety bond.[15] Bail bond agents are subject to Section I of the Insurance Code contained in chapter 627, F.S., which requires that their rates be filed with and approved by the Office of Insurance Regulation (OIR).

Licensed bail bond agents or licensed managing general agents retain up to 93.5% of the premium, and the insurance company retains the remainder.[16] Unlike other types of insurance companies, domestic bail bond providers file their required financial reports to the OIR, based on premiums collected *net* of any amounts retained by agents.[17] However, current law requires that the reporting and payment of insurance premium taxes and related excise taxes under ss. 624.509, 624.5091, and 624.5092, F.S., is calculated using *gross* bail bond premiums.[18]

Proposed Changes

The bill provides that insurance premiums tax on bail bond premiums shall be calculated as 1.75% of net bail bond premiums (i.e., excluding any portion of the premium retained by bail bond agents or managing general agents), as reported to the OIR. Other credits and exemptions applicable to insurance premiums tax may still be applied as under current law.

Additionally, it removes language from s. 624.4094(5), F.S., relating to calculation of insurance premiums tax on gross bail bond premiums, to conform to the changes detailed above.

B. SECTION DIRECTORY:

Section 1. Amends section 624.4094, F.S., repealing the provision that insurance premium taxes on bail bond premiums shall not be calculated based on premiums collected but excluding any portion of the premium retained by a bail bond agent.

Section 2. Amends section 624.509, F.S., to provide that insurance premiums tax on bail bond premiums shall be calculated as 1.75% of bail bond premiums but excluding any portion of the premium retained by a bail bond agent or managing general agent.

Section 3. Provides an effective date of January 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The Revenue Estimating Conference met on March 7, 2014, and estimated that the bill would have a cash and recurring impact of -$0.7 million to general revenue beginning in fiscal year 2014-2015.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None,

[15] Section 648.33(2), F.S.
[16] Section 624.4094(1), F.S.
[17] Section 624.4094, F.S.
[18] Section 624.4094(5), F.S.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill would reduce the insurance premiums tax levied on companies that provide bail bond insurance.

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

On March 20, 2014, the Finance & Tax Subcommittee adopted a strike-all amendment to the bill. The amendment applied the exemption to both foreign and domestic companies, and changed the effective date to January 1, 2015. The analysis has been updated to reflect these changes.

A bill to be entitled

An act relating to bail bond premiums; amending s. 624.4094, F.S.; repealing a provision separating the calculation of insurance premium taxes from financial reporting for bail bond premiums; amending s. 624.509, F.S.; specifying the amount of direct written premiums for bail bonds for the purpose of calculation of certain taxes; providing an effective date.

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

Section 1. Subsection (5) of section 624.4094, Florida Statutes, is amended, and subsection (1) of that section is republished, to read:

624.4094 Bail bond premiums.—

(1) The Legislature finds that a significant portion of bail bond premiums is retained by the licensed bail bond agents or licensed managing general agents. For purposes of reporting in financial statements required to be filed with the office pursuant to s. 624.424, direct written premiums for bail bonds by a domestic insurer in this state shall be reported net of any amounts retained by licensed bail bond agents or licensed managing general agents. However, in no case shall the direct written premiums for bail bonds be less than 6.5 percent of the total consideration received by the agent for all bail bonds written by the agent. This subsection also applies to any

determination of compliance with s. 624.4095.

~~(5) This section does not affect the reporting or payment of insurance premium taxes under ss. 624.509, 624.5091, and 624.5092, and the insurance premium tax and related excise taxes shall continue to be calculated using gross bail bond premiums.~~

Section 2. Subsection (1) of section 624.509, Florida Statutes, is amended, to read:

624.509 Premium tax; rate and computation.—

(1) In addition to the license taxes provided for in this chapter, each insurer shall also annually, and on or before March 1 in each year, except as to wet marine and transportation insurance taxed under s. 624.510, pay to the Department of Revenue a tax on insurance premiums, premiums for title insurance, or assessments, including membership fees and policy fees and gross deposits received from subscribers to reciprocal or interinsurance agreements, and on annuity premiums or considerations, received during the preceding calendar year, the amounts thereof to be determined as set forth in this section, to wit:

(a) An amount equal to 1.75 percent of the gross amount of such receipts on account of life and health insurance policies covering persons resident in this state and on account of all other types of policies and contracts (except annuity policies or contracts taxable under paragraph (b) and bail bond policies or contracts taxable under paragraph (c)) covering property, subjects, or risks located, resident, or to be performed in this

state, omitting premiums on reinsurance accepted, and less return premiums or assessments, but without deductions:

1. For reinsurance ceded to other insurers;

2. For moneys paid upon surrender of policies or certificates for cash surrender value;

3. For discounts or refunds for direct or prompt payment of premiums or assessments; and

4. On account of dividends of any nature or amount paid and credited or allowed to holders of insurance policies; certificates; or surety, indemnity, reciprocal, or interinsurance contracts or agreements.~~; and~~

(b) An amount equal to 1 percent of the gross receipts on annuity policies or contracts paid by holders thereof in this state.

(c) An amount equal to 1.75 percent of the direct written premiums for bail bonds excluding any amounts retained by licensed bail bond agents or licensed managing general agents.

Section 3. This act shall take effect January 1, 2015.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1001 Health Care
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** SB 1534

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

SUMMARY ANALYSIS

Current law requires the Agency for Health Care Administration (AHCA) to establish a preferred drug list (PDL) for the state's Medicaid Managed Assistance Program (MMA), in order to control drug expenditures. Recommendations for inclusion on the PDL are made by the Pharmaceutical and Therapeutics Committee (P&T Committee), based on clinical efficiency, safety, and costs. Current law requires the P&T Committee to review drugs newly approved by the FDA within three months of public availability, but does not mandate coverage of such drugs until they are reviewed. The proposed committee substitute (bill) requires MMA plans to include newly-approved drugs on the PDL until the P&T Committee has reviewed them for inclusion. The bill also requires that the PDL include at least two products in a therapeutic class whenever feasible. Additionally, the bill requires MMA plans to continue to cover drugs that they remove from their PDL, for recipients who have statements from their prescribers indicating continued use of the drug is medically necessary.

The bill also makes changes to Medicaid and commercial health insurance plans regarding step-therapy protocols, payment of claims, and notice requirements regarding preferred providers.

Step-therapy pharmaceutical programs are intended to contain costs for prescribed medications, by requiring providers to prescribe lower-cost drugs before trying other, usually more expensive, drugs. Many step-therapy programs allow prescribing providers to request an override of the step-therapy protocols. The bill requires insurers to provide prescribing providers a "clear and convenient process" to request an override, which must be granted within 24 hours of a completed request if the prescribing provider, based on sound clinical evidence, feels the protocol will be ineffective or is likely to cause an adverse effect to the insured.

Current law requires health maintenance organizations (HMOs) and health insurers to provide a grace period after an insured or subscriber fails to pay renewal premiums and must temporarily authorize claims for treatment sought during this grace period. If the insured/subscriber ultimately does not pay renewal premiums, the HMO or insurer may deny the claims. The bill amends current law to provide that HMOs and insurers may not retroactively deny a claim if they have (a) verified eligibility of an insured's plan at the time of treatment and received an authorization number or (b) if they have provided the insured with an identification card, which serves as proof of eligibility at the time of treatment.

Additionally, the bill requires insurers who offer coverage for services of a preferred provider to post a link to the insurer's website containing a list of preferred providers and to update the list within 24 hours of any change.

The fiscal impact on the state is currently indeterminate, but likely significant. AHCA has determined that the provisions related to MMA programs will likely cause them to incur costs of authorizing additional medications that previously would not have been approved. The State Group Health Insurance Program will also likely incur increased costs for medical claims. Insurers may incur increased costs in complying with the provisions of this bill. Such cost increases will be borne by employers and policyholders.

The bill takes effect July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

This Proposed Committee Substitute (PCS) addresses issues relating to managed care plans providing health care services to Medicaid recipients as well as issues relating to managed care organizations and health insurers serving commercial clients.

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elder Affairs. For Fiscal Year 2014-15, the federal government will pay for 59.10 percent of the costs of the program and the state must pay the balance.[1] For Fiscal Year 2014-15, Florida's Medicaid program is estimated to have 3.7 million enrolled recipients and $22.3 billion in total spending with $5.7 billion in general revenue.[2]

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections.

The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[3] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[4]

Florida Medicaid is the second largest single program in the state, behind public education. Florida's program is the 4th largest in the nation, and the 5th largest in terms of expenditures. Florida's Medicaid costs have increased significantly since its inception, due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures.

Medicaid Prescribed Drug Benefits

Medically necessary prescription drugs are an optional Medicaid service under federal law, which Florida chooses to cover.[5]

For Medicaid reimbursement, a drug must be included in a rebate agreement with the U.S. Department of Health and Human services, it must be medically necessary for the patient, and must either be prescribed for medically accepted indications and dosages found in the drug labeling or drug

[1] Social Services Estimating Conference, Medicaid Caseload and Expenditures, December 17, 2013, available at: http://edr.state.fl.us/Content/conferences/medicaid/index.cfm (last viewed March 22, 2014)
[2] Id.
[3] S. 409.905, F.S.
[4] S. 409.906, F.S.
[5] 42 U.S.C. 1396d; s. 409.906, F.S.

compendia in accordance with Section 1927(k)(6) of the Social Security Act, or prior authorized by a qualified clinical specialist approved by AHCA.[6]

Florida Medicaid processes over 1.3 million drug claims per month in the fee-for-service program.[7] In Fiscal Year 2013-2014, the legislature appropriated over $1.5 billion for the Medicaid prescription drug benefit. Federal rebates and state supplemental rebates account for 52.6% of the cost of drugs in the fee-for-service Medicaid program; general revenue accounts for covers 20.3% and federal matching funds cover 27%.[8]

The Legislature has enacted and AHCA has implemented many provisions to control the utilization and expense of the prescribed drug benefit, and reduce fraud and overpayments in the program. These include pharmacy provider standards, statutorily-defined pricing, a prescribing pattern review panel, a pharmacy lock-in program, counterfeit-proof prescription pads, a behavioral drug management system, state supplemental rebates, prior authorization, step-therapy, and a preferred drug list.[9]

Medicaid Preferred Drug List

Section 409.912(37), F.S., requires AHCA to establish a preferred drug list to control drug expenditures.[10] Recommendations for inclusion on the preferred drug list (PDL) are made by an 11-member Pharmaceutical and Therapeutics Committee (P&T Committee) of physicians, pharmacists, and a consumer representative, appointed by the Governor.[11] The P&T Committee is required to base its PDL recommendations on the clinical efficacy, safety and cost-effectiveness of a product.[12]

AHCA is authorized to negotiate state supplemental rebates with manufacturers (in addition to the HHS-negotiated federal rebate), and agreement to pay the minimum statutory rebate percentage guarantees the P&T Committee will consider the drug for inclusion on the PDL; however, it does not guarantee placement on the PDL. The PDL must include at least two drugs for each therapeutic class, and the P&T Committee must review each class every 12 months, if feasible.[13]

AHCA is required to ensure that the P&T Committee reviews a drug newly-approved by the U.S. Food and Drug Administration (FDA) *under a priority review classification* at the next meeting following three months of its public availability.[14] The FDA has two review classifications, to distinguish between drugs that demonstrate the potential to improve or prevent a serious or life-threatening condition from those that do not:[15]

- Priority review applies to drugs that treat serious conditions and provide significant improvements in the safety or effectiveness of the treatment, diagnosis, or prevention of serious

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[6] AHCA, Florida Medicaid Prescribed Drugs Coverage Limitations and Reimbursement Handbook, June 2012, p. 3-ii, available at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Prescribed_Drug_Services_Handbook_Publications_V1.pdf (last viewed March 22, 2014), incorporated by reference in Fla. Admin. Code Ann. r. 59G-4.250 (2012).

[7] AHCA, Medicaid Prescribed Drug Program Spending Control Initiatives for Quarters ending December 31, 2013 and September 30, 2013, p. 2., available at http://ahca.myflorida.com/medicaid/prescribed_drug/pdf/SFY_2012-13_Q1-Q2_FINAL.pdf (last visited March 22, 2014).

[8] AHCA, Prescribed Drug Program Spending report, supra note 7, p. 6.

[9] Pursuant to s. 409.912(37)(a)17.c, F.S., AHCA issues a quarterly report on the spending control initiatives for the prescribed drug benefit.

[10] Florida Medicaid Preferred Drug List, available at: http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml (last viewed March 22, 2014).

[11] S. 409.91195, F.S.

[12] S. 409.91195(8), F.S.

[13] Ss. 409.912(37), 409.91195(4), F.S.

[14] S. 409.91195(7), F.S.

[15] U.S. Food and Drug Administration, Center for Drug Evaluation and Research, Review Designation Policy, MAPP 6020.3 Rev. 2, July 2013, available at: http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/StaffPoliciesandProcedures/ucm082000.pdf (last viewed March 23, 2014).

conditions compared to available therapies. The FDA decides these applications within 6 months.
- Standard review applies to drugs that do not meet the priority review designation criteria. The FDA decides these applications within 10 months.

The AHCA Secretary makes the ultimate decision as to which drugs are placed on the PDL.

Medicaid Prescription Drug Prior Authorization

Generally, reimbursement for PDL drugs is automatically authorized. Drugs which are not on the PDL must be prior authorized.[16] Non-PDL drug prior authorization includes a "step-therapy" or "fail-first" requirement which may vary by drug. This requires the patient to have unsuccessfully tried PDL medications in the same class in the last 12 months. However, Medicaid patients can bypass the step-therapy requirement and obtain prior authorization for a non-PDL drug if the prescribing physician provides documentation indicating that the non-PDL drug is medically necessary because:

- No PDL drug is an acceptable clinical alternative;
- The PDL drugs have been ineffective in treating the patient's particular disease;
- The PDL drugs are likely to be ineffective, based on this particular patient's characteristics; or
- The number of doses has been ineffective.[17]

Separate from the non-PDL prior authorization requirement, Florida Medicaid imposes a clinical prior authorization requirement for a limited list of drugs:

- When prescribed for an indication not approved in FDA labeling;
- To ensure compliance with certain clinical guidelines; or
- If the product has the potential for overuse, misuse, or abuse (such as Oxycontin).[18]

AHCA must respond to a request for prior authorization within 25 hours, and must grant a 72-hour supply if the response takes longer than 24 hours.[19]

Currently, Medicaid managed care plans may use AHCA's PDL and prior-authorization rules for their prescription drug coverage programs, or may develop their own preferred drug lists and prior authorization and step-therapy or fail-first processes. These processes must be approved by AHCA.[20]

Statewide Medicaid Managed Care

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC requires AHCA to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care. Each Medicaid recipient will have one managed care organization to coordinate all health care services, rather than various entities as in the current Medicaid program. This comprehensive coordinated system of care was successfully implemented in a 5-county Medicaid reform pilot program which began in 2006.

The SMMC program has two components: the Long-term Care Managed Care Program and the Managed Medical Assistance (MMA) Program. The MMA program provides primary and acute medical assistance and related services. On December 28, 2012, AHCA released an Invitation to Negotiate

[16] AHCA Provider Handbook, supra note 7 at 3-vi. Oral contraceptives and HIV/AIDS anti-retroviral agents are not subject to the PDL process and are not subject to prior authorization. AHCA Provider Handbook supra note 6 at 3-xv.
[17] S. 409.912(37)(a)16., F.S.; AHCA Provider Handbook, supra note 6 at 3-vi.
[18] AHCA Provider Handbook, supra note 6 at 3-xv.
[19] S. 409.912(37)(a)1.a., b., F.S.
[20] AHCA, Legislative Bill Analysis, HB 1001, Feb. 14, 2014, p. 2.

(ITN) to competitively procure managed care plans on a statewide basis for the MMA program.[21] AHCA subsequently selected health maintenance organizations and provider service networks via the competitive procurement. On February 6, 2014, AHCA executed contracts with the MMA managed care plans.[22]

AHCA will begin implementing the MMA program in selected regions on May 1, 2014 with the last regions being implemented on August 1, 2014. The program must be fully implemented in all regions by October, 2014, as directed in s. 409.971, F.S.

MMA Prescribed Drug Benefits

The MMA contracts require the managed care plans to use the AHCA PDL for the first year of operation, to ensure a smooth transition of recipients and coverage.[23] After the first year, AHCA has the option of requesting that the MMA plans develop their own preferred drug lists and submit them for AHCA's consideration.[24] The MMA plans must use AHCA's prior-authorization rules for their prescription drug coverage programs; unless they receive permission from AHCA to develop their own prior authorization and step-therapy or fail-first processes.[25] The plan's prior authorization and step-therapy or fail-first processes cannot be more restrictive than those used by AHCA.

Effect of the Proposed Committee Substitute (Bill)

Medicaid

Managed care plans participating in MMA would have to comply with the provisions of the bill that specifically relate to the MMA program and the provisions that generally relate to managed care plans. Additionally, AHCA would have to amend the MMA contracts where the current contract provisions conflict with the provisions of the bill.

Override of Step-Therapy or Fail-First Protocols

The bill amends Medicaid law to create a less stringent override procedure for step-therapy and fail-first protocols than required under current Medicaid law and in the MMA contracts. The bill allows an override when the proscribing provider determines, or believes, based on clinical or medical evidence that the preferred treatment would be ineffective or cause harm. Additionally, the bill allows the prescriber to determine the length of time the Medicaid recipient uses the step-therapy drug. Under the bill, the prescribing provider can "deem the treatment clinically ineffective" and the recipient will automatically be granted an override.

Newly-Approved Drugs

Current law requires the Medicaid P&T Committee to review drugs that are newly-approved under a priority review classification by the FDA within three months of public availability, and does not require

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[21] Id.

[22] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Addendum 2* Solicitations Number: AHCA ITN 017-12/13; Feb. 26, 2013, available at: http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 22, 2014); AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, Solicitation Number: AHCA ITN 017-12/13, Dec. 28, 2012, available at: http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 22, 2014).

[23] Model Agreement, Attachment II, Exhibit II A, Medicaid Managed Medical Assistance Program, Agency for Health Care Administration, February, 2014, available at http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#mmaplans (last viewed March 23, 2014).

[24] Id.

[25] Id.

Medicaid to cover them without prior authorization until reviewed.[26] The bill requires the MMA plans to include, through prior authorization, newly-approved drugs before the plans have reviewed the drug for inclusion in their formularies – regardless of the FDA review classification. This both expands the mandatory P&T Committee review to include drugs which *do not* improve or prevent a serious or life-threatening condition, and mandates that they be covered without prior authorization until considered by the P&T Committee. The bill requires the review of the new drug to take place at the next meeting of a plan's formulary committee following three months of distribution of the drug to the general public, which is consistent with current law.

Drugs Removed from the PDL

The bill amends Medicaid law to require the MMA plans to continue to cover drugs that they remove from their formulary or PDL for recipients who have written statements from their prescribers indicating the drugs continue to be medically necessary.

Retroactive Claim Denial

The bill amends s. 641.3155, governing prompt payment of claims by HMOs, to prohibit a HMO that has verified the eligibility of a subscriber at the time of treatment and has provided an authorization number from retroactively denying a claim because of subscriber ineligibility. Currently, the Medicaid MMA contracts require the MMA plans to comply with s. 641.3155, F.S.[27], so changes to this section would be applied to MMA HMOs.

Identification Cards

Current Medicaid rules and contracts require providers to verify recipient eligibility, and HMO enrollment if applicable, prior to submitting a claim.[28] The rules specifically provide that possession of a Medicaid identification card "does **not** mean a recipient is eligible for Medicaid services".[29] Medicaid recipients may move in and out of eligibility often, and old Medicaid identification cards are reactivated when they become eligible again. A Medicaid identification card is not a reliable indicator of eligibility, and relying on them could result in claim denial if the recipient is no longer eligible.

The bill amends s. 641.3155, governing HMOs, to prohibit a HMO from retroactively denying a claim because of subscriber ineligibility if the HMO provided the subscriber with an identification card which, at the time of service, identifies the subscriber as eligible to receive services. This provision would also apply to Medicaid MMA plans. The bill would require Medicaid coverage of claims for people who were not eligible at the time of service, based on possession of a non-current identification card, with no obligation for the provider to verify eligibility.

Commercial plans

The bill also revises current law regarding payment of claims, step therapy pharmaceutical protocols, and contracts for health insurers and health maintenance organizations.

Payment of Claims and Grace Periods under Florida Law

Part VI, ch. 627, F.S., relates to health insurance policies. Section 627.608, F.S., requires that every health insurance policy by commercial health insurers provide a grace period after an insured fails to

[26] S. 409.91195(7), F.S.
[27] Model Agreement, Attachment II, Medicaid Managed Medical Assistance Program, Agency for Health Care Administration, February, 2014, available at http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#mmaplans (last viewed March 23, 2014).
[28] AHCA, Florida Medicaid Provider General Handbook, July 2012, p. 1-27, 3-5, 3-14, available at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/GH_12_12-07-01_Provider_General_Handbook.pdf (last viewed March 22, 2014), incorporated by reference in Fla. Admin. Code Ann. r. 59G-5.020 (2012).
[29] Id. at 3-3.

pay renewal premiums on time, so that the policy stays in force throughout the grace period and the policyholder can remain eligible for service during that grace period. Regardless whether the insurer reserves the right to refuse renewal, each policy must include a provision that the insured has a 7-day grace period for a weekly premium policy, a 10-day grace period for a monthly premium policy, or a 31-day grace period for all other policies, and the insured may pay the renewal premium during the grace period.[30]

For HMOs, s. 641.31(15), F.S., requires that all health maintenance contracts, certificates, and member handbooks contain a provision that the contract has a grace period of no less than 10 days, and the contract will stay in force during the grace period and any premium that was not paid on time may be paid during the grace period.[31]

If a patient seeks treatment during the grace period and a provider seeks prior authorization or seeks verification or of a patient's insured status during such time, the prevailing view is that an insurer cannot take any action other than following the policy terms, and must affirmatively respond that the patient is insured. Accordingly, an insurer would be violating the grace period statute if an insurer either disclosed to the provider that the patient was in a grace period and had yet not paid his or her renewal premium or denied the authorization. In essence, these statutes require HMOs and health insurers to give temporary authorizations during the pendency of the grace period. If the patient ultimately fails to pay his or her renewal premium by the end of the grace period, the insurer may deny the claim, which places providers in the position of collecting payment directly from the patient for any care rendered during the grace period.

Payment of Claims and Grace Period under Federal Law

The federal regulations implementing the Affordable Care Act also contain a grace period for enrollees in qualified health plans (QHPs) and federally facilitated exchanges.[32] *QHPs* are health plans that are subject to certain requirements related to marketing, choice of providers, plan network, essential benefits, and other features, and must be accredited by HHS and licensed by each state in order to provide coverage in those respective states. *Federally-facilitated marketplaces* are established and operated by the U.S. Department of Health and Human Services for states that did not elect to form and operate their own marketplaces. However, states may elect to perform use federal government services for reinsurance programs and Medicaid and CHIP eligibility assessments or determinations.

The CMS regulations provide that for enrollees in a qualified health plan who receive an advance premium tax credit, they remain eligible for services for a 90-day grace period.[33] In addition, the CMS regulations require that QHP issuers pay providers for services rendered during the first 30 days of the grace period, and those payments in the first month are not subject to recoupment. However, for the second and third months of the grace period, the QHP is permitted (but not required) to "pend" claims for services, by deferring payment until the patient pays the renewal premium. If the enrollee ultimately fails to pay his or her renewal premium by the end of the grace period, the QHP issuer may deny the claims for services rendered.[34]

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[30] If the insurer does reserve the right to refuse renewal, the grace period does not apply if the insurer has delivered or mailed written notice of the insurer's intent of non-renewal to the insured's last address at least 30 days before the premium due date. Section 627.608, F.S. It has been represented to staff that some large insurers, such as Florida Blue, have adopted a 31-day grace period for all policies.

[31] As with commercial health insurers, it has been represented to staff that many HMOs have also adopted a 31-day grace period for all health maintenance contracts. Additionally, s. 641.341(15)(b), F.S., provides that this minimum 10-day grace period for health maintenance contracts applies to group health maintenance contracts only.

[32] 45 C.F.R. Parts 155, 156, and 157. *See* 45 C.F.R. § 155.20 for definitions of qualified health plans and federally facilitated exchanges; *see also* "Building the Health Insurance Marketplace," at http://www.ncsl.org/research/health/american-health-benefit-exchanges.aspx (last viewed March 23, 2014).

[33] The enabling legislation requires QHPs to "allow a three-month grace period for non-payment of premiums before discontinuing coverage." 42 U.S.C. §18082(c)(2)(B)(iv).

[34] 45 C.F.R. §156.270, relating to termination of coverage for qualified individuals.

As is the case with HMOs and commercial health insurers, this grace period process places providers in the position of collecting payment directly from the patient for any care rendered during the final 60 days of the grace period, if the patient ultimately fails to pay the premium.

Retroactive Denial of Claims

Sections 627.6131 and 641.3155, F.S., contains required timeframes for health insurers and HMOs, respectively, to pay claims and sets forth provisions for disputed and overdue claims. These provisions cannot be waived, voided, or nullified by contract.[35] Both statutes also prohibit health insurers and HMOs from retroactively denying a claim because of an insured's or subscriber's ineligibility more than one year after the date of payment of the claim.

Effect of the Bill Relating to Payment of Claims

The bill amends ss. 627.6131(11) and 641.3155(10), F.S., to add that health insurers and HMOs, respectively, may not retroactively deny a claim because of an insured's or subscriber's ineligibility, if the health insurer or HMO has (a) verified the eligibility of an insured's or subscriber at the time of treatment and has provided an authorization number, or (b) provided the insured or subscriber with an identification card, as provided for in s. 627.642(3) that at the time of service identifies the insured or subscriber as eligible to receive services.

It is unclear whether the bill's provision that the presentation of an authorization number or an identification card will prevent an HMO or health insurer from retroactively denying a claim because of insured or subscriber ineligibility. First, the grace period statutes discussed above require HMOs and health insurers to give temporarily authorizations for treatment sought during the grace period, but allows HMOs and health insurers to deny payment if the patient ultimately pays to pay the premium at the end of the grace period and is ultimately ineligible. The bill's prohibition on retroactive denial, when a provider has relied on a temporary authorization, would in effect require health insurers and HMOs to authorize payment of claims even for ultimately ineligible patients.

Secondly, s. 627.642(3), F.S., which specifies minimum requirements of an identification card for a health insurance policy, currently does not require that the identification card identify whether the insured or subscriber is eligible. The statute only requires items such as the name of the insurer and the contract holder, type of plan, the member identification number, and contact phone numbers or electronic addresses for authorization, admission certifications, and for the provider to verify benefits and information to estimate patient financial responsibility. It is unknown how many insurers and HMOs include information, beyond what is statutorily required, on the identification cards that would enable providers to verify a patient's eligibility at the time of service and from the face of the cards.

Step-Therapy Pharmaceutical Protocols[36]

Managed care organizations and health insurance plans are increasingly adopting step-therapy pharmaceutical programs in an effort to contain costs and assess risks regarding prescribed medications. These programs typically require providers to prescribe lower-cost drugs before trying other, usually more expensive and sometimes riskier, drugs used for the same treatment. Generally, step-therapy requires a patient to try a first-line medication within a drug class, often using a generic alternative, prior to receiving coverage for a second-line or back-up medication, usually a branded product.[37]

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[35] Sections 627.6131(10) and 624.3155(9), F.S.

[36] Although "fail-first" is sometimes used, the clinical and academic literature on this topic, as well as the managed care industry, refer to these programs as "step-therapy."

[37] Mark,T. et al., "The Effects of Antidepressant Step Therapy Protocols on Pharmaceutical and Medical Utilization and Expenditures," *The American Journal of Psychiatry*, 2010: 167:1202-1209 available at http://ajp.psychiatryonline.org/article.aspx?articleid=102459 (last viewed on March 22, 2014). *See also* "Definition of Step Therapy,"

Organizations and plans which have implemented step-therapy programs have also established specific procedures allowing patients access to second-line drugs. Procedures vary, but many programs provide coverage of back-up drugs if:

- the patient has already tried the first-line drug and the medication was unsuccessful;
- the patient cannot take the generic drug (for example, because of an historic allergy); or
- the physician decides for medical reasons the patient needs a brand name or second-line medication.

If any of these situations apply, many managed care organizations or health insurers allow physicians to request an override which, if granted, allow the patient to receive the back-up medication.[38] Many step-therapy programs also allow patients to use a second-line medication if recent insurance claims are found for the first-line drug, or if members recently obtained a prescription for the second-line drug.[39]

Effect of the Bill Relating to Step-Therapy Protocols

The bill creates new provisions regarding step-therapy protocols implemented by health maintenance organizations or health insurers. The bill provides that when medications for the treatment of a medical condition are restricted for use by an insurer by a step-therapy or fail-first protocol, the prescribing provider must have access to a "clear and convenient process" to request an override of the protocol from the HMO or health insurance issuer. The HMO or health insurer must grant an override of the protocol within 24 hours under the following circumstances:

(a) The prescribing provider recommends, based on sound clinical evidence, that the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or
(b) Based on sound clinical evidence or medical and scientific evidence:
    1. The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol is expected or likely to be ineffective based on known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or
    2. The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol will cause or is likely to cause an adverse reaction or other physical harm to the insured.

The effect of these provisions is that a prescribing provider must be granted an override as long as in his or opinion, based on sound clinical evidence (which is undefined) the first line drug has been ineffective in the treatment of the insured's disease or medical condition, even if that runs counter to the rulings of the FDA, peer reviewed literature, and the assessment of the medical directors and medical and pharmaceutical review committees of the HMO or health insurer.

The bill also states that if the prescribing provider allows the patient to enter the step-therapy or fail-first protocol recommended by the insurer, the duration of the step-therapy or fail-first protocol may not exceed a period deemed appropriate by the provider. If the prescribing provider deems the treatment clinically ineffective, the patient is entitled to receive the recommended course of therapy without requiring the prescribing provider to seek approval for an override of the step-therapy or fail-first protocol.

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at http://www.medterms.com/script/main/art.asp?articlekey=40302 (last viewed on March23, 2014), and "Pharmacy Programs' Step Therapy: What is it?" at http://www.jmbhealthconnect.com/276 (last viewed on March 23, 2014).

[38] "Frequently Asked Questions – Step Therapy" available at: https://member.express-scripts.com/.../StepTherapyFAQs (last viewed on March23, 2014).

[39] *Supra* fn. 36 (Mark, T. et al)

The effect of this provision would appear to allow a physician to circumvent the procedures delineated above in (a) and (b) by enabling the provider to agree to a patient's participation in the step-therapy protocol and then immediately discontinuing the medication and prescribe a drug without requiring an override.

Notice Requirements Regarding Preferred Providers

Current law requires any insurer offering coverage for the services of a preferred provider to provide each policyholder with a current list of preferred providers. Additionally, current law requires the insurer to make the current list available for the public during regular business hours at the insurer's principal office.[40]

Since this law went into effect, the creation of the Internet has transformed the sharing of information. Insurers in Florida routinely update the list of their preferred providers and make the list available on their website. Insurers update their list regularly (usually within 24-48 hours), although the frequency of such updates is not currently mandated by statute. It is common practice for insurers to also list a phone number on the list for policyholders to call with questions, including inquiries regarding the availability of certain providers and service.[41]

Effect of the Bill Relating to Notice Requirements

The bill amends s. 627.6471(2), F.S., requiring any insurer offering coverage for the services of a preferred provider to post a link on the insurer's website containing the list of preferred providers. The bill requires insurer's to reflect on their website, any changes to the list within 24 hours. It is unclear whether the online list will need to be updated within 24 hours of any change to any of the contracts with preferred providers, or may be updated by the end of the next day.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.967(2)(c), F.S., relating to managed care plan accountability.

Section 2: Amends s. 627.6131(11), F.S., relating to payment of claims.

Section 3: Creates s. 627.6466, F.S., relating to fail-first protocols.

Section 4: Amends s. 627.6471(2), F.S., relating to contracts for reduced rates of payment; limitations; coinsurance and deductibles.

Section 5: Amends s. 641.3155(10), F.S., relating to prompt payment of claims.

Section 6: Creates s. 641.394, F.S., relating to fail-first protocols.

Section 7: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[40] S. 627.6471(2), F.S.

[41] Information obtained from representatives of the health insurance industry on 03/21/2014, on file with staff of the Insurance & Banking Subcommittee.

1. Revenues:

   None.

2. Expenditures:

   According to AHCA, the provisions related to the override of step-therapy and fail-first protocols and the plans having to continue to pay for some drugs after removal from the PDL could increase costs to the Medicaid program. AHCA has concluded the fiscal impact is indeterminate, but likely to be significant.[42] Similarly, the requirement that AHCA pay for all newly-approved drugs without prior authorization until considered by the P&T Committee will likely significantly increase the cost of the prescription drug benefit.

   AHCA is required to pay actuarially sound, risk-adjusted rates[43] to the managed care plans participating in the MMA program. To the extent the provisions of the bill increase the cost of the prescription drug benefit to the MMA plans, these costs will be passed on to the state through required increases in the rates paid to the plans. The bill requires HMOs to pay claims of people who have Medicaid identification cards, regardless of whether the recipient is actually eligible at the time of service. This will likely significantly increase Medicaid costs.

   The State Group Insurance Program is projected to spend $1.3 billion on medical claims[44] in FY 2014-15 and is projected to spend $487 million on pharmacy claims[45] in FY 2014-15.[46] To the extent the provisions of the bill increase the cost of the prescription drug benefit, the State Group Insurance Program will incur increased costs. Likewise, the provisions disallowing retroactive claims denial because of an incorrect authorization or the possession by a subscriber of an identification card will cause the State Group Insurance Program to incur increased costs for medical claims.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill's provisions relating to the payment of claims and step-therapy are likely to increase costs for the plans and the employers and consumers who receive services. Because of the current law regarding grace periods for HMOs and health insurers, the prohibition on retroactive denial of claims will result in plans having to pay claims when the subscriber or policyholder was, in fact, ineligible.

Although there are studies which indicate that some step-therapy programs result in patient non-compliance and ineffective treatment, the provisions in the bill relating to step-therapy will likely

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[42] 2014 Agency Legislative Bill Analysis of HB 1001, AHCA, February 21, 2014.
[43] S. 409.968, F.S. and 42 CFR §438.6(c)(2).
[44] HMO medical costs are projected to increase 8% in FY 2014-15 and 8% in FY 2015-2016. PPO medical costs for are projected to increase 7.5% for FY 2014-2015 and 7.5% for FY 2015-16.
[45] Costs for the HMO pharmacy benefit are projected to increase 8.6% in FY 2014-15 and 10.5% in FY 2015-2016. Costs for the PPO pharmacy benefit are projected to increase 6.3% for FY 2014-2015 and 10.5% for FY 2015-16.
[46] State Employees' Group Health Self-Insurance Trust Fund, Report on the Financial Outlook, March 4, 2014. Available at: http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf

increase overall costs, because the bill not only limits the application of step-therapy, it allows, in some cases, the circumvention of existing protocols.[47]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided by the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[47] One of the most recent discussions on the costs associated with step therapy occurred on December 18, 2013 at the meeting of the Pension & Health Benefits Committee of the California Public Employees' Retirement System (CalPERS). Material for Agenda Item 8 states, "As of 2011, 14 evaluations of step therapy programs have been published. Five therapy classes were evaluated, including antidepressants, antihypertensives, antipsychotics, nonsteroidal anti-inflammatory drugs and proton pump inhibitors. Research demonstrates that step therapy programs for all therapy classes but antipsychotics can provide significant drug savings. The drug cost savings result from greater use of generics, and to a lesser extent, a decrease in use of medications. In addition, findings conclude that step therapy programs did not impact utilization of hospitals and emergency rooms. Further research to evaluate the impact of step therapy programs on cost savings and clinical outcomes is recommended for other drug therapy classes." Available at www.calpers.ca.gov/eip-docs/about/committee.../item-8.pdf (last viewed on March23, 2014).

A bill to be entitled

An act relating to health care; amending s. 409.967, F.S.; revising contract requirements for managed care programs; providing requirements for plans establishing a drug formulary or list; establishing a process for providers to override certain treatment restrictions; amending s. 627.6131, F.S.; prohibiting retroactive denial of claims in certain circumstances; creating s. 627.6466, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override process in certain circumstances; amending s. 627.6471, F.S.; requiring insurers to post provider information on a website; amending s. 641.3155, F.S.; prohibiting retroactive denial of claims in certain circumstances; creating s. 641.394, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override process in certain circumstances; providing an effective date.; providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section

409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) Access.—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a region wide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance

indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2.a. If establishing a prescribed drug formulary or preferred drug list, a managed care plan shall:

(I) Provide a broad range of therapeutic options for the treatment of disease states consistent with the general needs of an outpatient population. Whenever feasible, the formulary or preferred drug list shall include at least two products in a therapeutic class.

(II) Include coverage through prior authorization for each drug newly approved by the United States Food and Drug Administration until the Medicaid Pharmaceutical and Therapeutics Committee reviews such drug for inclusion on the formulary. The timing of the formulary review must comply with s. 409.91195.

b. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible

to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.

c. If a prescription drug on a plan's formulary is removed or changed, the managed care plan shall permit an enrollee who was receiving the drug to continue to receive the drug if the provider submits a written request that demonstrates that the drug is medically necessary and the enrollee meets clinical criteria to receive the drug.

d. For enrollees ~~Medicaid recipients~~ diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. When medications for the treatment of a medical condition are restricted for use by a managed care plan by a step-therapy or fail-first protocol, the prescribing provider shall have access to a clear and convenient process to request an override of the protocol from the managed care plan. The managed care plan shall grant an override of the protocol within 24 hours under the following circumstances:

a. The prescribing provider recommends, based on sound clinical evidence, that the preferred treatment required under

the step-therapy or fail-first protocol has been ineffective in the treatment of the enrollee's disease or medical condition; or

b. Based on sound clinical evidence or medical and scientific evidence:

(I) The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol is expected or likely to be ineffective based on known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen; or

(II) The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the enrollee.

If the prescribing provider allows the enrollee to enter the step-therapy or fail-first protocol recommended by the managed care plan, the duration of the step-therapy or fail-first protocol may not exceed a period deemed appropriate by the provider. If the prescribing provider deems the treatment clinically ineffective, the enrollee is entitled to receive the recommended course of therapy without requiring the prescribing provider to seek approval for an override of the step-therapy or fail-first protocol.

Section 2. Subsection (11) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.—

(11)

(a) A health insurer may not retroactively deny a claim because of insured ineligibility more than 1 year after the date of payment of the claim.

(b) A health insurer that has verified the eligibility of an insured at the time of treatment and has provided an authorization number may not retroactively deny a claim because of insured ineligibility.

(c) A health insurer that has provided the insured with an identification card as provided in s. 627.642(3) that at the time of service identifies the insured as eligible to receive services may not retroactively deny a claim because of insured ineligibility.

Section 3. Section 627.6466, Florida Statutes, is created to read:

627.6466 Fail-first protocols.—When medications for the treatment of a medical condition are restricted for use by an insurer by a step-therapy or fail-first protocol, the prescribing provider shall have access to a clear and convenient process to request an override of the protocol from the health benefit plan or health insurance issuer. The plan or issuer shall grant an override of the protocol within 24 hours under the following circumstances:

(a) The prescribing provider recommends, based on sound clinical evidence, that the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in

the treatment of the insured's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence:

1. The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol is expected or likely to be ineffective based on known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

2. The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol will cause or is likely to cause an adverse reaction or other physical harm to the insured.

If the prescribing provider allows the patient to enter the step-therapy or fail-first protocol recommended by the insurer, the duration of the step-therapy or fail-first protocol may not exceed a period deemed appropriate by the provider. If the prescribing provider deems the treatment clinically ineffective, the patient is entitled to receive the recommended course of therapy without requiring the prescribing provider to seek approval for an override of the step-therapy or fail-first protocol.

Section 4. Subsection (2) of section 627.6471, Florida Statutes, is amended to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(2) Any insurer issuing a policy of health insurance in this state, which insurance includes coverage for the services of a preferred provider, shall ~~must~~ provide each policyholder and certificate holder with a current list of preferred providers, shall ~~and must~~ make the list available for public inspection during regular business hours at the principal office of the insurer within the state, and shall post a link to the list of preferred providers on the home page of the insurer's website. Changes to the list of preferred providers shall be reflected on the insurer's website within 24 hours.

Section 5. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(10)

(a) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility more than 1 year after the date of payment of the claim.

(b) A health maintenance organization that has verified the eligibility of a subscriber at the time of treatment and has provided an authorization number may not retroactively deny a claim because of subscriber ineligibility.

(c) A health maintenance organization that has provided the subscriber with an identification card as provided in s. 627.642(3) that at the time of service identifies the subscriber as eligible to receive services may not retroactively deny a claim because of subscriber ineligibility.

Section 6. Section 641.394, Florida Statutes, is created to read:

641.394 Fail-first protocols.— When medications for the treatment of a medical condition are restricted for use by a health maintenance organization by a step-therapy or fail-first protocol, the prescribing provider shall have access to a clear and convenient process to request an override of the protocol from the health maintenance organization. The health maintenance organization shall grant an override of the protocol within 24 hours under the following circumstances:

(a) The prescribing provider recommends, based on sound clinical evidence, that the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence:

1. The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol is expected or likely to be ineffective based on known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

2. The prescribing provider believes that the preferred treatment required under the step-therapy or fail-first protocol will cause or is likely to cause an adverse reaction or other physical harm to the insured.

If the prescribing provider allows the patient to enter the step-therapy or fail-first protocol recommended by the health maintenance organization, the duration of the step-therapy or fail-first protocol may not exceed a period deemed appropriate by the provider. If the prescribing provider deems the treatment clinically ineffective, the patient is entitled to receive the recommended course of therapy without requiring the prescribing provider to seek approval for an override of the step-therapy or fail-first protocol.

Section 7. This act shall take effect July 1, 2014.

INSURANCE & BANKING SUBCOMMITTEE

PCS for HB 1001 by Rep. Brodeur
Healthcare

AMENDMENT SUMMARY
March 25, 2014

Amendment 1 by Rep. Tobia (Lines 102-123): Requires managed care plans to grant an override of treatment protocol within 24 hours when the patient presents evidence that she/he has previously complied with step-therapy protocol requirements.

Amendment 2 by Rep. Tobia (Lines 131-143): Bars health insurers that verify eligibility of an insured at the time of treatment and that have provided an authorization number from retroactively denying a claim because of insured ineligibility. Repeals s. 627.608, F.S., requiring insurers to provide a grace period if premium is not paid on or before the date it is due.

Amendment 3 by Rep. Tobia (Lines 152-178) Requires insurers to grant an override of treatment protocol within 24 hours when the patient presents evidence that she/he has previously complied with step-therapy protocol requirements.

Amendment 4 by Rep. Tobia (Lines 193-208): Repeals provision that requires health maintenance contracts, certificates, and member handbooks to provide a grace period for premiums that are not paid when due. Bars health maintenance organizations that verify eligibility of an insured at the time of treatment and that have provided an authorization number from retroactively denying a claim because of insured ineligibility.

Amendment 5 by Rep. Tobia (Lines 218-243): Requires health maintenance organizations to grant an override of treatment protocol within 24 hours when the patient presents evidence that she/he has previously complied with step-therapy protocol requirements.

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 Tobia offered the following:

Amendment

Remove lines 102-123 and insert:

24 hours when the patient presents documented evidence, such as pharmacy records, proving that the patient has previously complied with the step-therapy protocol requirements. If the prescribing provider deems the treatment

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 Tobia offered the following:

Amendment (with title amendment)

Remove lines 131-143 and insert:

(11) A health insurer may not retroactively deny a claim because of insured ineligibility more than 1 year after the date of payment of the claim. A health insurer that has verified the eligibility of an insured at the time of treatment and has provided an authorization number may not retroactively deny a claim because of insured ineligibility.

Section 3. Section 627.608, Florida Statutes, is repealed:

~~627.608 Grace period.~~

~~(1) If the insurer reserves the right to refuse renewal, the contract shall include the following provision:~~

~~"Grace Period: This policy has a ...(insert a number not less than '7' for a weekly premium policy, '10' for a monthly premium policy, or '31' for all other policies)... day grace period. This provision means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following grace period. The grace period will not apply if, at least 30 days before the premium due date, the insurer has delivered or mailed to the insured's last address shown in the insurer's records written notice of the insurer's intent not to renew this policy. During the grace period, the policy will stay in force."~~

~~(2) If the insurer does not reserve the right to refuse renewal, the contract shall include the following provision:~~

~~"Grace Period: This policy has a ...(insert a number not less than '7' for a weekly premium policy, '10' for a monthly premium policy, or '31' for all other policies)... day grace period. This provision means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, the policy will stay in force."~~

T I T L E A M E N D M E N T

Amendment No. 2

Remove line 7 and insert:

restrictions; repealing s. 627.608, F.S.; providing a grace period; amending s. 627.6131, F.S.; prohibiting

Amendment No. 3

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 Tobia offered the following:

Amendment

Remove lines 152-178 and insert:

shall grant an override of the protocol within 24 hours when the patient presents documented evidence, such as pharmacy records, proving that the patient has previously complied with the step-therapy protocol requirements.

Amendment No. 4

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 Tobia offered the following:

Amendment (with title amendment)

Remove lines 193-208 and insert:

Section 5. Subsection (15) of section 641.31, Florida Statutes, is amended to read:

~~(15)(a) All health maintenance contracts, certificates, and member handbooks shall contain the following provision:~~

~~"Grace Period: This contract has a (insert a number not less than 10) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, the contract will stay in force."~~

~~(b) The required provision of paragraph (a) shall not apply to certificates or member handbooks delivered to individual subscribers under a group health maintenance contract when the employer or other person who will hold the contract on behalf of the subscriber group pays the entire premium for the individual subscribers. However, such required provision shall apply to the group health maintenance contract.~~

Section 6. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility more than 1 year after the date of payment of the claim. A health maintenance organization that has verified the eligibility of a subscriber at the time of treatment and has provided an authorization number may not retroactively deny a claim because of subscriber ineligibility.

T I T L E A M E N D M E N T

Remove line 15 and insert:

website; repealing subsection (15) of s. 641.31, F.S.; relating to grace periods for health maintenance contracts; amending s. 641.3155, F.S.; prohibiting

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COMMITTEE/SUBCOMMITTEE AMENDMENT

PCB Name: PCS for HB 1001 (2014)

Amendment No. 5

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 Tobia offered the following:

Amendment

Remove lines 218-243 and insert:

hours when the patient presents documented evidence, such as pharmacy records, proving that the patient has previously complied with the step-therapy protocol requirements.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1089 Property Insurance
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** SB 1274

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

SUMMARY ANALYSIS

Citizens Property Insurance Corporation (Citizens or corporation) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market. It is not a private insurance company. Current law provides an eligibility restriction for insurance in Citizens based on the location of the property. Major structures for which a building permit for new construction is applied for on or after July 1, 2014 or for which a building permit for a substantial improvement of the structure is applied for on or after July 1, 2014, and which is located seaward of the coastal construction control line or within the Coastal Barrier Resources System (CBRS) are ineligible for insurance in Citizens.

The PCS creates an exception to current law for Citizens' eligibility based on location of the property. The exception permits major structures that are substantially improved at any time to be insured in Citizens if they are located in a county where Citizens issues 75 percent or more of the total number of policies for personal lines residential, commercial residential, and commercial nonresidential insurance policies. It appears Monroe County is the only county in Florida that would currently fall within the exception created by the PCS and it appears the exception would apply to a maximum of 656 parcels of land in Monroe County.

Section 627.0629(1), F.S., requires rate filings for residential property insurance to include actuarially reasonable mitigation discounts. The Office of Insurance Regulation (OIR) determines the amount of the discount. The current OIR administrative rule relating to mitigation discount amounts allows insurance companies to modify the amounts if the insurer provides a detailed alternate study supporting the modification and allows the OIR to review all assumptions used in the study. The PCS requires Citizens to submit any alternate study it obtains relating to windstorm mitigation discounts to the OIR for review and approval as allowed under the current administrative rule. If the OIR approves the study, then Citizens must include any discounts provided in the study in their rates.

Typically, policyholders are responsible for substantiating the insured property has mitigation features using a uniform mitigation verification inspection form which is submitted to the insurer. All insurers must use the uniform mitigation verification inspection form developed by rule by the Financial Services Commission (FSC). The current uniform mitigation form recognizes the Florida Building Code adopted in 2001 or later and the South Florida Building Code adopted in 1994. The PCS allows the FSC to create an addendum to the uniform mitigation verification form to be used in a county that has a building code stronger than the highest code recognized on the uniform mitigation form.

The PCS has no fiscal impact on state or local governments. Owners of structures in counties where Citizens insures 75 percent or more of the property will be able to obtain or keep insurance in Citizens even if they substantially improve their structure after July 1, 2014.

The PCS is effective July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Citizens Property Insurance Corporation

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

As of February 12, 2014, Citizens is the largest property insurer in Florida with over one million policies extending approximately $315 billion of property coverage to Floridians.[1] Citizens insures over 383,000 residential and commercial policies in Florida's coastal areas and over 600,000 residential policies in Florida's non-coastal areas. The remaining policies are commercial policies insured in Florida's non-coastal areas.

Citizens was created by the Legislature in 2002 by the merger of two existing property insurance associations: The Florida Residential Property and Casualty Joint Underwriting Association (FRPCJUA) and the Florida Windstorm Underwriting Association (FWUA). The FRPCJUA provided full-coverage personal and commercial residential property policies in all counties of Florida while the FWUA provided personal and commercial residential property wind-only coverage in designated territories.

Citizens writes various types of property insurance coverage for its policyholders. The types of coverage are divided into three separate accounts within the corporation:

1. Personal Lines Account (PLA) – Multiperil Policies[2]
   Consists of homeowners, mobile homeowners, dwelling fire, tenants, condominium unit owners and similar policies;
2. Commercial Lines Account (CLA) – Multiperil Policies
   Consists of condominium association, apartment building, homeowner's association policies, and commercial non-residential multiperil policies on property located outside the Coastal Account area; and
3. Coastal Account – Wind-only[3] and Multiperil Policies
   Consists of wind-only and multiperil policies for personal residential, commercial residential, and commercial non-residential issued in limited eligible coastal areas.

Eligibility for Insurance in Citizens

Current law requires Citizens to provide a procedure for determining the eligibility of a potential risk for insurance in Citizens and provides specific eligibility requirements based on premium amount, value of the property insured, and the location of the property. Risks not meeting the statutory eligibility requirements cannot be insured by Citizens. Citizens has additional eligibility requirements set out in their underwriting rules. These rules, which are approved by the Office of Insurance Regulation (OIR), give flexibility for Citizens to denote some risks as uninsurable based on factors not enumerated in statute, such as age of home, condition and age of roof, vacant property, certain seasonal occupancy, and type of electrical wiring.

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[1] https://www.citizensfla.com/about/bookofbusiness/ (last viewed March 11, 2014).

[2] A multi-peril policy is defined as a package policy, such as a homeowners or business insurance policy that provides coverage against several different perils. It also refers to the combination of property and liability coverage in one policy. (http://www2.iii.org/glossary/) Multi-peril property insurance policies include coverage for damage from windstorm and from other perils, such as fire, theft, and liability.

[3] A wind-only policy is a property insurance policy that provides coverage against windstorm damage only. Coverage against non-windstorm events such as fire, theft, and liability are available in a separate policy.

Eligibility Based on Premium Amount
Under current law, a homeowner cannot buy insurance in Citizens if an insurer in the private market offers the homeowner insurance for a premium 15 percent or less than the Citizens' premium.[4] In addition, the coverage offered by the private insurer must be comparable to Citizens' coverage. Thus, a homeowner can buy insurance from Citizens only if the private insurer's premium is more than 15 percent than the Citizens' premium.

Under current law, a homeowner cannot renew insurance in Citizens if an insurer in the private market offers to insure the property at a premium equal to or less than the Citizens' renewal premium. The insurance from the private market insurer must be comparable to the insurance from Citizens in order for the renewal premium eligibility requirement to apply.

Eligibility Based on Value of Property Insured
In addition to the eligibility restrictions based on premium amount, current law provides eligibility restrictions for homes and condominium units based on the value of the property insured. Structures with a dwelling replacement cost or a condominium unit that has a dwelling and contents replacement cost of:

- $1 million or more cannot obtain insurance in Citizens starting January 1, 2014, but property insured by Citizens for $1 million or more on December 31, 2013 can remain insured in Citizens until the policy expires in 2014, but cannot be renewed.
- $900,000 or more cannot obtain insurance in Citizens starting January 1, 2015, but property insured for $900,000 or more on December 31, 2014 can remain insured in Citizens until the policy expires in 2015, but cannot be renewed.
- $800,000 or more cannot obtain insurance in Citizens starting January 1, 2016, but property insured for $800,000 or more on December 31, 2015 can remain insured in Citizens until the policy expires in 2016, but cannot be renewed.
- $700,000 or more cannot obtain insurance in Citizens starting January 1, 2017, but property insured for $700,000 or more on December 31, 2016 can remain insured in Citizens until the policy expires in 2017, but cannot be renewed.

However, Citizens is allowed to insure structures with a dwelling replacement cost or a condominium unit with a dwelling and contents replacement cost of $1 million or less in counties with no competition.

Citizens does not have any eligibility restrictions based on the value of the property insured for condominium association, homeowner association, or apartment building policies. Citizens has multiple eligibility and coverage restrictions for commercial businesses, depending on where the business is located and the type of policy the business purchases from Citizens. These restrictions are contained in the underwriting rules of Citizens, not in the statute.

Eligibility Based on Location of Property
Current law also provides an eligibility restriction for insurance in Citizens based on the location of the property. Major structures for which a building permit for new construction is applied for on or after July 1, 2014 or for which a building permit for a substantial improvement of the structure is applied for on or after July 1, 2014, and which is located seaward of the coastal construction control line[5] or within the

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

[5] The coastal construction control line (CCCL) establishes an area of jurisdiction in which special siting and design criteria are applied for construction and related activities. These standards may be more stringent than those that apply in the rest of the coastal building zone because during a storm event greater forces are expected to occur in the more seaward zone of the beach. Chapter 62B-33, Florida Administrative Code, provides the design and siting requirements that must be met to obtain a CCCL permit. Approval or denial of a permit application is based upon a review of the potential impacts to the beach dune system, adjacent properties, native salt resistant vegetation, and marine turtles. The CCCL is not a setback line or line of prohibition for construction. Rather, new construction as well as additions, remodeling, and repairs to existing structures are allowed seaward of the control line; however, such structures and activities, unless exempt by rule or law, require a CCCL permit from the Florida Department of Environmental Protection. An interactive map showing the CCCL is available online.

Coastal Barrier Resources System[6] (CBRS) are ineligible for insurance in Citizens. The definition of "major structure" that is contained in s. 161.54, F.S., is the one that applies to Citizens' eligibility and is very broad, encompassing all residential and commercial buildings. The definition specifies it covers houses, mobile homes, apartment buildings, condominiums, hotels, motels, and restaurants. The definition of "substantial improvement" that is also contained in s. 161.54, F.S., is the one that applies to Citizens' eligibility. Generally, this definition makes any repair, reconstruction, rehabilitation, or improvement to a structure that costs 50 percent or more of the market value of the structure to be a "substantial improvement." The statutory definition contains additional parameters and guidance and exclusions.

Statewide Impact of the Application of Citizens' Eligibility Based on Location of Property
Citizens has identified approximately 100,000 parcels of land statewide completely within the CBRS or seaward of the coastal construction control line.[7] Under current law, these parcels are ineligible for insurance in Citizens if:

- the parcel is currently improved (i.e., developed) and the structure located on the parcel is substantially improved with a building permit applied for on or after July 1, 2014, or
- if the parcel is currently unimproved (i.e.,vacant), but is later developed with a building permit applied for on or after July 1, 2014.

Of the 100,000 total parcels of land completely within the CBRS or seaward of the coastal construction control line, Citizens currently writes 25,000 policies statewide insuring structures on these parcels. Thus, any substantial improvement to these 25,000 properties where a building permit is applied for on or after July 1, 2014 would keep them from continuing to be insured by Citizens.

Citizens identified another 80,000-100,000 properties it currently insures that are so close to the CBRS or the coastal construction control line that any change in the boundaries of these areas[8] could move these properties into the CBRS or the control line, thus preventing the property from keeping insurance in Citizens if it is substantially improved with a building permit applied for on or after July 1, 2014.

Monroe County Impact of the Application of the CBRS Eligibility Restriction
There is no coastal construction control line in Monroe County. Thus, the provision in current law relating to eligibility for Citizens insurance for property located in the CBRS is the only applicable provision for Monroe County.

Monroe County has the following types of property located in whole or in part in the CBRS:

- 83 parcels are privately owned and improved (i.e., developed) and are completely contained within the CBRS.
- 1,239 parcels are privately owned and unimproved (i.e., vacant) and are completely contained within the CBRS.

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[6] The Coastal Barrier Resources Act (CBRA or Act)[6] was passed in 1982 and reauthorized in 1990, 2000 and 2005. Under CBRA, some undeveloped land located on coastal barriers is designated by the Secretary of the Interior as CBRA units in the Coastal Barrier Resource System (CBRS). The Act does not prohibit or regulate development of land in the CBRS, it simply precludes land owners from obtaining federal financial assistance for development of coastal barrier land. The Act encourages the conservation of hurricane prone, biologically rich coastal barriers by restricting federal expenditures that encourage development, such as federal flood insurance, road building, disaster relief, and wastewater systems. Areas within the CBRS can be developed if the private developer or other non-federal party bears the full cost of development. The U.S. Fish and Wildlife Service is the federal agency responsible for implementing CBRA. Florida has 128 units in the CBRS totaling 677,334 acres, and 454 shoreline miles. The CBRS boundaries are depicted on U.S. Geological Survey topographic quadrangle maps. With three exceptions, only Congress has the authority to change CBRA boundaries to include or exclude specific property. The exceptions allow the Secretary of the Interior to change the boundaries for (1) voluntary additions to the CBRS by property owners, (2) additions of excess federal property to the CBRS, and (3) the required CBRA 5-year review that solely considers changes to the CBRS by natural forces such as erosion or accretion.

[7] All information about parcel count in the CBRS or the coastal construction control line was obtained from Citizens and is on file with the Insurance & Banking Subcommittee.

[8] The Florida Department of Environmental Protection (DEP) establishes the coastal construction control line on a county basis. The line is subject to review at the discretion of DEP, upon request of officials of affected counties or municipalities, or upon request of a riparian upland owner who feels that the line is unduly restrictive or prevents a legitimate use of the owner's property. (s. 161.053(2)(a), F.S.). Congress can change the boundaries of the CBRA which define the CBRS, with three exceptions that allow the Secretary of the Interior to change the boundaries. (see footnote 6).

- 573 parcels are privately owned and improved and intersect the CBRS in some manner (but are not wholly in the CBRS).
- 1,311 parcels are privately owned and unimproved and intersect the CBRS in some manner (but are not wholly in the CBRS).[9]

Potentially all of these properties (3,206 total) could become ineligible for insurance in Citizens in the future under the current law. For the 83 parcels that are currently improved and are completely within the CBRS, if the property owner substantially improves the property and applies for a building permit to do so on or after July 1, 2014, Citizens cannot insure it, even if they do so presently. For the 573 parcels that are currently improved, but are only partly within the CBRS, if the structure on the property is built on the part of the parcel in the CBRS and is substantially improved with a building permit applied for on or after July 1, 2014, Citizens cannot insure it, even if they do so presently.

For the 1,239 parcels that are currently vacant and are completely within the CBRS, if the property owner develops the parcel with a building permit applied for on or after July 1, 2014, Citizens cannot insure the structure built. For the 1,311 parcels that are currently vacant, but are only partly within the CBRS, if the property owner develops the parcel with a building permit applied for on or after July 1, 2014 and the structure is built on the part of the parcel in the CBRS, Citizens cannot insure the structure. However, if the structure is built on the part of the parcel not in the CBRS, Citizens can insure the structure.

Although it is unknown how many of the 3,206 parcels in the CBRS in Monroe County are presently insured by Citizens, there can be no more than 656 parcels because that is the number of developed parcels located in whole or in part in the CBRS. Citizens only insures structures and does not insure vacant land, so the parcel must be classified as improved for Citizens to insure it. Thus, there is a maximum of 656 properties that are currently insured by Citizens and that could be ineligible for insurance from Citizens in the future if the property is substantially improved with a building permit applied for on or after July 1, 2014. If these properties became ineligible for insurance from Citizens, an insurer in the admitted or surplus lines market has to insure the property.[10]

As of January 31, 2014, Citizens insures over 24,000 total properties (residential, commercial residential, and commercial nonresidential) in Monroe County, so the majority of property insured by Citizens in Monroe County is not located in the CBRS and thus not impacted by the CBRS eligibility restriction in current law.[11]

Effect of Proposed Changes Related to Citizens' Eligibility

The PCS creates an exception to current law for Citizens' eligibility based on location of the property. The exception created permits major structures that are substantially improved at any time to be insured in Citizens if they are located in a county where Citizens issues 75 percent or more of the total number of policies for personal lines residential, commercial residential, and commercial nonresidential insurance policies. Currently, it appears Monroe County is the only county in Florida that would fall within the exception created by the PCS. Furthermore, for the reasons outlined above, the exception should only apply to a maximum of 656 parcels as this is the number of improved parcels of land located in whole or in part in CBRS in Monroe County.

The PCS does not apply to structures located seaward of the coastal construction control line, only structures located within the CBRS. Thus, substantial improvements to major structures located seaward of the coastal construction control line will still be ineligible for insurance in Citizens if a building permit for the improvement is applied for on or after July 1, 2014.

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[9] Monroe County also has government owned parcels of land contained in whole or in part in the CBRS. These parcels are not included as they are not insured by Citizens and thus are not impacted by the current law relating to eligibility for insurance in Citizens.

[10] The admitted market is composed of Florida licensed and regulated insurers. The surplus lines market is composed of insurers deemed eligible to write insurance by the Office of Insurance Regulation. Insurers in this market are not as heavily regulated as those in the admitted market.

[11] Information from Citizens combined month end report for January 2014 on file with the Insurance & Banking Subcommittee.

Mitigation Discounts

The Legislature first adopted hurricane mitigation discounts for residential property insurance in 1993. As enacted in 1993, section 627.0629(1), F.S., required insurance companies to include "appropriate discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures actuarially demonstrated to reduce the amount of loss in a windstorm have been installed" in all residential property insurance rate filings filed after July 1, 1994. To help insurers implement the mitigation discount statute, in 1998 the Department of Insurance (now the OIR) promulgated an administrative rule on mitigation discounts. This resulted in insurers giving insurance premium credits for the installation of hurricane shutters or other wind protective devices.

The mitigation discount statute was unchanged from 1993 to 2001. In 2001, mitigation discounts for the use of construction techniques that mitigate a home were added to the 1993 mitigation discount law and a sample list of construction fixtures or techniques that qualified for mitigation discounts was delineated in statute. The 2001 change also required mitigation discounts for residential properties built to the Florida Building Code. Thus, after the 2001 statutory change, mitigation discounts were not only given for mitigation fixtures that were installed by a homeowner after construction but to homes constructed using mitigation fixtures or techniques.

To facilitate insurer compliance with the windstorm mitigation discounts required by statute, the Department of Community Affairs[12] in cooperation with the Department of Insurance (now the OIR), contracted with Applied Research Associates, Inc. for a public domain study to provide insurers data and information on estimated loss reduction for wind resistive building features in single-family residences. The study, titled Development of Loss Relativities for Wind Resistive Features of Residential Structures, was completed in 2002. The study's mathematical results, termed "wind loss relativities", were the basis for calculating the specific mitigation discount amount on the wind premium for mitigation features contained by the property.[13]

The 2002 study dealt with both existing construction and new construction built to the 2001 Florida Building Code and wind loss relativities were developed separately for construction built prior to and after the 2001 Florida Building Code. In an Informational Memorandum issued on January 23, 2003, the OIR notified insurance companies of its suggested mitigation credits for new and existing construction based on its analysis of the study completed by Applied Research Associates. A similar study by Applied Research Associates, Inc. was also done in 2002 for residential buildings with five or more units.

Mitigation discounts were initially given at 50 percent of the actuarial value of the discount.[14] In 2006, the Legislature amended the mitigation discount law to require the OIR to reevaluate mitigation discounts by July 1, 2007 to determine the full actuarial value of the discounts.[15] Thus, the OIR amended the administrative rule[16] relating to mitigation discounts to require insurers to provide mitigation discounts in an amount equal to 100 percent of the mitigation discount amount, as determined by the loss relativities in the 2002 study done by Applied Research Associates, Inc. Insurers that made rate filings on or after January 1, 2007 were required to include the full value of the discount in the rate filing and all residential property insurers were required to submit a new rate filing

[12] The Department of Community Affairs was dissolved in 2011 and its duties absorbed by other state agencies. See ch. 2011-142, L.O.F.

[13] The relativities applied only to the portion of a policy's wind premium associated with the dwelling, its contents and loss of use.

[14] In an Informational Memorandum issued on January 23, 2003, the OIR notified insurance companies of its suggested mitigation credits for new and existing construction based on its analysis of a 2002 study completed by Applied Research Associates. However, the OIR tempered the mitigation credits derived from the study by 50 percent. As stated by the OIR in the memorandum, the 50 percent tempering of the credits was due to the large rate decreases that could result from application of the credits, the approximations needed to produce practical results, and the potential for differences in results using different hurricane models. The OIR cautioned in the memorandum that the tempering implemented would be curtailed in the future.

[15] Section 14, Ch. 2006-12, L.O.F.

[16] Rule 69O-170.017, F.A.C.

adopting the full value of the discounts into the rates by March 1, 2007. In 2008, the OIR obtained a new study to evaluate the appropriate mitigation discount amounts, but did not change the amounts.

The current OIR administrative rule relating to mitigation discount amounts allows insurance companies to modify the amounts if the insurer provides a detailed alternate study supporting the modification and allows the OIR to review all assumptions used in the study. To date, OIR has approved alternate discount studies for three insurers. The OIR is currently reviewing alternate studies for two more insurers.[17]

Section 627.711, F.S., requires insurers to clearly notify an applicant for or policyholder of a personal lines residential property insurance policy of the availability and range of each premium discount, credit, other rate differential, or reduction in deductibles, for wind mitigation. The notice must be provided when the policy is issued and renewed and provided on a form developed by the OIR.

Effect of Proposed Changes Relating to Mitigation Discounts

The PCS also requires Citizens to submit any alternate study it obtains relating to windstorm mitigation discounts to the OIR for review and approval as allowed under the current administrative rule. If the OIR approves the study, then Citizens must include any discounts provided in the study in their rates.

Citizens currently does not have any alternate study relating to mitigation discounts, however, a non-profit group in Monroe County is currently working on a study, with funding from Citizens, that will verify the quality and characteristics of building stock in Monroe County.[18] In December 2012, the non-profit group Fair Insurance Rates in Monroe (FIRM) presented a proposal to the Citizens Board of Governors relating to a Monroe County Windstorm Risk Remodeling and Analysis Initiative (Initiative).[19] The purpose of the Initiative is "to provide enhanced risk insight to FIRM enabling it to make recommendations to residents, government agencies, Citizens and other insurance structures concerning risk financing decisions from a position of knowledge and strength."[20] According to the proposal, actuaries, engineers, statisticians, and insurance specialists will be used by FIRM to analyze data inputs and perform risk modeling and loss forecasting.[21] With the results of that analysis, FIRM indicated in its presentation that Monroe County would seek insurance coverage through the private market or establish a mutual or reciprocal company.[22] The board of Citizens voted to provide $485,000 funding to FIRM for the Initiative in April 2013.[23] The Initiative has not yet been completed, although work has begun on it.

Mitigation Verification Inspection Form

Typically, policyholders are responsible for substantiating to their insurers the insured property has mitigation features. Policyholders submit a completed uniform mitigation verification inspection form to the insurer to substantiate mitigation features. All insurers must use the uniform mitigation verification inspection form developed by rule by the Financial Services Commission (FSC).[24] The current version

[17] Information received from the OIR by staff of the Insurance and Banking Subcommittee.

[18] Rate Study Funding Agreement entered into by Fair Insurance Rates in Monroe (FIRM) and Citizens on file with the Insurance & Banking Subcommittee. Because the study by FIRM is not yet complete, it is unknown whether it will qualify as an alternate study required to be submitted to OIR by the PCS.

[19] Presentation available at https://www.citizensfla.com/about/mDetails_boardmtgs.cfm?show=PDF&link=/bnc_meet/docs/421/08I_AI_Monroe_County_Remodeling_Proposal_11_29_12.pdf&event=421&when=Past (last viewed March 11, 2014).

[20] Id. at page 2.

[21] Id.

[22] Id.

[23] A copy of the Rate Study Funding Agreement completed by Citizens and FIRM is on file with the Insurance & Banking Subcommittee.

[24] The Financial Services Commission is comprised of the Governor and Cabinet (s. 20.121(3), F.S.). The form is adopted by Rule 69O-170.0155, F.A.C.

of the form was approved by the FSC in 2012 and recognizes the Florida Building Code adopted in 2001[25] or later and the South Florida Building Code[26] adopted in 1994.[27]

Insurers must accept mitigation forms prepared by home inspectors, building code inspectors, contractors, engineers, and architects and may accept forms prepared by persons determined to be qualified by the insurer to prepare the form. Insurers can require mitigation forms provided to the insurer by mitigation inspectors or a mitigation inspection company be independently verified for quality assurance purposes before accepting the mitigation form as valid. The insurer must pay for the independent verification.[28] At their expense, insurers can also independently verify, for quality assurance purposes, mitigation forms submitted by policyholders or insurance agents.

Effect of Proposed Changes Relating to Mitigation Verification Inspection Form
The PCS allows the FSC to create an addendum to the uniform mitigation verification form to be used in a county that has a building code stronger than the highest code recognized on the uniform mitigation form.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.351, F.S., relating to insurance risk apportionment plans.

Section 2: Amends s. 627.711, F.S., relating to notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection form.

Section 3: 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:

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[25] Building permit application date of 3/1/2002 or later. The Florida Building Code is adopted every three years by the Florida Building Commission located in the Florida Department of Business & Professional Regulation.

[26] The South Florida Building Code was first adopted by Miami-Dade County on December 31, 1957. In 1976, Broward County adopted a local referendum making the South Florida Building Code, Broward County Edition, a county-wide standard and incorporated the Code into the county charter. (http://www.broward.org/CODEAPPEALS/Pages/HistorySouthFloridaBuildingCode.aspx) (last viewed March 11, 2014). The 1994 South Florida Building Code applies to building permit application dates starting 9/1/94 in Miami-Dade and Broward Counties. The South Florida Building Code, however, was superseded by the 2001 Florida Building Code. Currently local governments can adopt amendments to the technical provisions in the statewide code to apply solely to the local jurisdiction as long as the amendments are more stringent than the code (s. 553.73(4)(b), F.S.).

[27] Information about the form adopted in 2012 is available at http://www.floir.com/sections/pandc/productreview/uniformmitigationform.aspx (last viewed March 11, 2014).

[28] s. 627.711(8), F.S.

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Owners of structures in counties where Citizens insures 75 percent or more of the property will be able to obtain or keep insurance in Citizens even if they substantially improve their structure after July 1, 2014.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided by the PCS.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to property insurance; amending s. 627.351, F.S.; providing an exemption from the restriction on obtaining coverage from Citizens Property Insurance Corporation for major structures under certain conditions; requiring the corporation to submit a study relating to windstorm mitigation discounts to the Office of Insurance Regulation; requiring the corporation to include discounts in a rate filing under certain conditions; amending s. 627.711, F.S.; allowing the Financial Services Commission to adopt an addendum to the mitigation verification form under certain conditions; providing an effective date.

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

Section 1. Paragraphs (a) and (n) of subsection (6) of section 627.351, Florida Statutes, are amended to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(a) The public purpose of this subsection is to ensure that there is an orderly market for property insurance for residents and businesses of this state.

1. The Legislature finds that private insurers are unwilling or unable to provide affordable property insurance coverage in this state to the extent sought and needed. The absence of affordable property insurance threatens the public

health, safety, and welfare and likewise threatens the economic health of the state. The state therefore has a compelling public interest and a public purpose to assist in assuring that property in the state is insured and that it is insured at affordable rates so as to facilitate the remediation, reconstruction, and replacement of damaged or destroyed property in order to reduce or avoid the negative effects otherwise resulting to the public health, safety, and welfare, to the economy of the state, and to the revenues of the state and local governments which are needed to provide for the public welfare. It is necessary, therefore, to provide affordable property insurance to applicants who are in good faith entitled to procure insurance through the voluntary market but are unable to do so. The Legislature intends, therefore, that affordable property insurance be provided and that it continue to be provided, as long as necessary, through Citizens Property Insurance Corporation, a government entity that is an integral part of the state, and that is not a private insurance company. To that end, the corporation shall strive to increase the availability of affordable property insurance in this state, while achieving efficiencies and economies, and while providing service to policyholders, applicants, and agents which is no less than the quality generally provided in the voluntary market, for the achievement of the foregoing public purposes. Because it is essential for this government entity to have the maximum financial resources to pay claims following a

catastrophic hurricane, it is the intent of the Legislature that the corporation continue to be an integral part of the state and that the income of the corporation be exempt from federal income taxation and that interest on the debt obligations issued by the corporation be exempt from federal income taxation.

2. The Residential Property and Casualty Joint Underwriting Association originally created by this statute shall be known as the Citizens Property Insurance Corporation. The corporation shall provide insurance for residential and commercial property, for applicants who are entitled, but, in good faith, are unable to procure insurance through the voluntary market. The corporation shall operate pursuant to a plan of operation approved by order of the Financial Services Commission. The plan is subject to continuous review by the commission. The commission may, by order, withdraw approval of all or part of a plan if the commission determines that conditions have changed since approval was granted and that the purposes of the plan require changes in the plan. For the purposes of this subsection, residential coverage includes both personal lines residential coverage, which consists of the type of coverage provided by homeowner's, mobile home owner's, dwelling, tenant's, condominium unit owner's, and similar policies; and commercial lines residential coverage, which consists of the type of coverage provided by condominium association, apartment building, and similar policies.

3. With respect to coverage for personal lines residential

structures:

a. Effective January 1, 2014, a structure that has a dwelling replacement cost of $1 million or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $1 million or more is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2013, may continue to be covered by the corporation until the end of the policy term. The office shall approve the method used by the corporation for valuing the dwelling replacement cost for the purposes of this subparagraph. If a policyholder is insured by the corporation before being determined to be ineligible pursuant to this subparagraph and such policyholder files a lawsuit challenging the determination, the policyholder may remain insured by the corporation until the conclusion of the litigation.

b. Effective January 1, 2015, a structure that has a dwelling replacement cost of $900,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $900,000 or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2014, may continue to be covered by the corporation only until the end of the policy term.

c. Effective January 1, 2016, a structure that has a dwelling replacement cost of $800,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $800,000 or more, is not eligible for

coverage by the corporation. Such dwellings insured by the corporation on December 31, 2015, may continue to be covered by the corporation until the end of the policy term.

d. Effective January 1, 2017, a structure that has a dwelling replacement cost of $700,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $700,000 or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2016, may continue to be covered by the corporation until the end of the policy term.

The requirements of sub-subparagraphs b.-d. do not apply in counties where the office determines there is not a reasonable degree of competition. In such counties a personal lines residential structure that has a dwelling replacement cost of less than $1 million, or a single condominium unit that has a combined dwelling and contents replacement cost of less than $1 million, is eligible for coverage by the corporation.

4. It is the intent of the Legislature that policyholders, applicants, and agents of the corporation receive service and treatment of the highest possible level but never less than that generally provided in the voluntary market. It is also intended that the corporation be held to service standards no less than those applied to insurers in the voluntary market by the office with respect to responsiveness, timeliness, customer courtesy, and overall dealings with policyholders, applicants, or agents

of the corporation.

5.a. Effective January 1, 2009, a personal lines residential structure that is located in the "wind-borne debris region," as defined in s. 1609.2, International Building Code (2006), and that has an insured value on the structure of $750,000 or more is not eligible for coverage by the corporation unless the structure has opening protections as required under the Florida Building Code for a newly constructed residential structure in that area. A residential structure is deemed to comply with this sub-subparagraph ~~subparagraph~~ if it has shutters or opening protections on all openings and if such opening protections complied with the Florida Building Code at the time they were installed.

b. Any major structure as defined in s. 161.54(6)(a) for which a permit is applied on or after July 1, 2014, for new construction or substantial improvement as defined in s. 161.54(12) is not eligible for coverage by the corporation if the structure is seaward of the coastal construction control line established pursuant to s. 161.053 or is within the Coastal Barrier Resources System as designated by 16 U.S.C. ss. 3501-3510. This sub-subparagraph does not apply to substantial improvement of major structures located in a county where the office determines that the corporation issues 75 percent or more of the total of the number of policies insured for each line of personal residential, commercial residential, and commercial nonresidential insurance.

(n)1. Rates for coverage provided by the corporation must be actuarially sound and subject to s. 627.062, except as otherwise provided in this paragraph. The corporation shall file its recommended rates with the office at least annually. The corporation shall provide any additional information regarding the rates which the office requires. The office shall consider the recommendations of the board and issue a final order establishing the rates for the corporation within 45 days after the recommended rates are filed. The corporation may not pursue an administrative challenge or judicial review of the final order of the office.

2. In addition to the rates otherwise determined pursuant to this paragraph, the corporation shall impose and collect an amount equal to the premium tax provided in s. 624.509 to augment the financial resources of the corporation.

3. After the public hurricane loss-projection model under s. 627.06281 has been found to be accurate and reliable by the Florida Commission on Hurricane Loss Projection Methodology, the model shall serve as the minimum benchmark for determining the windstorm portion of the corporation's rates. This subparagraph does not require or allow the corporation to adopt rates lower than the rates otherwise required or allowed by this paragraph.

4. The rate filings for the corporation which were approved by the office and took effect January 1, 2007, are rescinded, except for those rates that were lowered. As soon as possible, the corporation shall begin using the lower rates that

were in effect on December 31, 2006, and provide refunds to policyholders who paid higher rates as a result of that rate filing. The rates in effect on December 31, 2006, remain in effect for the 2007 and 2008 calendar years except for any rate change that results in a lower rate. The next rate change that may increase rates shall take effect pursuant to a new rate filing recommended by the corporation and established by the office, subject to this paragraph.

5. Beginning on July 15, 2009, and annually thereafter, the corporation must make a recommended actuarially sound rate filing for each personal and commercial line of business it writes, to be effective no earlier than January 1, 2010.

6. Beginning on or after January 1, 2010, and notwithstanding the board's recommended rates and the office's final order regarding the corporation's filed rates under subparagraph 1., the corporation shall annually implement a rate increase which, except for sinkhole coverage, does not exceed 10 percent for any single policy issued by the corporation, excluding coverage changes and surcharges.

7. The corporation may also implement an increase to reflect the effect on the corporation of the cash buildup factor pursuant to s. 215.555(5)(b).

8. The corporation's implementation of rates as prescribed in subparagraph 6. shall cease for any line of business written by the corporation upon the corporation's implementation of actuarially sound rates. Thereafter, the corporation shall

annually make a recommended actuarially sound rate filing for each commercial and personal line of business the corporation writes.

9. The corporation must submit any alternate study relating to windstorm mitigation discounts to the office. Upon the office's approval of the alternate study, the corporation must include any discounts provided for by the study in the next filing of its recommended rates.

Section 2. Paragraph (a) of subsection (2) of section 627.711, Florida Statutes, is amended to read:

627.711 Notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection form.—

(2)(a) The Financial Services Commission shall develop by rule a uniform mitigation verification inspection form that shall be used by all insurers when submitted by policyholders for the purpose of factoring discounts for wind insurance. The commission may develop an addendum to the form for use in a county that has adopted a building code that is stronger than the building code or codes recognized by the form. In developing the form, the commission shall seek input from insurance, construction, and building code representatives. Further, the commission shall provide guidance as to the length of time the inspection results are valid. An insurer shall accept as valid a uniform mitigation verification form signed by the following authorized mitigation inspectors:

1. A home inspector licensed under s. 468.8314 who has

completed at least 3 hours of hurricane mitigation training approved by the Construction Industry Licensing Board which includes hurricane mitigation techniques and compliance with the uniform mitigation verification form and completion of a proficiency exam;

2. A building code inspector certified under s. 468.607;

3. A general, building, or residential contractor licensed under s. 489.111;

4. A professional engineer licensed under s. 471.015;

5. A professional architect licensed under s. 481.213; or

6. Any other individual or entity recognized by the insurer as possessing the necessary qualifications to properly complete a uniform mitigation verification form.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1109 Property Insurance
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** SB 1672

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

SUMMARY ANALYSIS

Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market. Under current law, a homeowner cannot buy insurance in Citizens if an insurer in the private market offers comparable insurance for a premium 15 percent or less than the Citizens' premium. A homeowner cannot renew insurance in Citizens if an insurer in the private market offers comparable insurance at a premium equal to or less than the Citizens' renewal premium. In 2013, the Legislature created the Citizens Property Insurance Corporation Policyholder Eligibility Clearinghouse Program (Clearinghouse). The Clearinghouse diverts new applicants for personal residential insurance in Citizens and Citizens' renewal policyholders into the private insurance market if a private market insurer is willing to insure the risk within the eligibility premium parameters in current law for insurance in Citizens.

Surplus lines insurance refers to a category of insurance for which there is no market available through Florida licensed insurance companies. Surplus lines insurers currently cannot participate in the Clearinghouse, but the PCS allows them to participate starting January 1, 2015. Insurance may be offered by a surplus lines insurer through the Clearinghouse only if the risk receives no coverage offers from authorized insurers through the Clearinghouse. Unlike offers of insurance made to homeowners through the Clearinghouse from Florida licensed insurers, if a homeowner receives an offer of insurance through the Clearinghouse from a surplus lines insurer with a premium that is 15 percent or less than the Citizens' premium, the homeowner can still be insured by Citizens if they choose. Likewise, homeowners can choose to have their insurance renewed in Citizens even if they receive an offer of insurance from a surplus lines insurer with a premium that is the same as or less than the Citizens' renewal premium. A surplus lines insurer covering risks through the Clearinghouse must meet enhanced financial requirements than the ones required in current law and must provide additional notifications to policyholders.

Current law requires Citizens to provide annual reports on these issues: non-catastrophe losses, probable maximum loss, financing options for the probable maximum loss, and potential assessments associated with the financing options. The PCS requires Citizens to provide an annual report that estimates its: 12-month borrowing capacity, claims-paying capacity, and calendar year end balance.

The Division of Administrative Hearings (DOAH) is a state agency that employs Administrative Law Judges (ALJs) to conduct hearings in most cases in which the substantial interests of a person are determined by an agency and which involve a disputed issue of material fact. Current law requires Citizens' purchase of commodities and contractual services to comply with the procurement law that governs state agency procurement. Protests relating to a solicitation or contract award by Citizens must be decided by the Citizens Board of Governors at a board meeting, with subsequent jurisdiction given to Leon County Circuit Court. The PCS removes the authority for the Citizens' Board to decide protests and requires them to be heard by DOAH instead, with the Citizens Board taking final action on the protest after consideration of the recommended order of the ALJ. The First District Court of Appeal is given subsequent jurisdiction.

The PCS has no fiscal impact on local government. The fiscal impact to homeowners, Citizens, and to DOAH is outlined in the Fiscal Analysis. The PCS is effective July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Citizens Property Insurance Corporation

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

As of February 12, 2014, Citizens is the largest property insurer in Florida with over one million policies extending approximately $315 billion of property coverage to Floridians.[1] Citizens insures over 383,000 residential and commercial policies in Florida's coastal areas and over 600,000 residential policies in Florida's non-coastal areas. The remaining policies are commercial policies insured in Florida's non-coastal areas.

Citizens was created by the Legislature in 2002 by the merger of two existing property insurance associations: The Florida Residential Property and Casualty Joint Underwriting Association (FRPCJUA) and the Florida Windstorm Underwriting Association (FWUA). Citizens writes various types of property insurance coverage for its policyholders. The types of coverage are divided into three separate accounts within the corporation:

1. Personal Lines Account (PLA) – Multiperil Policies[2]
   Consists of homeowners, mobile homeowners, dwelling fire, tenants, condominium unit owners and similar policies;
2. Commercial Lines Account (CLA) – Multiperil Policies
   Consists of condominium association, apartment building, homeowner's association policies, and commercial non-residential multiperil policies on property located outside the Coastal Account area; and
3. Coastal Account – Wind-only[3] and Multiperil Policies
   Consists of wind-only and multiperil policies for personal residential, commercial residential, and commercial non-residential issued in limited eligible coastal areas.

Eligibility for Insurance in Citizens

Current law requires Citizens to provide a procedure for determining the eligibility of a potential risk for insurance in Citizens and provides specific eligibility requirements based on premium amount, value of the property insured, and the location of the property. Risks not meeting the statutory eligibility requirements cannot be insured by Citizens. Citizens has additional eligibility requirements set out in their underwriting rules. These rules, which are approved by the Office of Insurance Regulation (OIR), give flexibility for Citizens to denote some risks as uninsurable based on factors not enumerated in statute, such as age of home, condition and age of roof, vacant property, certain seasonal occupancy, and type of electrical wiring.

Eligibility Based on Premium Amount

Under current law, a homeowner cannot buy insurance in Citizens if an insurer in the private market offers the homeowner insurance for a premium 15 percent or less than the Citizens' premium.[4] In addition, the coverage offered by the private insurer must be comparable to Citizens' coverage. Thus,

[1] https://www.citizensfla.com/about/bookofbusiness/ (last viewed March 11, 2014).
[2] A multi-peril policy is defined as a package policy, such as a homeowners or business insurance policy that provides coverage against several different perils. It also refers to the combination of property and liability coverage in one policy. (http://www2.iii.org/glossary/) Multi-peril property insurance policies include coverage for damage from windstorm and from other perils, such as fire, theft, and liability.
[3] A wind-only policy is a property insurance policy that provides coverage against windstorm damage only. Coverage against non-windstorm events such as fire, theft, and liability are available in a separate policy.
[4] s. 627.351(6)(c)5.a., F.S. Commercial non-residential property is not subject to this eligibility restriction.

a homeowner can buy insurance from Citizens only if the private insurer's premium is more than 15 percent than the Citizens' premium.

Under current law, a homeowner cannot renew insurance in Citizens if an insurer in the private market offers to insure the property at a premium equal to or less than the Citizens' renewal premium. The insurance from the private market insurer must be comparable to the insurance from Citizens in order for the renewal premium eligibility requirement to apply.

Citizens Property Insurance Corporation Policyholder Eligibility Clearinghouse Program
In 2013, the Florida Legislature passed CS/SB 1770[5] creating s. 627.3518, F.S., which mandated the creation of the Citizens Property Insurance Corporation Policyholder Eligibility Clearinghouse Program (Clearinghouse) for personal residential risks. The Clearinghouse has two purposes:

- to determine if a new or renewal policy is eligible for Citizens coverage and
- to enhance access of new Citizens applicants and existing Citizens policyholders to offers of coverage from authorized insurers.[6]

The Clearinghouse facilitates the diversion of ineligible applicants and existing policyholders from Citizens into the voluntary private insurance market. A risk should not be submitted to the clearinghouse if the insurance agent is aware of an offer of coverage from a private-market insurer with which the agent is appointed that would render the risk ineligible for Citizens. Risks should only be submitted to the clearinghouse if the agent is unaware of any other offers of coverage that make the risk ineligible for coverage with Citizens and the risk meets all of Citizens' regular eligibility requirements.

Citizens launched the personal residential Clearinghouse for new applicants for insurance from Citizens on January 27, 2014.[7] At launch, four insurers in the private voluntary market participated in the clearinghouse, with another six insurers scheduled to participate starting March 30, 2014.[8]

For a homeowner not already insured by Citizens, but who wants to purchase insurance from Citizens (i.e., a new applicant), the Clearinghouse works as follows:[9]

1. When a new applicant for insurance from Citizens contacts a Citizens-appointed insurance agent for coverage, if the agent is unable to find coverage in the private market for a premium that is 15 percent or less than the Citizens' premium, the agent will enter the risk characteristics of the property to be insured into the Clearinghouse.
2. The Clearinghouse submits the risk to participating insurance companies, which have two days to return an offer of coverage. However, because the Clearinghouse is fully automated, in most cases, results are available immediately.
3. If the Clearinghouse identifies one or more participating insurers willing to write a policy for the applicant at a premium that is no more than 15 percent higher than Citizens' premium for comparable coverage, the applicant will be ineligible for coverage with Citizens. The applicant may purchase coverage from their choice of the participating insurers that extend offers of coverage.[10]
4. If no comparable private market offers of coverage are received or the premiums on the offer or offers are over 15 percent higher than the Citizens' premium, the applicant will be eligible for coverage with Citizens, pending underwriting review and approval.

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[5] Ch. 2013-60, L.O.F.
[6] s. 627.3518(2), F.S. An authorized insurer is one licensed in Florida.
[7] Citizens Property Insurance Corporation, Citizens Statement on Property Insurance Clearinghouse Rollout (January 27, 2014). https://www.citizensfla.com/shared/press/articles/141/01.27.2014.pdf (last viewed on March 19, 2014). At launch, the Clearinghouse is available only for multi-peril homeowner's policies. It is currently not available for mobile homeowners' policies.
[8] https://www.citizensfla.com/clearinghouse/?defaultinfo=/clearinghouse/Join.cfm (last viewed March 19, 2014).
[9] s. 627.351(6)(c)5.a., F.S.
[10] If the new applicant does not want coverage from one of the insurers participating in the Clearinghouse that offered coverage, the applicant can obtain coverage from another insurer in the voluntary or surplus lines market that is willing to insure the risk. The applicant, however, will not be able to obtain insurance from Citizens.

Although the Clearinghouse is not yet operational for Citizens' renewals, once operational, the process will work similarly as that for new applicants for insurance in Citizens. The primary difference is that if the Clearinghouse results in one or more offers of coverage from a participating insurer with a premium that is the same or less than the renewal premium from Citizens, then the policy is ineligible to be renewed by Citizens. In this circumstance, the renewal applicant may purchase coverage from their choice of the participating insurer or insurers that extend offers of coverage at or below the Citizens' renewal premium.[11]

Surplus Lines Insurance

Surplus lines insurance refers to a category of insurance for which there is no market available through standard insurance carriers in the admitted market (insurance companies licensed to transact insurance in Florida). There are three basic categories of surplus lines risks:

1. specialty risks that have unusual underwriting characteristics or underwriting characteristics that admitted insurers view as undesirable;
2. niche risks for which admitted carriers do not have a filed policy form or rate; and
3. capacity risks which are risks where an insured needs higher coverage limits than those that are available in the admitted market.

Surplus lines insurers are not "authorized" insurers as defined in the Florida Insurance Code[12] and thus do not obtain a certificate of authority from the OIR to transact insurance in Florida. Rather, surplus lines insurers are "unauthorized" insurers, but are eligible to transact surplus lines insurance under the surplus lines law as "eligible surplus insurers."

The OIR determines whether a surplus lines insurer is "eligible" based on statutory guidelines. Statutory guidelines in current law require surplus lines insurers to have at least $15 million in surplus and three years of successful operation in their home state.[13]

In addition, surplus lines policies have policyholder notice requirements that are different than those required for policies issued by insurers in the admitted market.[14] Surplus lines policies must have stamped or printed on the face of the policy in at least 14-point, boldface type, the following statement: "SURPLUS LINES INSURERS' POLICY RATES AND FORMS ARE NOT APPROVED BY ANY FLORIDA REGULATORY AGENCY."[15]

The surplus lines policy must also state: "THIS INSURANCE IS ISSUED PURSUANT TO THE FLORIDA SURPLUS LINES LAW. PERSONS INSURED BY SURPLUS LINES CARRIERS DO NOT HAVE THE PROTECTION OF THE FLORIDA INSURANCE GUARANTY ACT TO THE EXTENT OF ANY RIGHT OF RECOVERY FOR THE OBLIGATION OF AN INSOLVENT UNLICENSED INSURER."[16]

For personal lines residential property insured by a surplus lines insurer, current law (s. 626.916(1)(e), F.S.) requires the agent to provide written notice that coverage may be available and less expensive from Citizens, but also explains that Citizens assessments are higher and that Citizens coverage may be less than the property's existing coverage.

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[11] If the Citizens' renewal policyholder does not want coverage from one of the insurers participating in the Clearinghouse that offered coverage, the policyholder can obtain coverage from another insurer in the voluntary or surplus lines market that is willing to insure the risk. The policyholder, however, will not be able to renew insurance in Citizens.

[12] The Florida Insurance Code is comprised of these chapters in Florida Statutes: chapters 624-632, 634-636, 641-642, 648, and 651.

[13] Section 626.918(2)(d)1.a., F.S., provides the surplus requirements and s. 626.918(2)(b), F.S., requires three years of operation in the home state. There are limited exceptions to three year operational requirement. The exceptions are also found in s. 627.918(2)(b), F.S.

[14] The admitted market is the market composed of Florida licensed insurers (i.e., Florida authorized insurers).

[15] s. 626.924(2), F.S.

[16] s. 626.924(1), F.S.

Effect of Proposed Changes Relating to the Citizens Clearinghouse
Surplus lines insurers are authorized by the PCS to participate in the Citizens Clearinghouse beginning January 1, 2015. A surplus lines insurer must offer similar coverage to that provided by Citizens. Coverage may be offered by a surplus lines insurer only if the risk receives no coverage offers from authorized insurers through the Clearinghouse.

Unlike offers of insurance made to homeowners through the Clearinghouse from Florida licensed insurers, if a homeowner receives an offer of insurance through the Clearinghouse from a surplus lines insurer with a premium that is 15 percent or less than the Citizens' premium, the homeowner can still be insured by Citizens if they choose. Likewise, homeowners can choose to have their insurance renewed in Citizens even if they receive an offer of insurance from a surplus lines insurer with a premium that is the same as or less than the Citizens' renewal premium.

When a surplus lines insurer makes an offer of coverage through the Clearinghouse, the insurer must provide prominent notice to be signed by the policyholder and kept on file with the surplus lines insurer, that:

- An applicant in the Clearinghouse is not required to accept an offer of coverage from a surplus lines insurer.
- An offer of coverage from a surplus lines insurer does not affect the applicant's eligibility for coverage from Citizens.
- An applicant who accepts an offer of coverage from a surplus lines insurer may submit a new application for coverage to Citizens at any time.
- Surplus lines policies are not covered by the Florida Insurance Guaranty Association.[17]
- Rates for surplus lines insurance are not subject to review by the OIR.
- Notice regarding any information required by the OIR.

These notices are in addition to the ones required under current law outlined previously.

A Citizens policyholder who accepts an offer of coverage from a surplus lines insurer and subsequently applies for coverage with Citizens within 36 months of being insured by Citizens will be considered a renewal policy. The rates on such policies will be rated as renewals and thus be subject to the 10 percent limit on annual rate increases. A similar provision is contained in current law for new applicants for insurance in Citizens declared ineligible at renewal for continued insurance in Citizens through the Clearinghouse during the previous 36 months.

Surplus lines insurers participating in the Clearinghouse must meet enhanced financial requirements. The surplus lines insurer must maintain at least a $50 million surplus on a company or pooled basis, rather than $15 million. The insurer must also:

- be eligible to offer coverage under Florida's Surplus Lines Law (ss. 626.913-626.937, F.S.);
- have a superior, excellent, exceptional or comparable financial strength rating;
- have the financial ability to cover the insurer's 100-year probable maximum hurricane loss[18] at least twice in a single hurricane season; and
- submit evidence of its reinsurance to the OIR for review.

Annual Reports Required From Citizens Property Insurance Corporation

Current law requires annual reports from Citizens on a variety of issues. By January 15th each year, Citizens must report its loss ratios for residential non-catastrophic losses on statewide average and county basis to the OIR.[19] This information must also be put on Citizens' website. The PCS changes

[17] The Florida Insurance Guaranty Fund is the guaranty association for property and casualty insurance. The Fund ensures policyholders of liquidated property and casualty insurers are protected with respect to insurance premiums paid and settlement of outstanding claims, up to limits provided by law.
[18] A 100-year probable maximum loss is the loss associated with a 1-in-100 year hurricane which has a 1 percent probability of occurring.
[19] s. 627.351(6)(hh), F.S.

the reporting date from January 15th to March 1st to allow Citizens more time to gather, calculate, and report the data from the prior year. Under current law, Citizens only has 15 days to gather, calculate, and report data from the previous calendar year.

Citizens must annually report to the Legislature and the Financial Services Commission[20] (FSC) on its aggregate net probable maximum loss,[21] financing options, and potential assessments by February 1st.[22] The report must also include the amount and term of debt needed to be issued by Citizens to support the probable maximum loss reported. The assessment percentage that is needed to support the debt must also be reported. A similar report is also required to be done by the FSC under current law (s. 627.3519, F.S.). The PCS repeals the report to be done by the FSC as it is duplicative of the one required from Citizens in s. 627.35191, F.S. The report required from Citizens by s. 627.35191, F.S., is not changed by the PCS and will thus, still be provided to the Legislature and the FSC.

The PCS requires Citizens to provide a new annual report. This report is due to the Legislature and the FSC each May. The report must estimate Citizens': 12-month borrowing capacity, claims-paying capacity, and calendar year end balance. In determining these estimates, Citizens must consider that the Florida Hurricane Catastrophe Fund[23] and the Florida Insurance Guaranty Fund may be concurrently issuing debt. The report required by the PCS is similar to the one required by current law (s. 627.35191, F.S.) on Citizens' financing options and potential assessments, but not identical.

The Division of Administrative Hearings & Protests Relating to Procurement Against Citizens

The Division of Administrative Hearings (DOAH) is a state agency that employs full-time Administrative Law Judges to conduct hearings in most cases in which the substantial interests of a person are determined by an agency and which involve a disputed issue of material fact.[24] When a state agency proposes to take some action that is adverse to a person, the affected person is normally entitled to request an administrative hearing to determine the matter.[25] Requests for hearings are initially made to the appropriate state agency.[26] If the case does not involve disputed facts, the agency itself will conduct a proceeding and subsequently render a decision.[27] If the request for hearing indicates that the affected person disputes facts upon which the proposed action is based, the agency ordinarily refers the case to DOAH for a hearing.[28]

DOAH provides a hearing conducted by an independent and neutral Administrative Law Judge who thereafter enters a Recommendation or Final Order, which is provided to the state agency and the parties in the case. In the case of a Recommended Order, the agency reviews the Order and issues a final decision which usually adopts the Judge's factual findings, but may under certain circumstances reject or modify certain legal conclusions of the Judge or the recommended penalty, if any. If the final decision is adverse to the non-agency party, an appeal may be taken within a limited time to a District Court of Appeal.[29]

Legislation enacted in 2013[30] required Citizens' purchase of commodities and contractual services to comply with s. 287.057, F.S., which governs the purchase of commodities and contractual services by state agencies. The law makes Citizens an "agency" for purposes of s. 287.057, F.S., with one limited

[20] The Financial Services Commission is comprised of the Governor and Cabinet (s. 20.121(3), F.S.).
[21] Probable maximum loss is an estimate of maximum dollar value that can be lost under realistic situations.
[22] s. 627.35191, F.S
[23] The Florida Hurricane Catastrophe Fund is a tax-exempt trust fund created in 1993 as a form of reinsurance for residential property insurers. The purpose of the FHCF is to protect and advance the state's interest in maintaining insurance capacity in Florida by providing reimbursements to insurers for a portion of their catastrophic hurricane losses.
[24] Ch. 120, F.S.
[25] s. 120.68(1), F.S.
[26] See Uniform Rule 28-106.201(2).
[27] s. 120.57(2), F.S.
[28] s. 120.57(1), F.S.
[29] s. 120.68(2)(a), F.S.
[30] Ch. 2013, 60, L.O.F.

exception.[31] The executive director of Citizens is the "agency head," except for bid protests where the Citizens' Board of Governors[32] (Board) is the "agency head."[33] For protests relating to solicitations or contract awards, the law specifies the protest must be decided by the Board at the board meeting after Citizens tries to resolve the protest by mutual agreement. Once the Board decides the protest, the Circuit Court of Leon County has jurisdiction for any further legal proceedings.

The PCS removes the authority for the Citizens' Board to decide protests relating to solicitations or contract awards and requires those protests to be heard by DOAH instead. DOAH is required to do a recommended order on the protest and the Citizens' Board, as the "agency head" must consider the recommended order in a public meeting and take final action on the protest. Once the Board takes final action, the PCS gives the First District Court of Appeal, rather than Leon County Circuit Court, jurisdiction for any further legal proceeding.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.351, F.S., relating to insurance risk apportionment plans.

Section 2: Amends s. 627.3518, F.S., relating to Citizens Property Insurance Corporation policyholder eligibility clearinghouse program.

Section 3: Repeals s. 627.3519, F.S., relating to annual report of aggregate net probable maximum losses, financing options, and potential assessments.

Section 4: Amends s. 627.35191, F.S., relating to annual report of aggregate net probable maximum losses, financing options, and potential assessments.

Section 5: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

DOAH will receive payment from Citizens for their expenses associated with hearing Citizens protests relating to solicitations or contract awards, although the net fiscal impact of this payment should be zero as the payment received from Citizens should equal DOAH's expenses associated with each protest determined by DOAH.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

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

[32] Citizens operates under the direction of an nine member Board of Governors (Board). The Governor, Chief Financial Officer, Senate President, and Speaker of the House of Representatives each appoint two members of the Board, with one member appointed chair by the Chief Financial Officer. Board members serve three year staggered terms. At least one of the two board members appointed by each appointing officer must have demonstrated expertise in insurance. The board members are not Citizens' employees and are not paid. There is also a consumer representative on the Board that is appointed by the Governor.

[33] s. 627.351(6)(e)1.b., F.S.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The number of policies obtaining insurance in Citizens and the number of policies renewing insurance in Citizens could decline because the PCS authorizes a new kind of insurer (i.e., a surplus lines insurer) to participate in the Clearinghouse. The precise impact on the policy count of Citizens due to participation in the Clearinghouse by surplus lines insurers is unknown for several reasons. First, it is unknown how many surplus lines insurers will choose to participate in the Clearinghouse or how many offers of coverage these insurers will make through the Clearinghouse. Also, because a new applicant for Citizens' insurance or a Citizens' renewal policyholder can decline coverage offered by a surplus lines insurer under any circumstance and obtain or renew coverage in Citizens, the number of policies that will be prevented from initially being insured by Citizens or renewed by Citizens is indeterminate. However, any decline in the number of policies in Citizens will lower Citizens' exposure which in turn lowers the likelihood and amount of assessments levied by Citizens against Citizens' and non-Citizens' policyholders.[34]

Homeowners insured by Citizens that choose to be insured by a surplus lines insurer through the Clearinghouse are no longer subject to a maximum 45 percent assessment levied by Citizens against its policyholders.[35] In addition, these homeowners may obtain property insurance with more coverage from the surplus lines insurer.[36]

Citizens will incur additional costs to pay DOAH for their expenses associated with determining protests relating to solicitations and contract awards. Currently, the Citizens Board determines bid protests at regularly scheduled board meetings, so any additional cost to Citizens for the determination by their Board is minimal.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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[34] In the event Citizens incurs a deficit (i.e. its obligations to pay claims exceeds its capital plus reinsurance recoveries), it may levy assessments on most of Florida's property and casualty insurance policyholders in a specific sequence set by statute. If Citizens incurs a deficit, Citizens will first levy surcharges on its policyholders (Citizens Policyholder Assessment) of up to 15 percent of premium per account in deficit, for a maximum total of 45 percent. If the Coastal Account incurs a deficit that the levy of a Citizens Policyholder Assessment does not cure, then Citizens may levy another assessment, a regular assessment, of up to 2 percent of premium or 2 percent of the remaining deficit in the Coastal Account. The regular assessment is levied on virtually all property and casualty policies in the state, but not on Citizens' policies. The assessment is also not levied on workers' compensation, medical malpractice, accident and health, crop or federal flood insurance policies. If the PLA or CLA incurs a deficit that a Citizens Policyholder Assessment levy does not cure, then Citizens may levy another assessment, an emergency assessment, to cure the deficit. An emergency assessment may also be levied for deficits in the Coastal Account that a Citizens Policyholder Assessment and regular assessment do not cure. Emergency assessments are limited to 10 percent of premium or 10 percent of the deficit per account, for a maximum total of 30 percent. This assessment can be collected for as many years as is necessary to cure a deficit. Emergency assessments are levied on virtually all property and casualty policies in the state, including Citizens' own policies. However, this assessment is not levied on workers' compensation, medical malpractice, accident and health, crop or federal flood insurance policies.

[35] In the event Citizens incurs a deficit (i.e. its obligations to pay claims exceeds its capital plus reinsurance recoveries), it may levy assessments on most of Florida's property and casualty insurance policyholders in a specific sequence set by statute. If Citizens incurs a deficit, Citizens will first levy surcharges on its policyholders (Citizens Policyholder Assessment) of up to 15 percent of premium per account in deficit, for a maximum total of 45 percent.

[36] In recent years, Citizens has significantly reduced coverages and reduced the policy limits on certain coverage. For example, Citizens no longer insures screen enclosures or carports. And, Citizens has a 10 percent mandatory sinkhole deductible and a policy limit for personal liability of $100,000, instead of $300,000. Some insurers in the private market have made coverage reductions similar to some of the ones made by Citizens, but no private insurer has made all of the reductions Citizens has made.

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided by the PCS.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to property insurance; amending s. 627.351, F.S.; requiring the corporation's board to contract with the Division of Administrative Hearings to hear protests of the corporation's decisions regarding the purchase of commodities and contractual services and issue a recommended order; requiring the board to take final action in a public meeting; revising the date for submitting the annual loss ratio report for residential coverage; amending s. 627.3518, F.S.; defining the term "surplus lines insurer"; authorizing eligible surplus lines insurers to participate in the corporation's clearinghouse program and providing criteria for such eligibility; conforming cross-references; providing that certain applicants who accept an offer from a surplus lines insurer are considered a renewal; repealing s. 627.3519, F.S., relating to an annual report requirement relating to aggregate net probable maximum losses; amending s. 627.35191, F.S.; requiring the corporation to annually provide certain estimates for the next 12-month period to the Legislature and the Financial Services Commission; providing an effective date.

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

Section 1. Paragraphs (e), and (hh) of subsection (6) of section 627.351, Florida Statutes, are amended to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(e) The corporation is subject to s. 287.057 for the purchase of commodities and contractual services except as otherwise provided in this paragraph. Services provided by tradepersons or technical experts to assist a licensed adjuster in the evaluation of individual claims are not subject to the procurement requirements of this section. Additionally, the procurement of financial services providers and underwriters must be made pursuant to s. 627.3513. Contracts for goods or services valued at or more than $100,000 are subject to approval by the board.

1. The corporation is an agency for purposes of s. 287.057, except that, for purposes of s. 287.057(22), the corporation is an eligible user.

a. The authority of the Department of Management Services and the Chief Financial Officer under s. 287.057 extends to the corporation as if the corporation were an agency.

b. The executive director of the corporation is the agency head under s. 287.057, except for resolution of bid protests for which the board would serve as the agency head.

2. The corporation must provide notice of a decision or intended decision concerning a solicitation, contract award, or

exceptional purchase by electronic posting. Such notice must contain the following statement: "Failure to file a protest within the time prescribed in this section constitutes a waiver of proceedings."

a. A person adversely affected by the corporation's decision or intended decision to award a contract pursuant to s. 287.057(1) or (3)(c) who elects to challenge the decision must file a written notice of protest with the executive director of the corporation within 72 hours after the corporation posts a notice of its decision or intended decision. For a protest of the terms, conditions, and specifications contained in a solicitation, including ~~any~~ provisions governing the methods for ranking bids, proposals, replies, awarding contracts, reserving rights of further negotiation, or modifying or amending any contract, the notice of protest must be filed in writing within 72 hours after ~~the~~ posting ~~of~~ the solicitation. Saturdays, Sundays, and state holidays are excluded in the computation of the 72-hour time period.

b. A formal written protest must be filed within 10 days after the date the notice of protest is filed. The formal written protest must state with particularity the facts and law upon which the protest is based. Upon receipt of a formal written protest that has been timely filed, the corporation must stop the solicitation or contract award process until the subject of the protest is resolved by final board action unless the executive director sets forth in writing particular facts

and circumstances that require the continuance of the solicitation or contract award process without delay in order to avoid an immediate and serious danger to the public health, safety, or welfare.

(I) The corporation must provide an opportunity to resolve the protest by mutual agreement between the parties within 7 business days after receipt of the formal written protest.

(II) If the subject of a protest is not resolved by mutual agreement within 7 business days, the corporation's board must transmit the protest to the Division of Administrative Hearings and contract with the division to conduct a hearing to determine the merits of the protest and to issue a recommended order ~~place the protest on the agenda and resolve it at its next regularly scheduled meeting~~. The contract must provide for the corporation to reimburse the division for any costs incurred by the division for court reporters, transcript preparation, travel, facility rental, and other customary hearing costs in the manner set forth in s. 120.65(9). The division has jurisdiction to determine the facts and law concerning the protest and to issue a recommended order. The division's rules and procedures apply to these proceedings; the division's applicable bond requirements do not apply. The protest must be heard by the division ~~board~~ at a publicly noticed meeting in accordance with procedures established by the division ~~board~~.

c. In a protest of an invitation-to-bid or request-for-proposals procurement, submissions made after the bid or

proposal opening which amend or supplement the bid or proposal may not be considered. In protesting an invitation-to-negotiate procurement, submissions made after the corporation announces its intent to award a contract, reject all replies, or withdraw the solicitation that amends or supplements the reply may not be considered. Unless otherwise provided by law, the burden of proof rests with the party protesting the corporation's action. In a competitive-procurement protest, other than a rejection of all bids, proposals, or replies, the corporation's board must conduct a de novo proceeding to determine whether the corporation's proposed action is contrary to the corporation's governing statutes, the corporation's rules or policies, or the solicitation specifications. The standard of proof for the proceeding is whether the corporation's action was clearly erroneous, contrary to competition, arbitrary, or capricious. In any bid-protest proceeding contesting an intended corporation action to reject all bids, proposals, or replies, the standard of review by the board is whether the corporation's intended action is illegal, arbitrary, dishonest, or fraudulent.

d. Failure to file a notice of protest or failure to file a formal written protest constitutes a waiver of proceedings.

3. The board, acting as agency head, shall consider the recommended order of an administrative law judge in a public meeting and take final action on the protest. ~~Contract actions and decisions by the board under this paragraph are final.~~ Any further legal remedy lies with the First District Court of

Appeal ~~must be made in the Circuit Court of Leon County~~.

(hh) The corporation shall ~~must~~ prepare a report for each calendar year outlining both the statewide average and county-specific details of the loss ratio attributable to losses that are not catastrophic losses for residential coverage provided by the corporation, which information must be presented to the office and available for public inspection on the Internet website of the corporation by March 1 ~~January 15th~~ of the following calendar year.

Section 2. Paragraph (e) is added to subsection (1) of section 627.3518, Florida Statutes, subsection (2) and paragraph (e) of subsection (4) of that section are amended, present subsections (5) through (10) of that section are redesignated as subsections (6) through (11), respectively, present subsection (11) is redesignated as subsection (13), new subsections (5) and (12) are added to that section, and present subsections (5) through (7) of that section are 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.

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

(e) "Surplus lines insurer" means an unauthorized insurer that has been made eligible by the office to issue coverage under the Surplus Lines Law.

(2) In order to confirm eligibility with the corporation

and to enhance the access of new applicants for coverage and existing policyholders of the corporation to offers of coverage from authorized insurers and surplus lines insurers, the corporation shall establish a program for personal residential risks in order to facilitate the diversion of ineligible applicants and existing policyholders ~~from the corporation~~ into the voluntary insurance market. The corporation shall also develop appropriate procedures for facilitating the diversion of ineligible applicants and existing policyholders for commercial residential coverage into the private insurance market and shall report such procedures to the President of the Senate and the Speaker of the House of Representatives by January 1, 2014.

(4) Any authorized insurer may participate in the program; however, participation is not mandatory for any insurer. Insurers making offers of coverage to new applicants or renewal policyholders through the program:

(e) May participate through their single-designated managing general agent or broker; however, the provisions of paragraph (7)(a) ~~(6)(a)~~ regarding ownership, control, and use of the expirations continue to apply.

(5) Effective January 1, 2015, an eligible surplus lines insurer may make an offer of similar coverage on a risk submitted though the clearinghouse program if no offers of coverage were submitted by authorized insurers participating in the program and the office determines that the eligible surplus lines insurer:

(a) Maintains a surplus of $50 million on a company or pooled basis;

(b) Is rated as having a superior, excellent, exceptional, or equally comparable financial strength by a rating agency acceptable to the office;

(c) Maintains reserves, surplus, reinsurance, and reinsurance equivalents to cover the eligible surplus lines insurer's 100-year probable maximum hurricane loss at least twice in a single hurricane season, and submits such reinsurance to the office for review for purposes of participation in the program; and

(d) Provides prominent notice to the policyholder:

1. That the policyholder does not have to accept an offer of coverage from a surplus lines insurer;

2. That an offer of coverage from a surplus lines insurer does not affect whether the policyholder is eligible for coverage from the corporation;

3. That a policyholder who accepts an offer of coverage from a surplus lines insurer may, at any time, submit a new application for coverage to the corporation;

4. That surplus lines policies are not covered by the Florida Insurance Guaranty Association;

5. That rates for surplus lines insurance are not subject to review by the office; and

6. Of any additional information required by the office.

Such notice must be signed by the policyholder and kept on file with the surplus lines insurer for as long as the policyholder remains insured by the surplus lines insurer.

(6) ~~(5)~~ Notwithstanding s. 627.3517, an ~~any~~ applicant for new coverage from the corporation is not eligible for coverage from the corporation if provided an offer of coverage from an authorized insurer through the program at a premium that is at or below the eligibility threshold established in s. 627.351(6)(c)5.a. Whenever an offer of coverage for a personal lines risk is received for a policyholder of the corporation at renewal from an authorized insurer through the program, if the offer is equal to or less than the corporation's renewal premium for comparable coverage, the risk is not eligible for coverage with the corporation. If ~~In the event~~ an offer of coverage for a new applicant is received from an authorized insurer through the program, and the premium offered exceeds the eligibility threshold contained in s. 627.351(6)(c)5.a., the applicant or insured may elect to accept such coverage, or may elect to accept or continue coverage with the corporation. If ~~In the event~~ an offer of coverage for a personal lines risk is received from an authorized insurer at renewal through the program~~,~~ and if the premium offered is more than the corporation's renewal premium for comparable coverage, the insured may elect to accept such coverage~~,~~ or may elect to accept or continue coverage with the corporation. Section 627.351(6)(c)5.a.(I) does not apply to an offer of coverage from an authorized insurer obtained through

the program. An applicant for personal lines residential coverage from the corporation who was declared ineligible for coverage at renewal by the corporation in the previous 36 months due to an offer of coverage pursuant to this subsection is ~~shall be~~ considered a renewal under this section if the corporation determines that the authorized insurer making the offer of coverage pursuant to this subsection continues to insure the applicant and increased the rate on the policy in excess of the increase allowed for the corporation under s. 627.351(6)(n)6.

(7) ~~(6)~~ Independent insurance agents submitting new applications for coverage or that are the agent of record on a renewal policy submitted to the program:

(a) Are granted and must maintain ownership and the exclusive use of expirations, records, or other written or electronic information directly related to such applications or renewals written through the corporation or through an insurer participating in the program, notwithstanding s. 627.351(6)(c)5.a.(I)(B) and (II)(B). Such ownership is granted for as long as the insured remains with the agency or until sold or surrendered in writing by the agent. Contracts with the corporation or required by the corporation must not amend, modify, interfere with, or limit such rights of ownership. Such expirations, records, or other written or electronic information may be used to review an application, issue a policy, or for any other purpose necessary for placing such business through the program.

(b) May not be required to be appointed by any insurer participating in the program for policies written solely through the program, notwithstanding ~~the provisions of~~ s. 626.112.

(c) May accept an appointment from an ~~any~~ insurer participating in the program.

(d) May enter into ~~either~~ a standard or limited agency agreement with the insurer, at the insurer's option.

Applicants ineligible for coverage in accordance with subsection (6) ~~(5)~~ remain ineligible if their independent agent is unwilling or unable to enter into a standard or limited agency agreement with an insurer participating in the program.

(8) ~~(7)~~ Exclusive agents submitting new applications for coverage or that are the agent of record on a renewal policy submitted to the program:

(a) Must maintain ownership and the exclusive use of expirations, records, or other written or electronic information directly related to such applications or renewals written through the corporation or through an insurer participating in the program, notwithstanding s. 627.351(6)(c)5.a.(I)(B) and (II)(B). Contracts with the corporation or required by the corporation must not amend, modify, interfere with, or limit such rights of ownership. Such expirations, records, or other written or electronic information may be used to review an application, issue a policy, or for any other purpose necessary for placing such business through the program.

(b) May not be required to be appointed by any insurer participating in the program for policies written solely through the program, notwithstanding ~~the provisions of~~ s. 626.112.

(c) Must only facilitate the placement of an offer of coverage from an insurer whose limited servicing agreement is approved by that exclusive agent's exclusive insurer.

(d) May enter into a limited servicing agreement with the insurer making an offer of coverage, and only after the exclusive agent's insurer has approved the limited servicing agreement terms. The exclusive agent's insurer must approve a limited service agreement for the program for an ~~any~~ insurer for which it has approved a service agreement for other purposes.

Applicants ineligible for coverage in accordance with subsection (6) ~~(5)~~ remain ineligible if their exclusive agent is unwilling or unable to enter into a standard or limited agency agreement with an insurer making an offer of coverage to that applicant.

(12) An applicant for coverage from the corporation who was a policyholder of the corporation within the previous 36 months and who subsequently accepted an offer of coverage from a surplus lines insurer is considered a renewal under this section.

Section 3. Section 627.3519, Florida Statutes, is repealed.

Section 4. Section 627.35191, Florida Statutes, is amended to read:

627.35191 Required reports ~~Annual report of aggregate net probable maximum losses, financing options, and potential assessments~~.—

(1) By ~~No later than~~ February 1 of each year, the Florida Hurricane Catastrophe Fund and Citizens Property Insurance Corporation shall each submit a report to the Legislature and the Financial Services Commission identifying their respective aggregate net probable maximum losses, financing options, and potential assessments. The report issued by the fund and the corporation must include their respective 50-year, 100-year, and 250-year probable maximum losses; analysis of all reasonable financing strategies for each such probable maximum loss, including the amount and term of debt instruments; specification of the percentage assessments that would be needed to support each of the financing strategies; and calculations of the aggregate assessment burden on Florida property and casualty policyholders for each of the probable maximum losses.

(2) In May of each year, Citizens Property Insurance Corporation shall also provide to the Legislature and the Financial Services Commission a statement of the estimated borrowing capacity of the corporation for the next 12-month period, the estimated claims-paying capacity of the corporation, and the corporation's estimated balance as of December 31 of the current calendar year. Such estimates must take into account that the corporation, the Florida Hurricane Catastrophe Fund, and the Florida Insurance Guaranty Association may all be

concurrently issuing debt instruments following a catastrophic event.

Section 5. This act shall take effect July 1,2014.

INSURANCE & BANKING SUBCOMMITTEE

PCS for HB 1109 by Rep. Wood
Property Insurance

AMENDMENT SUMMARY
March 25, 2014

Amendment 1 by Rep. Santiago (Between Lines 340 & 341): Allows insurers to pay losses for older roofs on an actual cash value basis as long as disclosure is provided to the consumer and the consumer is provided an actuarially appropriate discount for not having roof losses paid at replacement cost.

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 Santiago offered the following:

Amendment (with title amendment)

Between lines 340 and 341, insert:

627.70115 Residential coverage; actual cash value for losses to roof covering.—

(1) For residential coverage, notwithstanding s. 627.7011, insurers other than the Citizens Property Insurance Corporation may issue a policy or endorsement, or renew a policy, providing that any loss relating to the property's roof covering that is repaired or replaced will be adjusted on the basis of actual cash value if the roof covering:

(a) Is constructed out of material other than tile, slate, clay, concrete, or metal.

(b) Is more than 20 but less than 25 years old.

(c) Has not been replaced within the previous 25 years.

(d) Has less than 3 years of remaining useful life as certified by a qualified inspector.

(2) For residential coverage, notwithstanding s. 627.7011, insurers other than the Citizens Property Insurance Corporation may issue a policy or endorsement, or renew a policy, providing that any loss relating to the property's roof covering that is repaired or replaced will be adjusted on the basis of actual cash value if the roof covering:

(a) Is constructed out of tile, slate, clay, concrete or metal.

(b) Is more than 45 but less than 50 years old.

(c) Has not been replaced within the previous 50 years.

(d) Has less than 3 years of remaining useful life as certified by a qualified inspector.

(3) For residential coverage, notwithstanding s. 627.7011, insurers other than the Citizens Property Insurance Corporation may issue a policy or endorsement or renew a policy providing that any loss relating to a mobile or manufactured home's roof covering that is repaired or replaced will be adjusted on the basis of actual cash value if the roof covering:

(a) Is more than 20 but less than 25 years old.

(b) Has not been replaced within the previous 25 years.

(c) Has less than 3 years of remaining useful life as certified by a qualified inspector.

(4) An insurer may adjust losses relating to roof covering on the basis of actual cash value as specified in subsections (1), (2) or (3) only if the following conditions are met:

(a) The insurer nonrenews a policy that require losses relating to roof covering that is repaired or replaced to be adjusted at replacement cost and offers a new policy that requires these losses to be adjusted on the basis of actual cash value. The insurer cannot renew a property insurance policy pursuant to s. 627.43141 to change the adjustment for losses related to roof covering from a replacement cost basis to an actual cash value basis.

(b) The policy including payment for losses related to roof covering at actual cash value must, on its face, include in boldfaced type no smaller than 18 points the following statement:

This policy pays actual cash value for any loss relating to the roof covering. Payment of actual cash value for losses relating to roof covering will not fully pay for the repair or replacement of your roof if there is major roof damage. There will be a significant difference between the insurance proceeds paid to you by your insurer for the roof damage and the cost you will incur to repair or replace your roof. Therefore, you may pay significant out of pocket costs for roof repair or replacement. Additionally, the insurer may require you, at your expense, to fully repair or replace your roof in order for the

insurer to continue to provide property insurance on this property.

(c) The agent of record on the policy must obtain an acknowledgment signed by the policyholder that the policyholder has read and understands the disclosure required in paragraph (b). This acknowledgment must be obtained at policy issuance and at each renewal.

(d) An insurer issuing a policy requiring the insurer to adjust losses relating to roof covering on an actual cash basis must provide the policyholder an actuarially reasonable premium credit or discount that reflects the expected cost savings associated with this policy.

(e) If the structure insured by a property insurance policy that requires insurers to adjust losses to roof covering on the basis of actual cash value is subject to a mortgage or lien, the policyholder must provide the insurer with a written statement from the mortgageholder or lienholder indicating that the mortgageholder or lienholder approves the policyholder electing a property insurance policy that adjusts losses to the roof covering on an actual cash basis.

(5) For purposes of this section, a person is a qualified inspector if the person is:

(a) A general, residential, building, or roofing contractor licensed under chapter 489;

(b) A building inspector licensed under chapter 468;

(c) An architect licensed under chapter 481; or

(d) A building code enforcement official licensed under chapter 468.

T I T L E A M E N D M E N T

Remove line 23 and insert:

Financial Services Commission; creating s. 627.70115, F.S.; providing that residential coverage for roof coverings for certain homes and mobile or manufactured homes may be adjusted on the basis of actual cash value; providing requirements; providing an effective

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1395 Bail Bonds
SPONSOR(S): Nelson
TIED BILLS: **IDEN./SIM. BILLS:** SB 854

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Salzverg	Cooper
2) Civil Justice Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

Current law allows individuals who are qualified, licensed, and appointed by the Department of Financial Services (DFS) to perform the functions of a bail bond agent or temporary bail bond agent. A bail bond agent must prove his or her suretyship when placing a bond by attaching currency in the amount of the bond or by attaching a power of attorney form issued by the insurance company he or she utilizes. The power of attorney form must be approved by DFS.

This bill amends Florida Statutes to explicitly allow for the electronic transmission of bail bonds by licensed bail bond agents in the judicial circuit and county which the bail bond agency is located, with the approval of the sheriff of the respective county. The bill requires the bail bond agent to have a physical location within the judicial circuit where the electronic bond is submitted. The bill expands the definition of "bail bond agency" to include an entity located in a judicial circuit that transmits electronic bonds, while clarifying that only a licensed, appointed, and registered bail bond agent may transmit an electronic bond with an attached power of attorney (which must be approved by the DFS).

The bill prohibits a licensed bail bond agent from authorizing another person to countersign his or her name to a bond or allow an unlicensed person or a licensed person not properly appointed to transmit or post an electronic bond.

This bill does not appear to have any fiscal impact on state or local governments. The DFS has stated that compliance with this bill would be absorbed into their current operations, with only minimal, if any, additional workload.

The bill provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Chapter 648 of the Florida Statutes governs the practices of bail bond agents. Currently, the Department of Financial Services (DFS) administers the provisions set forth in this chapter and is tasked with enforcement of rules and regulations.[1]

In order for a person to act in the capacity of a bail bond agent or temporary bail bond agent or perform any of the functions prescribed for bail bond agents, he or she must be qualified, licensed, and appointed by DFS.[2] In order for a bail bond agent to become a surety, he or she must register with the office of the sheriff and with the clerk of the circuit court in the county in which the bail bond agent resides.[3]

A bond agent must justify his or her suretyship by attaching a copy of the power of attorney issued by the surety/insurance company or by attaching currency to the bond, usually in the form of a money order or cashier's check. Every insurer engaged in the writing of bail bonds through bail bond agents must submit and have approved by DFS a sample power of attorney, which is the only form of power of attorney the insurer will issue to bail bond agents in the state.[4]

The current industry norm is for licensed bail bond agents to physically deliver the bond and power of attorney paperwork to the court or detention center.[5] Gadsden, Jefferson, and Madison counties accept electronic transmittal of bail bonds. To date, there have been no issues reported regarding the use of electronic transmittal in these counties.[6]

Effect of the Bill

This bill amends sections within chapter 648 and chapter 903 of the Florida Statutes to explicitly allow for the electronic transmission of bail bonds by licensed bail bond agents in the judicial circuit and county which the bail bond agency is located, with the approval of the sheriff of the respective county. The bill requires the bail bond agent to have a physical location within the judicial circuit where the electronic bond is submitted. The bill expands the definition of "bail bond agency" to include an entity located in a judicial circuit that transmits electronic bonds, while clarifying that only a licensed, appointed, and registered bail bond agent may transmit an electronic bond with an attached power of attorney.

Additionally, the bill requires that a sample power of attorney be attached to the electronic bond which must be approved by DFS before it can be used for submission. The power of attorney is designed to justify the bail bond agent's suretyship when electronically transmitting a bail bond.

The bill prohibits a licensed bail bond agent from authorizing another person to countersign his or her name to a bond. It also prohibits a licensed and appointed bail bond agent from being able to facilitate,

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[1] Section 648.26, F.S.
[2] Section 648.30, F.S.
[3] Section 648.42, F.S.
[4] Section 903.09, F.S.
[5] Information obtained from representatives of the Florida bail bond industry, as provided to the staff of the Insurance & Banking Subcommittee on March 17, 2014.
[6] Information obtained from the Department of Financial Services, March 17, 2014. On file with the Insurance & Banking Subcommittee staff.

or allow an unlicensed person or a licensed person not properly appointed to transmit or post an electronic bond.

B. SECTION DIRECTORY:

Section 1: Amends s. 648.25, F.S. Amends the definition of "bail bond agency" to include an entity that is physically located in a judicial circuit and that transmits electronic bonds. Defines the terms "delivery", "electronic bond", and "surety". Amends the definition of "temporary bail bond agent" to include "temporary licensee".

Section 2: Amends s. 648.30, F.S. Clarifies that a person may not transmit or post an electronic bond with attached power of attorney unless he or she is a duly qualified, licensed, and appointed bail bond agent.

Section 3: Amends s. 648.42, F.S. Clarifies that a duly qualified, licensed, appointed, and registered bail bond agent may transmit or post electronic bonds in the judicial circuit in which the agency is located if the sheriff agrees to accept such bonds.

Section 4: Amends s. 648.43, F.S. Provides that an electronic power of attorney must be attached to an electronic bond and be approved by the Department of Financial Services.

Section 5: Amends s. 648.44, F.S. Clarifies that a bail bond agent or temporary bail bond agent may not transmit or post an electronic bond with an attached power of attorney unless he or she is: a duly qualified, licensed, appointed, and registered bail bond agent, registered in the county within the judicial circuit, and has an agency physically located within the judicial circuit the bond is being submitted. Clarifies that a bail bond agent may not authorize another person to countersign his or her name to a bond, facilitate, or allow an unlicensed person or a person without a proper appointment to transmit or post an electronic bond.

Section 6: Amends s. 648.441, F.S. Provides that an insurer or managing general agent may not furnish to an unlicensed individual or entity a form necessary for the electronic transmittal or posting of electronic bonds.

Section 7: Amends s. 903.09, F.S. Provides the methods for which a bail bonds agent must justify their suretyship when posting an electronic bond. Clarifies that this section does not prohibit multiple sureties from each posting any portion of a bond amount and being liable for only that amount, so long as the total amount posted by the cosureties is equal to the amount of the bond required.

Section 8: Amends s. 903.101, F.S. Reiterates that a duly qualified, licensed, appointed, and registered bail bond agent may transmit or post an electronic bond in the judicial circuit in which the bail bond agency is located if the sheriff agrees to accept such electronic bonds.

Section 9: Amends s. 903.33, F.S. Clarifies that an electronic bond is considered an original document and may not be discharged on the ground that it is not such a document.

Section 10: Amends s. 903.34, F.S. Provides requirements for a bond to be approved by a committing trial court judge or the sheriff.

Section 11: 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:

   This bill does not appear to have any impact on state expenditures. The DFS has stated that compliance with this bill would be absorbed into their current operations, with only minimal, if any, additional workload.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

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

2. Expenditures:

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

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Bail bond agents may incur costs in opening an office within the judicial circuit where they plan to transmit electronic bonds, if they do not currently have a physical location within that judicial circuit.

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:

Section 10 requires the surety company to hold a certificate of authority with the Department of Financial Services. According to DFS, it should be changed to the Office of Insurance Regulation.

An amendment has been drafted to address this issue.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to bail bonds; amending s. 648.25, F.S.; revising and providing definitions; amending s. 648.30, F.S.; prohibiting a person from transmitting or posting an electronic bond with attached power of attorney unless he or she is duly qualified, licensed, and appointed as a bail bond agent; providing criminal penalties; amending s. 648.42, F.S.; authorizing a duly qualified, licensed, appointed, and registered bail bond agent to transmit electronic bonds within the judicial circuit in which the bail bond agency is located under certain circumstances; amending s. 648.43, F.S.; requiring the Department of Financial Services to approve a sample form for an electronic power of attorney to be attached to an electronic bond; amending s. 648.44, F.S.; prohibiting a bail bond agent or temporary bail bond agent from transmitting or posting an electronic bond with attached power of attorney under certain circumstances; prohibiting a bail bond agent from authorizing another person to countersign his or her name to a bond or power of attorney; prohibiting a bail bond agent from facilitating or allowing an unlicensed person or a person without proper appointment to transmit or post electronic bonds; providing a criminal penalty; amending s. 648.441,

F.S.; prohibiting an insurer or managing general agent from furnishing an unlicensed individual or entity a form necessary for transmitting or posting electronic bonds; providing criminal penalties; amending s. 903.09, F.S.; revising requirements for a bail bond agent to justify his or her suretyship to include electronic bonds; amending s. 903.101, F.S.; authorizing a qualified, licensed, appointed, and registered bail bond agent to transmit or post electronic bonds within the judicial circuit in which the bail bond agency is located under certain circumstances; amending s. 903.33, F.S.; providing that electronic bonds are considered original documents; amending s. 903.34, F.S.; providing requirements for a bond, posted in person or initiated electronically, to be approved by a committing trial court judge or the sheriff; providing an effective date.

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

Section 1. Section 648.25, Florida Statutes, is amended to read:

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

(1) "Bail bond agency" means:

(a) The building where a licensee maintains an office and

where all records required by ss. 648.34 and 648.36 are maintained; ~~or~~

(b) An entity that:

1. Charges a fee or premium to release an accused defendant or detainee from jail; ~~or~~

2. Engages in or employs others to engage in any activity that may be performed only by a licensed and appointed bail bond agent; or

(c) An entity that is physically located in a judicial circuit and that transmits electronic bonds. Such bonds may only be transmitted to a jail that is located in the same judicial circuit as the agency.

(2) "Bail bond agent" means a limited surety agent or a professional bail bond agent ~~as hereafter defined~~.

(3) "Delivery" means:

(a) Hand delivering a bond with attached power of attorney; or

(b) Electronic transmission of a bond with attached power of attorney.

(4) "Electronic bond" means a bond that is:

(a) Transmitted or posted electronically with attached power of attorney by delivery to a jail or place where a defendant is being held using a delivery method other than hand delivering the executed power of attorney and completed bond form to the facility.

(b) Originated through the surety company guaranteeing its

undertaking which is admitted to and authorized by this state and which possess a certificate of authority to underwrite bail bonds in this state.

(c) Filed using a computer program to transmit information electronically to another party.

(5) ~~(3)~~ "Managing general agent" means an ~~any~~ individual, partnership, association, or corporation appointed or employed by an insurer to supervise or manage the bail bond business written in this state by limited surety agents appointed by the insurer.

(6) ~~(4)~~ "Insurer" means a ~~any~~ domestic, foreign, or alien surety company which has been authorized to transact surety business in this state.

(7) ~~(5)~~ "Limited surety agent" means an ~~any~~ individual appointed by an insurer by power of attorney to execute or countersign bail bonds in connection with judicial proceedings who receives or is promised money or other things of value therefor.

(8) ~~(6)~~ "Primary bail bond agent" means a licensed bail bond agent who is responsible for the overall operation and management of a bail bond agency location and whose responsibilities include hiring and supervising all individuals within that location. A bail bond agent may be designated as primary bail bond agent for only one bail bond agency location.

(9) ~~(7)~~ "Professional bail bond agent" means a ~~any~~ person who pledges United States currency, United States postal money

orders, or cashier's checks as security for a bail bond in connection with a judicial proceeding and receives or is promised therefor money or other things of value.

(10) "Surety" means a property and casualty insurance company holding a certificate of authority to transact surety business in this state.

(11) ~~(8)~~ "Temporary bail bond agent" or "temporary licensee" means a person employed by a bail bond agent or agency, insurer, or managing general agent, and such licensee has the same authority as a licensed bail bond agent, including presenting defendants in court; apprehending, arresting, and surrendering defendants to the proper authorities, while accompanied by a supervising bail bond agent or an agent from the same bail bond agency; and keeping defendants under necessary surveillance. However, a temporary bail bond agent or temporary licensee may not execute or sign bonds, handle collateral receipts, or deliver bonds to appropriate authorities. A temporary bail bond agent or temporary licensee may not operate an agency or branch agency separate from the location of the supervising bail bond agent, managing general agent, or insurer by whom the temporary bail bond agent or licensee is employed. This does not affect the right of a bail bond agent or insurer to hire counsel or to obtain the assistance of law enforcement officers.

Section 2. Section 648.30, Florida Statutes, is amended to read:

648.30 Licensure and appointment required.—

(1) A person may not:

(a) Act in the capacity of a bail bond agent or temporary bail bond agent or perform any of the functions, duties, or powers prescribed for bail bond agents or temporary bail bond agents under this chapter unless that person is qualified, licensed, and appointed as provided in this chapter.

(b) ~~(2) A person may not~~ Represent himself or herself to be a bail enforcement agent, bounty hunter, or other similar title in this state.

(c) ~~(3) A person, other than a certified law enforcement officer, may not~~ Apprehend, detain, or arrest a principal on a bond, wherever issued, unless that person is qualified, licensed, and appointed as provided in this chapter; ~~or~~ licensed as a bail bond agent or bail bond enforcement agent; ~~,~~ or holds an equivalent license by the state where the bond was written.

(d) Transmit or post an electronic bond with attached power of attorney unless he or she is duly qualified, licensed, and appointed as a bail bond agent.

(2) ~~(4)~~ A ~~Any~~ person who violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 3. Section 648.42, Florida Statutes, is amended to read:

648.42 Registration of bail bond agents.—

(1) A bail bond agent may not become a surety on an

undertaking unless he or she has registered in the office of the sheriff and with the clerk of the circuit court in the county in which the bail bond agent resides. The bail bond agent may register in a like manner in any other county. A~~, and any~~ bail bond agent shall file a certified copy of his or her appointment by power of attorney from each insurer that ~~which~~ he or she represents as a bail bond agent with each of such officers. Registration and filing of a certified copy of renewed power of attorney shall be performed by April 1 of each odd-numbered year. The clerk of the circuit court and the sheriff may ~~shall~~ not permit the registration of a bail bond agent unless such bail bond agent is currently licensed and appointed by the department. ~~Nothing in~~ This section does not ~~shall~~ prevent the registration of a temporary licensee at the jail for the purposes of enabling the licensee to perform the duties under such license described ~~as set forth~~ in this chapter.

(2) A duly qualified, licensed, appointed, and registered bail bond agent may transmit or post electronic bonds in the judicial circuit in which the bail bond agency is located if the sheriff agrees to accept such electronic bonds.

Section 4. Subsection (1) of section 648.43, Florida Statutes, is amended to read:

648.43 Power of attorney; to be approved by department; filing of copies; notification of transfer bond.—

(1) Every insurer engaged in the writing of bail bonds through bail bond agents in this state shall submit and have

approved by the department ~~a~~ sample powers ~~power~~ of attorney, including an electronic power of attorney to be attached to an electronic bond, which will be the only forms ~~form~~ of powers ~~power~~ of attorney the insurer will issue to bail bond agents in this state.

Section 5. Paragraph (q) is added to subsection (1) of section 648.44, Florida Statutes, and subsection (3) and paragraph (a) of subsection (9) of that section are amended, to read:

648.44 Prohibitions; penalty.—

(1) A bail bond agent or temporary bail bond agent may not:

(q) Transmit or post an electronic bond with attached power of attorney unless he or she:

1. Is duly qualified, licensed, appointed, and registered as a bail bond agent as provided in this chapter.

2. Is registered in the county within the judicial circuit.

3. Has an agency physically located in the judicial circuit in which the bond is being transmitted.

(3) A bail bond agent may not:

(a) Sign or countersign in blank any bond or otherwise authorize another person to countersign his or her name to a bond; or~~, give a power of attorney to, or otherwise authorize, anyone to countersign his or her name to bonds unless the person so authorized is a licensed and appointed bail bond agent~~

~~directly employed by the bail bond agent giving such power of attorney.~~

(b) Facilitate or allow an unlicensed person or a person without a proper appointment to transmit or post an electronic bond.

(9)(a) A ~~Any~~ person who violates a ~~any~~ provision ~~provisions~~ of paragraph (1)(e), paragraph (1)(f), paragraph (1)(g), paragraph (1)(j), ~~or~~ paragraph (1)(n), or paragraph (1)(q), or subsection (2) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 6. Section 648.441, Florida Statutes, is amended to read:

648.441 Furnishing supplies to unlicensed bail bond agent prohibited; civil liability and penalty.—

(1) An insurer, managing general agent, bail bond agent, or temporary bail bond agent appointed under this chapter may not furnish to any person any blank forms, applications, stationery, business card, or other supplies to be used in soliciting, negotiating, or effecting bail bonds until such person has received from the department a license to act as a bail bond agent and is appointed by the insurer. This section does not prohibit an unlicensed employee, under the direct supervision and control of a licensed and appointed bail bond agent, from possessing or executing in the bail bond agency, any forms, except for powers of attorney, bond forms, and collateral receipts, while acting within the scope of his or her

employment.

(2) An insurer or managing general agent may not furnish to an unlicensed individual or entity a form necessary for the electronic transmittal or posting of electronic bonds.

(3) ~~(2)~~ An ~~Any~~ insurer, licensee, or appointee who furnishes to any bail bond agent or other person not named or appointed by the insurer represented any of the supplies specified ~~mentioned~~ in subsection (1) and accepts any bail bond business from or writes any bail bond business for such bail bond agent, person, or agency is subject to civil liability to any insured of such insurer or indemnitor to the same extent and in the same manner as if such bail bond agent or other person had been appointed or authorized by the insurer, managing general agent, or bail bond agent to act in its or his or her behalf by the department.

(4) ~~(3)~~ A ~~Any~~ person who violates this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, except that the violator is subject to a fine of up to ~~not to exceed~~ $5,000 in addition to, or in lieu of, any term of imprisonment.

Section 7. Section 903.09, Florida Statutes, is amended to read:

903.09 Justification of sureties.—

(1) A surety shall execute an affidavit stating that she or he possesses the qualifications and net worth required to become a surety. The affidavit shall describe the surety's

property and any encumbrances and shall state the number and amount of any bonds entered into by the surety at any court that remain undischarged.

(2) A bail bond agent, as defined in s. 648.25(2), shall justify her or his suretyship by any of the following:

(a) Attaching the original ~~attaching a copy of the~~ power of attorney issued by the company bearing an original signature of a duly qualified, licensed, appointed, and registered bail bond agent to the bond ~~to the bond or by attaching to the bond United States currency, a United States postal money order, or a cashier's check in the amount of the bond; but the United States currency, United States postal money order, or cashier's check cannot be used to secure more than one bond. Nothing herein shall prohibit two or more qualified sureties from each posting any portion of a bond amount, and being liable for only that amount, so long as the total posted by all cosureties is equal to the amount of bond required~~.

(b) Transmitting or posting electronic bonds from the surety company of the executed power of attorney, if allowed by the sheriff.

(c) Attaching to the bond United States currency, a United States postal money order, or a cashier's check in the amount of the bond; however, the United States currency, United States postal money order, or cashier's check may not be used to secure more than one bond.

(3) This section does not prohibit two or more qualified

sureties from each posting any portion of a bond amount and being liable for only that amount, so long as the total posted by all cosureties is equal to the amount of bond required.

Section 8. Section 903.101, Florida Statutes, is amended to read:

903.101 Sureties; licensed persons; to have equal access.—Subject to rules adopted by the Department of Financial Services and by the Financial Services Commission, each ~~every~~ surety who meets the requirements of ss. 903.05, 903.06, 903.08, and 903.09, and each ~~every~~ person who is currently licensed by the Department of Financial Services and registered as required by s. 648.42 shall have equal access to the jails of this state for the purpose of making bonds. A duly qualified, licensed, appointed, and registered bail bond agent may transmit or post electronic bonds in the judicial circuit in which the bail bond agency is located if the sheriff agrees to accept such electronic bonds.

Section 9. Section 903.33, Florida Statutes, is amended to read:

903.33 Bail not discharged for certain defects.—The liability of a surety is ~~shall~~ not be affected by his or her lack of any qualifications required by law, any agreement not expressed in the undertakings, or the failure of the defendant to join in the bond. An electronic bond is considered an original document and may not be discharged on the ground that it is not such a document.

Section 10. Section 903.34, Florida Statutes, is amended to read:

903.34 Who may admit to bail.—

(1) In criminal actions instituted or pending in a ~~any~~ state court, bonds given by defendants before trial until appeal shall be approved by a committing trial court judge or the sheriff. The bond must:

(a) Be posted in person by a duly qualified, licensed, appointed, and registered bail bond agent pursuant to s. 648.42 by attaching to the bond a power of attorney in a form approved by the Department of Financial Services and issued by a qualified surety insurance company for whom a certificate of authority has been issued by the Department of Financial Services; or

(b) Be transmitted and posted as an electronic bond as defined in s. 648.25 by a duly qualified, licensed, appointed, and registered bail bond agent pursuant to s. 648.42. The transmittal or posting of an electronic bond must originate through the surety company guaranteeing its undertaking. The surety company must electronically transmit the bond and power of attorney on forms approved by the Department of Financial Services for the qualified surety insurance company for whom a certificate of authority has been issued by the Department of Financial Services; and

1. The sheriff must agree to accept the transmittal and posting of an electronic bond and attached power of attorney.

2. The transmittal and posting of an electronic bond and attached power of attorney must be originated by a duly qualified, licensed, appointed, and registered bail bond agent whose office and agency is physically located in the county where the bond is to be posted.

(2) Appeal bonds shall be approved as provided in s. 924.15.

Section 11. This act shall take effect July 1, 2014.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB IBS 14-02 Public Records and Meetings/Insurance Flood Loss Model
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

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

SUMMARY ANALYSIS

PCB IBS 14-02 (PCB) is linked with HB 879, which is designed to attract private insurers to write flood insurance in Florida. Among its provisions, HB 879 allows flood losses to be projected by a flood model found acceptable or reliable by the Florida Commission on Hurricane Loss Projection (Commission). It also requires the Commission to adopt, by July 1, 2016, actuarial methods, principals, standards, models, or output ranges for flood loss to be used in setting rates for personal lines residential flood coverage.

With respect to flood loss models, the PCB makes the following confidential and exempt from public disclosure:

- Trade secrets used in designing and constructing a flood loss model and provided by a private company pursuant to s. 627.0628, F.S., to the Commission, the Office of Insurance Regulation, or consumer advocate.
- That portion of a Commission meeting or of a rate proceeding on an insurer's rate filing at which trade secrets used in designing and constructing a flood loss model are discussed. Although such portion of a meeting must be recorded, the recording is confidential and exempt from public disclosure.

Current law provides these exemptions for trade secrets in hurricane loss models under s.627.0628(3), F.S.

The PCB provides for repeal of the exemptions on October 2, 2019, unless reviewed and saved from repeal by the Legislature. It also provides a statement of public necessity as required by the State Constitution.

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

The PCB is effective upon becoming a law if HB 879 or similar legislation introduced during the 2014 Legislative Session is enacted into law. It does not appear to have a fiscal impact on state or local governments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

The State of Florida has a long history of providing public access to governmental records and meetings. The Florida Legislature enacted the first public records law in 1892.[1] One hundred years later, Floridians adopted an amendment to the State Constitution that raised the statutory right of access to public records to a constitutional level.[2] Article I, s. 24, of the State Constitution, provides that:

> (a) Every person has the right to inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except with respect to records exempted pursuant to this section or specifically made confidential by this Constitution. This section specifically includes the legislative, executive, and judicial branches of government and each agency or department created thereunder; counties, municipalities, and districts; and each constitutional officer, board, and commission, or entity created pursuant to law or this Constitution.

In addition to the State Constitution, the Public Records Act,[3] which pre-dates the State Constitution's public records provisions, specifies conditions under which public access must be provided to records of an agency.[4] Section 119.07(1)(a), F.S., states:

> Every person who has custody of a public record shall permit the record to be inspected and copied by any person desiring to do so, at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public records.

Unless specifically exempted, all agency records are available for public inspection. The term "public record" is broadly defined to mean:

> [A]ll documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency.[5]

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business which are used to perpetuate, communicate, or formalize knowledge.[6] All such materials, regardless of whether they are in final form, are open for public inspection unless made exempt.[7]

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[1] Section 1390, 1391 F.S. (Rev. 1892).
[2] Fla. Const. art. I, s. 24.
[3] Chapter 119, F.S.
[4] The word "agency" is defined in s. 119.011(2), F.S., to mean "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency." The Florida Constitution also establishes a right of access to any public record made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except those records exempted by law or the State Constitution. *See supra* fn. 3.
[5] Section 119.011(12), F.S.
[6] *Shevin v. Byron, Harless, Schaffer, Reid and Associates, Inc.*, 379 So. 2d 633, 640 (Fla. 1980).
[7] *Wait v. Florida Power & Light Co.*, 372 So. 2d 420 (Fla. 1979).

There is a difference between records that the Legislature has made exempt from public inspection and those that are *confidential* and exempt. If the Legislature makes a record confidential and exempt, such information may not be released by an agency to anyone other than to the persons or entities designated in the statute.[8] If a record is simply made exempt from disclosure requirements, an agency is not prohibited from disclosing the record in all circumstances.[9]

Only the Legislature is authorized to create exemptions to open government requirements.[10] Exemptions must be created by general law, and such law must specifically state the public necessity justifying the exemption. Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law.[11] A bill enacting an exemption[12] may not contain other substantive provisions, although it may contain multiple exemptions that relate to one subject.[13]

Open Government Sunset Review Act

The Open Government Sunset Review Act (Act)[14] provides for the systematic review, through a 5-year cycle ending October 2 of the fifth year following enactment, of an exemption from the Public Records Act or the Public Meetings Law.

The Act states that an exemption may be created, revised, or expanded only if it serves an identifiable public purpose and if the exemption is no broader than necessary to meet the public purpose it serves.[15] An identifiable public purpose is served if the exemption meets one of three specified criteria and if the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption. An exemption meets the three statutory criteria if it:

- 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 information of a confidential nature concerning entities, including, but not limited to, a formula, pattern, device, combination of devices, or compilation of information that is used to protect or further a business advantage over those who do not know or use it, the disclosure of which would injure the affected entity in the marketplace.[16]

While the standards in the Open Government Sunset Review Act may appear to limit the Legislature in the exemption review process, those aspects of the Act are only statutory, as opposed to constitutional. Accordingly, the standards do not limit the Legislature because one session of the Legislature cannot bind another.[17] The Legislature is only limited in its review process by constitutional requirements.

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[8] Florida Attorney General Opinion 85-62.
[9] *Williams v. City of Minneola*, 575 So. 2d 683, 687 (Fla. 5th DCA 1991), *review denied*, 589 So. 2d 289 (Fla. 1991).
[10] *Supra* fn. 1.
[11] *Memorial Hospital-West Volusia v. News-Journal Corporation*, 784 So. 2d 438 (Fla. 2001); *Halifax Hospital Medical Center v. News-Journal Corp.*, 724 So. 2d 567, 569 (Fla. 1999).
[12] Under s. 119.15, F.S., an existing exemption may be considered a new exemption if the exemption is expanded to cover additional records.
[13] *Supra* fn. 1.
[14] Section 119.15, F.S.
[15] Section 119.15(6)(b),F.S.
[16] *Id.*
[17] *Straughn v. Camp*, 293 So. 2d 689, 694 (Fla. 1974).

Florida Commission on Hurricane Loss Projection

In 1995 the Legislature established the Florida Commission on Hurricane Loss Projection (Commission) to serve as an independent body within the State Board of Administration.[18] The Commission is comprised of 12 members. Members include experts in insurance finance, statistics, computer system design, structural engineering, and meteorology who are full-time faculty members in the State University System, three actuaries, the Executive Director of Citizens Property Insurance Corporation, the senior employee responsible for Florida Hurricane Catastrophe Fund operations, the Insurance Consumer Advocate, and the Director of Emergency Management. The Commission sets standards for hurricane loss projection methodology and examines the methods employed in proprietary hurricane loss models used by private insurers in setting property insurance rates to determine whether they meet the Commission's standards.

The Commission adopts findings on the accuracy or reliability of the methods, standards, principles, models and other means used to project hurricane losses. Only hurricane loss models or methods the Commission deems accurate or reliable can be used by insurers in rate filings to estimate hurricane losses used to set property insurance rates.

Hurricane Loss Models and Trade Secrets

Florida law provides the following public records/public meetings exemptions for trade secrets[19] in hurricane loss models:[20]

- Trade secrets used in designing and constructing a hurricane loss model and provided by a private company pursuant to s. 627.0628, F.S., to the Commission, the Office of Insurance Regulation, or consumer advocate are confidential and exempt from s. 119.07(1), F.S., and s 24(a), Art. I of the State Constitution.
- That portion of a Commission meeting or of a rate proceeding on an insurer's rate filing at which trade secrets used in designing and constructing a hurricane loss model are discussed is exempt from s. 286.011, F.S., and s. 24(b), Art. I of the State Constitution, but must be recorded. The recording of the closed portion of the meeting is exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

Use of Flood Models to Set Flood Rates

PCB IBS 14-02 (PCB) is linked with HB 879, which is designed to attract private insurers to write flood insurance in Florida. To support a flood insurance rate for those filed with and approved by the Office of Insurance Regulation (OIR) before use, HB 879 allows flood losses to be projected by a flood model found acceptable or reliable by the Commission. For flood rates not filed with or approved by the OIR, if the OIR examines the rates after use, it will consider whether the insurer's flood rates were set based on flood losses projected by a Commission-approved model. HB 879 also expands the Commission's duties to require the Commission to adopt, by July 1, 2016, actuarial methods, principals, standards, models, or output ranges for flood loss to be used in setting rates for personal lines residential flood coverage. This is consistent with the Commission's duties relating to hurricane loss.

Effect of the PCB

The PCB extends the exemptions for trade secrets in hurricane loss models set forth above in the section entitled "Hurricane Loss Models and Trade Secrets" to trade secrets in flood loss models. Specifically, the following is made confidential and exempt from public disclosure:

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[18] The Commission is created in s. 627.0628, F.S. This statute also provides the composition and duties of the Commission.

[19] Section 688.002, F.S., defines a trade secret as information, including a formula, pattern, compilation, program, device, method, technique, or process that: (a) Derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

[20] See ch. 2005-264, L.O.F.; s. 627.0628(3)(f), F.S.

- Trade secrets used in designing and constructing a flood loss model and provided by a private company pursuant to s. 627.0628, F.S., to the Commission, OIR, or consumer advocate are confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.
- That portion of a Commission meeting or of a rate proceeding on an insurer's rate filing at which trade secrets used in designing and constructing a flood loss model are discussed is exempt from s. 286.011, F.S., and s. 24(b), Art. I of the State Constitution, but must be recorded. The recording of the closed portion of the meeting is exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

The PCB provides for repeal of the exemptions on October 2, 2019, unless reviewed and saved from repeal by the Legislature. It also provides a statement of public necessity as required by the State Constitution.

B. SECTION DIRECTORY:

Section 1. Amends s. 627.0628, F.S., relating to the Florida Commission on Hurricane Loss Methodology; public records exemption; public meetings exemption. .
Section 2. Sets forth legislative findings that the newly created public records exemptions and public meeting exemption for trade secrets in flood loss models are a public necessity.
Section 3. Provides for the bill to take effect upon becoming a law if HB 879 or similar legislation is adopted during the 2014 Legislative Session.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The PCB should benefit consumers because it will facilitate the development of flood loss models which will be used by insurers to offer flood insurance policies that may ultimately compete in price and coverage options with the National Flood Insurance Program.

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 public records and meetings; amending s. 627.0628, F.S.; providing an exemption from public records and public meetings requirements for trade secrets used to design an insurance flood loss model held in records or discussed in meetings of the Florida Commission on Hurricane Loss Projection Methodology, the Office of Insurance Regulation, or the appointed consumer advocate; providing for legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Paragraph (f) of subsection (3) of section 627.0628, Florida Statutes, is amended to read:

627.0628 Florida Commission on Hurricane Loss Projection Methodology; public records exemption; public meetings exemption.—

(3) ADOPTION AND EFFECT OF STANDARDS AND GUIDELINES.—

(f)1. A trade secret, as defined in s. 688.002, which ~~that~~ is used in designing and constructing a hurricane or flood loss model and which ~~that~~ is provided pursuant to this section, by a private company, to the commission, office, or consumer advocate

appointed pursuant to s. 627.0613~~,~~ is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

2.a. That portion of a meeting of the commission or of a rate proceeding on an insurer's rate filing at which a trade secret made confidential and exempt by this paragraph is discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution. The closed meeting must be recorded, and no portion of the closed meeting may be off the record.

b. The recording of a closed portion of a meeting is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

c. This paragraph ~~subparagraph~~ is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2019 ~~2015~~, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that a trade secret, as defined in s. 688.002, Florida Statutes, which is used in designing and constructing a flood loss model and which is provided by a private company to the Florida Commission on Hurricane Loss Projection Methodology, the Office of Insurance Regulation, or a consumer advocate appointed pursuant to s. 627.0613, Florida Statutes, be made confidential and exempt from public records requirements and from public meetings requirements.

(1) Disclosing trade secrets would negatively impact the

business interests of a private company that has invested substantial economic resources in developing such model, and competitor companies would gain an unfair competitive advantage if provided access to such information. Reliable projections of flood losses are necessary in order to ensure that rates for flood insurance meet the statutory requirement that rates must not be excessive, inadequate, or unfairly discriminatory. This goal is served by enabling the commission, the office, and the consumer advocate to have access to all aspects of flood loss models and by encouraging private companies to submit such models to the commission, office, and consumer advocate for review without concern that trade secrets will be disclosed through a public records request.

(2) In addition, the Legislature finds that it is a public necessity to protect trade secrets relating to such model which are discussed during a meeting of the commission or during a rate proceeding on an insurer's rate filing held by the office, because the release of such information via a public meeting or proceeding would allow competitors and other persons to attend those meetings and discover the protected trade secrets and would defeat the purpose of the public records exemption. The Legislature also finds that it is a public necessity to exempt from public records requirements the recordings generated during those portions of a commission meeting or a rate proceeding at which confidential and exempt trade secrets are discussed. Release of such recordings would compromise the discussions that

take place during the closed meeting or proceeding and would negate the public meetings exemption. Current law provides a public records exemption for trade secrets. As such, release of the recordings generated during those closed portions of a meeting or proceeding on trade secrets would compromise the current protections already afforded to trade secrets.

Section 3. This act shall take effect upon becoming a law if HB 879 or similar legislation is adopted in the same legislative session or an extension thereof and becomes a law.